Quality Standards

Anxiety Disorders

Care in All Settings

Health Quality Ontario

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About This Quality Standard

The following 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 includes content that is relevant for children and adolescents (under age 18 years).

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, 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

Quality standards are developed by Health Quality Ontario, in collaboration with health care professionals, patients, and caregivers across Ontario.

For more information, contact qualitystandards@hqontario.ca.

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the Patient Declaration of Values for Ontario. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

Health care professionals should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. It is important for care to be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis peoples. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social

harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guideline sources developed by groups that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

This quality standard is underpinned by the principle of recovery, as described in the Mental Health Strategy for Canada. People with an anxiety disorder can lead meaningful lives. People with an anxiety disorder have a right to services provided in an environment that promotes hope, empowerment, self-determination, and optimism, and that are embedded in the values and practices associated with recovery-oriented care.[1] 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".[2] 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".[1]

Mental wellness is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as individuals have: purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.[3] These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The First Nations Mental Wellness Continuum Framework provides an approach that "respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing".[3]

Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for people with an anxiety disorder.

Quality Statement 1: Identification
People suspected to have an anxiety disorder are identified early 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 had a positive screening result for an anxiety disorder, receive a timely comprehensive assessment to determine 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.

Quality Statement 3: Support for Family
People with an anxiety disorder are encouraged to involve their family during their assessment and treatment, considering individual needs and preferences. Family members are connected to available resources and supports and provided with psychoeducation.

Quality Statement 4: Stepped-Care Approach
People with an anxiety disorder receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first, based on symptom severity, level of functional impairment, and individual needs and preferences.

Quality Statement 5: 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 their individual needs and preferences and in alignment with a stepped-care approach.

Quality Statement 6: Cognitive Behavioural Therapy
People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences and in alignment with a stepped-care approach. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.

Quality Statement 7: 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 and in alignment with a stepped-care approach.

Quality Statement 8: 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 their clinical presentation.

Quality Statement 9: Support During Initial Treatment Response
People with an anxiety disorder are informed about what to expect and supported during their initial treatment response. When initial treatment is not working, people with an anxiety disorder are reassessed. They are offered other treatment options, considering their individual needs and preferences and in alignment with a stepped-care approach.

Quality Statement 10: 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 expertise in anxiety disorders.

Quality Statement 11: Relapse Prevention
People with an anxiety disorder who are receiving treatment are provided with information and education about how to prevent relapse and manage symptoms if they re-emerge.

Quality Statement 12: Transitions in Care
People with an anxiety disorder are given appropriate care throughout their lifespan and experience seamless transitions between services and health care professionals, including between care settings and from child and adolescent services to adult services.

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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 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).

Few clinical practice guidelines were available to support the development of a comprehensive quality standard for children and adolescents. In this standard, guidance is provided where relevant clinical practice guideline recommendations and content for children and adolescents were available.

This quality standard uses the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*) categorization of anxiety disorders[4]:

- **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 [of escape being difficult or help not being available when needed in the event of having panic-like symptoms] … 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 (including post-traumatic stress disorder).

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

Why This Quality Standard Is Needed

Anxiety disorders are characterized by excessive and persistent feelings of worry or fear. The most common mental health disorder are anxiety disorders.[5] The prevalence of anxiety disorders (including obsessive–compulsive disorder and post-traumatic stress disorder) in Canada was 4.9% in 2015.[6] In the United States, 32% of people have had an anxiety disorder

at some time in their life (lifetime prevalence).[7] In Ontario, 2.5% of adults have experienced generalized anxiety disorder.[8]

Anxiety disorders have a substantial effect on those with a disorder and their families, contributing to poorer quality of life.[9,10] Anxiety disorders can lead to significant distress and functional impairment for people living with them.[11] The incident cases of social phobia, panic disorder, and agoraphobia in Ontario were approximately 9,000, 21,000, and 1,500 per year, respectively; these had an impact on people's health and function that equated to losses of approximately 33,000, 10,000, and 5,300 health-adjusted life-years, respectively.[8]

Anxiety disorders also contribute to considerable economic burden.[9,10,12] Anxiety has been estimated to cost the Canadian economy $17.3 billion a year due to lost productivity.[13] In 2015, Canada's estimated public and private expenditure on mental health, including anxiety disorders, was $15.8 billion.[14]

In 2017/18, 81% of those admitted to hospital in Canada with a mental health or addictions condition were admitted through the emergency department (ED).[14] Rates of people with ED visits attributable to anxiety disorders vary across Ontario. In 2018, there was a nearly a threefold difference between the local health integration networks (LHINs) with the highest and lowest rates of adults with ED visits for anxiety (593 per 100,000 population in the North East LHIN, compared with 198 per 100,000 population in the Central LHIN [NACRS, provided by ICES, 2019*, Statistics Canada[15]]). For people who visited the ED for an anxiety disorder, the rates of unscheduled ED revisits within 30 days for mental health and addictions varied across Ontario. There was an 1.5-fold difference between the LHINs with the highest and lowest rates of ED visits for an anxiety disorder that were followed within 30 days by an unscheduled visit to the ED for mental health and addictions (13.0% for the Central West LHIN compared with 20.7% for the Toronto Central and North West LHINs; NACRS, provided by ICES, 2019*).

In 2018, 32.5% of adults and 38.0% of children and youth in Ontario had their first contact for an anxiety disorder in the ED, which means that they had not accessed mental health or addictions services from a physician in the 2 years prior to that (NACRS, DAD, OMHRS, and OHIP Claims Database, provided by ICES, 2019*). This finding may reflect people getting care from providers who are not physicians, people unable to access mental health and addictions services delivered by physicians, and potential missed opportunities for mental health services in primary and community care.[11] Rates of first contact in the ED for an anxiety disorder were higher in rural areas (NACRS, DAD, OMHRS, and OHIP Claims Database, provided by ICES, 2019*).

Furthermore, in Ontario, only about one-third of patients admitted to hospital for an anxiety disorder (including OCD) 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 home.[16]

Several equity factors—including gender, age, income, Indigenous identity, and geography—may affect specific populations with anxiety disorders. Women have high prevalence rates and are more likely to have an anxiety disorder than men. Older adults with anxiety often present and describe symptoms differently from younger people, making detection more difficult. The lowest neighbourhood income quintile had the highest proportion of people who reported a

*DAD, Discharge Abstract Database; NACRS, National Ambulatory Care Reporting System; ICES, Institute for Clinical Evaluative Sciences; OHIP, Ontario Health Insurance Plan; OMHRS, Ontario Mental Health Reporting System.

diagnosis of an anxiety disorder or obsessive–compulsive disorder (Canadian Community Health Survey, Mental Health, 2012). As well, more people in rural areas reported a diagnosis of an anxiety disorder or obsessive–compulsive disorder than people in urban areas (7.5% versus 4.8%, respectively; Canadian Community Health Survey, Mental Health, provided by the Institute for Clinical Evaluative Sciences, 2012). In 2017, fewer mental health workers were available in rural areas than in urban areas.[14]

There are significant opportunities, through the delivery of high-quality health care, to improve care in Ontario for people living with anxiety disorders. Anxiety disorders are underdiagnosed and undertreated.[10] The median time between the onset of a person's symptoms and the person seeking care is 16.1 years[17]; and even among people diagnosed with anxiety and related disorders, about 40% are untreated.[10] Earlier identification and diagnosis are key first steps to accessing appropriate evidence-based treatment.[10,17]

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources are included below.

For Patients

This quality standard consists of quality statements. These describe what high-quality care looks like for people with an anxiety disorder.

Within each quality statement, we've included information on what these statements mean for you, as a patient.

In addition, you may want to download this accompanying patient guide on anxiety disorders, to help you and your family have informed conversations with your health care providers. Inside, you will find questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people with an anxiety disorder.

They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions (Appendix 2) to help you assess the quality of care you are delivering, and identify gaps in care and areas for

improvement. While it is not mandatory to use or collect data when using a quality standard to improve care, measurement is key to quality improvement.

There are also a number of resources online to help you, including:

- Our patient guide on anxiety disorder, which you can share with patients and families to help them have conversations with you and their other health care providers. Please make the patient guide available where you provide care
- Our measurement resources, which include our data tables to help you identify gaps in care and inform your resource planning and improvement efforts; our measurement guide of technical specifications for the indicators in this standard; and our "case for improvement" slide deck to help you to share why this standard was created and the data behind it
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where health care providers can share information, inform, and support each other, and it includes tools and resources to help you implement the quality statements within each standard
- Quality Improvement Plans, which can help your organization outline how it will improve the quality of care provided to your patients, residents, or clients in the coming year

While you implement this quality standard, there may be times you find it challenging to provide the care outlined due to system-level barriers. Appendix 1 provides our recommendations to provincial partners to help remove these barriers so you can provide high-quality care. In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

How to Measure Overall Success

The Anxiety Disorders and Obsessive–Compulsive Disorder Quality Standards Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with an anxiety disorder in Ontario. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

See Appendix 2 for additional details on how to measure these indicators and our measurement guide for more information and support.

Indicators That Can Be Measured Using Provincial Data

- Percentage of people with an unscheduled ED visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care
- Percentage of repeat unscheduled ED visits 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 an anxiety disorder. See the section below on local measurement for additional indicators that may be used to assess quality of care.

Indicators That Can Be Measured Using Only Local Data

- Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result 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 for whom cognitive behavioural therapy (CBT) was determined to be appropriate and who receive disorder-specific 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 CBT and have reliable recovery‡
- Percentage of people with an anxiety disorder who complete CBT and have reliable improvement‡

†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/

‡As measured by anxiety disorder-specific validated severity-rating scales before treatment is initiated and after treatment is completed. Please see quality statement 1 for more information about the scales.

Quality Statements to Improve Care: The Details

Quality Statement 1: Identification

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

Definitions

People suspected to have an anxiety disorder: People who present 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.

Identified early: Identification of a possible anxiety disorder should occur as early as possible (early after symptoms emerge, and early in life). People identified as having a possible anxiety disorder require further evaluation or referral to a health care professional who can conduct a more comprehensive assessment (see quality statement 2). Use of validated screening tools, recognized screening questions, and validated severity-rating scales is intended for people who present with symptoms typical of anxiety disorder or to rule out an anxiety disorder before making a diagnosis.

Validated screening tool: The following are examples of validated screening tools.

- Specific phobia: Specific Phobia Questionnaire[18] (SPQ)
- Social anxiety disorder: 3-item Mini-Social Phobia Inventory[19] (Mini-SPIN)
- Generalized anxiety disorder: Generalized Anxiety Disorder 7-item scale[20] (GAD-7)
- Panic disorder: Panic Disorder Severity Scale[21] (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?[22]
- Are you fearful or embarrassed in social situations?[22]
- Does fear of embarrassment cause you to avoid doing things or speaking to people?[10]
- Do you avoid activities in which you are the centre of attention?[10]
- Is being embarrassed or looking stupid among your worst fears?[10]

For generalized anxiety disorder[10]:

- 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[10]:

- 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?

For specific phobia:

- Do you find yourself avoiding situations, objects, or animals because you are afraid of something that might happen?

Validated severity-rating scales: Many validated severity-rating scales are available to measure the severity of symptoms for the different anxiety disorders, including the following examples:

- Specific phobia: Severity Measure for Specific Phobia[23]
- Social anxiety disorder: Social Phobia Inventory[24] (SPIN)
- Generalized anxiety disorder: Generalized Anxiety Disorder 7-item scale[20] (GAD-7) and the Penn State Worry Questionnaire[25] (PSWQ)
- Panic disorder: Panic Disorder Severity Scale[21] (PDSS)
- Agoraphobia: Panic and Agoraphobia Scale[25] (PAS), Mobility Inventory for Agoraphobia[27] (MI)
- A specific anxiety disorder in the pediatric population: Revised Children's Anxiety and Depression Scale[28] (RCADS), Multidimensional Anxiety Scale for Children[28] (MASC), Panic Disorder Severity Scale for Children[30] (PDSS-C) and for Adolescents (PDSS-A), Liebowitz Social Anxiety Scale for Children and Adolescents[30] (LSAS-CA), Social Phobia and Anxiety Inventory for Children[32] (SPAIC-C)
- A specific anxiety disorder in a special population: Perinatal Anxiety Screening Scale[33] (PASS), Geriatric Anxiety Inventory[34] (GAI)

Sources: British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

Anxiety disorders are underdiagnosed and undertreated. Studies report that approximately 40% of people diagnosed with anxiety and related disorders are untreated.[1] 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,[10,36] but this depends on the type of phobia
- Social anxiety disorder: 11 years old[37]
- Generalized anxiety disorder: 33 years old[10]
- Panic disorder: 30 years old[37]
- Agoraphobia: 21 years old[37]

By itself, identification does not provide a diagnosis of an anxiety disorder; however, it does provide preliminary documentation of symptoms and quantify severity in a time-limited setting, and it indicates who may need further assessment (see quality statement 2).

Timely diagnostic clarity 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 applicability of validated tools for assessment of specific populations; factors to consider include age and developmental stage, language, cultural relevance, and cognitive ability.

For children and adolescents, screening questions should include developmentally appropriate language[38] and be based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*). In addition to the young person's self-report, information from parents and other sources (e.g., teachers) can help describe the impact of the patient's anxiety on family members and at school.[38]

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
When your patient presents with symptoms that you suspect could be an anxiety disorder, use a validated screening tool (when available) or recognized screening questions, and use validated severity-rating scales to identify people who would benefit from further comprehensive assessment and appropriate treatment.

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

Quality Indicators: How to Measure Improvement for This Statement

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

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 2: Comprehensive Assessment

People suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, receive a timely comprehensive assessment to determine 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.

Definitions

People who have had a positive screening result for an anxiety disorder: People identified for further comprehensive assessment to determine if they have an anxiety disorder. People are identified using a validated screening tool or recognized screening questions, and a validated severity-rating scale (see quality statement 1).

Timely comprehensive assessment: The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee agreed that, ideally, comprehensive assessment based on the criteria from the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*)[4] should occur within 4 to 8 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. Assessments are communicated in accessible language for the patient.

The time frame 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 can still conduct a comprehensive assessment using validated tools to help people suspected to have an anxiety disorder to be triaged to the most appropriate care. Health care professionals should let people know their qualifications when they conduct the assessment.

Severity of symptoms: Assessed using a validated severity-rating scale for the specific type of anxiety disorder (based on the list provided in the Definitions section of quality statement 1).

Comorbid conditions: People with an anxiety disorder may 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 (e.g., depression, bipolar disorder) or other mental health disorder, attention-deficit/hyperactivity disorder, psychosis, autism, and other anxiety disorders. More than half of people with an anxiety disorder have multiple anxiety disorders.[10,21,35]

Associated functional impairment: May include a person's level of distress and impairment, any physical symptoms, or effects on their quality of life. The following are examples of validated tools to assess functional impairment: Illness Intrusiveness Rating Scale, the World Health Organization Disability Assessment Schedule (WHODAS), or the Work and Social Adjustment Scale (WSAS).

Sources: American Academy of Child and Adolescent Psychiatry, 2007[38] | British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

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. Other physical illnesses or physical substances can mimic or cause anxiety symptoms, so a comprehensive assessment 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.[10]

Common risk factors for an anxiety disorder include a family history of anxiety, a personal history of anxiety or a mood disorder, stressful life events or trauma in childhood, having a chronic medical illness, and behavioural inhibition.[10]

For children and adolescents, developmentally appropriate language should be used and collateral information from parents and other sources (e.g., teachers) should be considered. An anxiety disorder is different from the developmentally appropriate worries and fears of children and adolescents.[38] Children may express anxiety through crying, tantrums, freezing, or clinging, as well as through play. Refer to the *DSM-5* for diagnostic criteria specific to children.[10]

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

What This Quality Statement Means

For People Suspected to Have an Anxiety Disorder or Who Have Had a Positive Screening Result 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 professional 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 Planners
Ensure that systems, processes, and resources are in place in all health settings for clinicians to conduct comprehensive assessments and accurately diagnose people with an anxiety disorder.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment
- Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who have a comprehensive assessment initiated within 8 weeks of the first point of contact
- Number of days from when someone suspected to have an anxiety disorder or someone who had a positive screening result for an anxiety disorder has their first point of contact to when a comprehensive assessment is initiated

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 3: Support for Family

People with an anxiety disorder are encouraged to involve their family during their assessment and treatment, considering individual needs and preferences. Family members are connected to available resources and supports and provided with psychoeducation.

Definition

Family: The people closest to a person in terms of knowledge, care, and affection; they may include biological family, family through marriage, or family of choice and friends. The person with an anxiety disorder defines their family and who will be involved in their care**.**

Sources: National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

Anxiety disorders affect surrounding people and relationships, especially a person's family. For adults, family involvement is based on the person's preferences, values, and needs, acknowledging that not everyone may want to involve their family in their care.

Family members should be given comprehensive information (both verbal and written) about the disorder, its likely causes, its course, and its treatment. For children and adolescents, it is especially important to consider the needs of family and caregivers and develop a collaborative approach with them.

What This Quality Statement Means

For People With an Anxiety Disorder
If your family is involved, they should also be offered education, information, and support.

For Clinicians
Ensure that families receive psychoeducation about anxiety disorders. Families should be included in care and treatment planning, according to the wishes of the person with an anxiety disorder.

For Health Services Planners
Ensure that systems, processes, and resources are in place so that families can be involved in the care of people with an anxiety disorder.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of adults with an anxiety disorder who choose to have their family involved in their care and whose family is connected to available resources and supports and provided with psychoeducation by a health care professional
- Percentage of children and adolescents with an anxiety disorder whose family is connected to available resources and supports and provided with psychoeducation by a health care professional
- Percentage of people with an anxiety disorder whose family is involved in their care and whose family reports feeling supported and informed about anxiety disorders

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 4: Stepped-Care Approach

People with an anxiety disorder receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first, based on symptom severity, level of functional impairment, and individual needs and preferences.

Definition

Stepped-care approach: Involves choosing the least intensive, most effective treatment first. In this approach, care is guided by the level of symptom severity, the comprehensive assessment, the person's response to treatment (effectiveness and tolerability), and their needs and preferences.

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), a person with an anxiety disorder can move to a higher step without completing 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 ongoing 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: higher-intensity psychological treatment and/or pharmacological treatments; consultation or referral 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; consideration of inpatient care

Source: National Institute for Health and Care Excellence, 2011[36]

Rationale

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

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 people to determine the most effective interventions based on the severity of their disorder and their individual needs and preferences.

For Health Services Planners
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: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder who have a treatment plan that follows a stepped-care approach
- Percentage of people with an anxiety disorder who have followed a stepped-care approach to treatment and have shown improvement in symptoms

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 5: 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 their individual needs and preferences and in alignment with a stepped-care approach.

Definitions

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. Self-help materials can:

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

Self-help approaches are aimed at empowering the person to gather information about anxiety disorders and develop management strategies. Self-help approaches complement regular visits with a health care professional.

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

Sources: British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

Through self-help strategies, people can learn about their disorder and ways to cope effectively. People with anxiety disorders should be given information and access to educational materials about their disorder, including its nature and biology, and treatment options. 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 treatment.[39]

Peer support is also important. The empathetic relationship between people who have a common lived experience 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.[40,41]

Families 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.

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 ways to manage your symptoms. 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.

For Health Services Planners
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 Indicator: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder for whom self-help was determined to be appropriate and who report feeling supported in accessing self-help resources based on their individual needs and preferences

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 6: Cognitive Behavioural Therapy

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

Definitions

Timely access to cognitive behavioural therapy: The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee agreed that, ideally, cognitive behavioural therapy (CBT) should begin within 4 to 6 weeks of the comprehensive assessment.

Cognitive behavioural therapy: 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.[10] Cognitive behavioural therapy 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 disorder and include cognitive techniques and treatments based on exposure to the source of their anxiety.

Cognitive behavioural therapy may be delivered in different formats (i.e., in individual or group sessions, in person, via videoconference, or guided via the Internet), with sessions that vary in length but typically last 1 to 2 hours.[22,36] 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; a typical duration is 12 to 15 weekly sessions for adults and 8 to 12 sessions for children and adolescents.[21,35,38] For children and adolescents, it is important to take into account cognitive and emotional maturity.[22] Individual sessions may need to be shorter (e.g., 45 minutes).[22]

Health care professionals with expertise in anxiety disorders have training in the delivery of CBT specific to anxiety disorders. For example, 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.

Sources: American Academy of Child and Adolescent Psychiatry, 2007[38] | Anxiety Disorders Association of Canada, 2014[10] | British Association for Psychopharmacology, 2014[34] Health Quality Ontario, 2017[42] | National Institute for Health and Care Excellence, 2011,[36] 2013[22] | Royal Australian and New Zealand College of Psychiatrists, 2018[43]

Rationale

Psychological treatments play an important role in the management of anxiety disorders. Cognitive behavioural therapy (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, so it is important to discuss the potential benefits and risks of any treatment before starting.[34] Treatment responses to psychological interventions are not immediate; a prolonged course may be needed to maintain an initial treatment response.[34]

For children and adolescents, parents and caregivers are involved to ensure effective delivery of the treatment.[22] Based on validated psychological treatment protocols, CBT for children and adolescents should be based on the patient's developmental age.[10,42]

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, in alignment with a stepped-care approach. If you choose this treatment, you should be able to receive this therapy promptly, from a health care professional who has expertise in treating anxiety disorders.

For Clinicians
Offer CBT to people with an anxiety disorder, in alignment with a stepped-care approach. They should receive CBT from a health care professional who has expertise in anxiety disorders within 4 to 6 weeks of their comprehensive assessment.

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

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder for whom CBT was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders
- 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
- Local availability of CBT programs given by trained and certified health care professionals

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 7: 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 and in alignment with a stepped-care approach.

Definitions

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. Because the efficacy of medications varies, clinicians should be familiar with the evidence base for each medication.

For children and adolescents, selective serotonin reuptake inhibitors (SSRIs) are the medication of choice for anxiety disorders.[34,37] If SSRIs are prescribed, careful monitoring is needed for worsening depression, agitation, or suicidality.[38] In a minority of people under age 30 years, SSRIs have been associated with an increased risk of suicidal thinking and self-harm.[21,35,42]

For adults, the following are examples of first-line medications for each anxiety disorder type[10]:

- 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
- Specific phobia: Medication plays no role or a minimal role in the treatment of specific phobias

Benzodiazepines should not be routinely prescribed for anxiety disorders unless specifically indicated.[21,35,43] Benzodiazepines may be useful as an adjunctive therapy early in treatment for acute crises, but due to concerns about tolerance, dependency, sedation, cognitive impairment, and other side effects, they should be restricted to short-term use.[10,43]

Sources: American Academy of Child and Adolescent Psychiatry, 2007[38] | Anxiety Disorders Association of Canada, 2014[10] | British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22] | Royal Australian and New Zealand College of Psychiatrists, 2018[43] | World Federation of Societies of Biological Psychiatry, 2012[44]

Rationale

Treatment should be appropriate to the severity of a person's illness, their preference, and their response. 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.[10] Further, pharmacological treatment is not routinely offered to children and adolescents to treat social anxiety disorder.[22]

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 psychological treatment, your health care professional 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, disorder-specific pharmacological treatment in alignment with a stepped-care approach. Ensure pharmacological treatments are at adequate dosages for people with moderate to severe anxiety disorders or those who are not responding to psychological treatment.

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

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, who receive pharmacological treatment based on their specific anxiety disorder
- Percentage of people with an anxiety disorder who are offered pharmacological treatment for their specific anxiety disorder and who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 8: 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 their clinical presentation.

Definitions

Effectiveness and tolerability: Effectiveness is indicated by an improvement in symptoms. Tolerability is the acceptability of the treatment, including side effects or adverse effects.[10] Goals for effectiveness and tolerability are individualized based on the person's needs and preferences.[10] 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, and impact on school and employment.[44] Other factors that should be monitored regularly include side effects, adverse effects, adherence to treatment, and suicidal ideation.

Monitored regularly: Monitoring by the treating clinician involves using validated tools and clinical judgment in conjunction with an assessment of the person's clinical presentation. Monitoring response to treatment also includes assessing the person's level of engagement with the treatment choice (e.g., participation in therapy, adherence to medication). Some improvement can be expected by 4 to 6 weeks,[43] with full response closer to 6 to 8 weeks.

- For psychotherapy: Monitoring occurs session by session, and the person's treatment response is recorded at each session
- For medication: Monitoring and documentation of treatment response usually occur weekly or biweekly when the medication is initiated and when the dosage is adjusted, and at least monthly until the person's disorder 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. Regular follow-up should occur as needed, at a frequency mutually agreed upon by the health care professional and the person with an anxiety disorder

Sources: British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

Regular monitoring of a person's response to treatment ensures that effectiveness can be assessed and treatment can be adjusted if needed.[44] Monitoring treatment response is critical to optimizing care and should be part of every treatment plan.

For children, adolescents, and young adults, careful monitoring is important when prescribing a selective serotonin reuptake inhibitor (SSRI), because it is associated with an increased risk of suicidal thinking and self-harm in a minority of people under age 30 years.[22,36]

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. When prescribing SSRIs, carefully monitor people under age 30 years for potential risk of suicidal thinking and self-harm.

For Health Services Planners
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: How to Measure Improvement for This Statement

- 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 in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician
- Percentage of people with an anxiety disorder who are receiving pharmacotherapy and whose disorder is not yet stabilized who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician
- Percentage of people with an anxiety disorder who are in remission and who receive follow-up by a health care professional at least once within 12 months

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 9: Support During Initial Treatment Response

People with an anxiety disorder are informed about what to expect and supported during their initial treatment response. When initial treatment is not working, people with an anxiety disorder are reassessed. They are offered other treatment options, considering their individual needs and preferences and in alignment with a stepped-care approach.

Definition

Reassessed: When initial treatment is unsatisfactory, health care professionals should explore the possible impact of interference from comorbid health conditions, adherence to treatment, the presence of psychosocial stressors, and the ability to tolerate an adequate trial of psychotherapy or the maximum recommended medication dosages.[39] For children and adolescents, additional factors may include the impact of learning disorders, psychosocial and environmental risk factors (e.g., family discord), or the presence of mental health problems among family members. Additional interventions may need to be considered to address these factors.

Sources: British Association of Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011[36]

Rationale

Often, initial psychological or pharmacological treatments do not relieve all anxiety symptoms. It is necessary to inform people with an anxiety disorder about this and discuss their expectations of initial treatments. In the case of medications, many people may feel no positive effects for the first few weeks but improve greatly over time. It is important that people with an anxiety disorder participate in an adequate trial of psychotherapy or receive a complete trial of medication (when appropriate) to experience the full benefits of the initial treatment and determine its effectiveness and tolerability.

When initial treatments are unsatisfactory, people with an anxiety disorder should be reassessed before being offered other treatments. The goal of reassessment is to identify any other factors that may be influencing their treatment response and help determine the next appropriate treatment option.

What This Quality Statement Means

For People With an Anxiety Disorder
Your health care professional will talk with you about how long it may take to see a treatment response. If your treatment is not working after a full trial, your health care professional should ask you questions to reassess your disorder and your situation. You should then be offered another treatment option, considering your needs and preferences and in alignment with a stepped-care approach.

For Clinicians
Inform people with anxiety disorder about what to expect and provide support. Ensure that people with an anxiety disorder who are not responding to initial treatment receive a comprehensive reassessment. Based on the stepped-care approach, offer the next-step treatment, which may include increasing intensity, switching modalities, combining treatment, or consulting a health care professional with specialized expertise in anxiety disorders.

For Health Services Planners
Ensure that systems, processes, and resources are in place so that people with an anxiety disorder are informed and supported through their initial treatment response. People who are not responding to initial treatment are reassessed and offered other treatment options based on a stepped-care approach.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder who are not responding to initial treatment and who are reassessed by a health care professional before being offered other treatment options
- Percentage of people with an anxiety disorder who are not responding to initial treatment and are reassessed who have a treatment plan that follows a stepped-care approach
- Percentage of people with an anxiety disorder who have followed a stepped-care approach to treatment who have shown improvement in symptoms

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 10: 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 expertise in anxiety disorders.

Definitions

Connected to a health care professional: Involves consultation with or 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.[36]

Specialized expertise in anxiety disorders: A health care professional with additional training in anxiety disorders beyond basic competencies (e.g., training at an institution with recognized expertise in anxiety disorders, ongoing supervision or consultation, membership in recognized professional organizations). This can be any member of a health care team, such as an occupational therapist, psychiatrist, psychologist, or social worker.

Sources: British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011[36]

Rationale

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 a severe anxiety disorder may also require care from a health care professional with specialized expertise in anxiety disorders, especially if their disorder is complicated by a treatment-refractory anxiety disorder, considerable functional impairment, multiple comorbidities, self-neglect, or a high risk of self-harm.[9]

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 with additional training in anxiety disorders beyond basic competencies.

For Health Services Planners
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 Indicator: How to Measure Improvement for This Statement

- 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

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 11: Relapse Prevention

People with an anxiety disorder who are receiving treatment are provided with information and education about how to prevent relapse and manage symptoms if they re-emerge.

Definition

How to prevent relapse: Relapse is when symptoms worsen and return to the level that 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 for managing symptoms if they return; this is often called "relapse prevention." Information and education about maintaining recovery and preventing relapse should include:

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

Sources: British Association for Psychopharmacology, 2014[34] | National Institute for Health and Care Excellence, 2011,[36] 2013[22]

Rationale

Anxiety disorders can have an episodic course with a cyclical pattern of exacerbation. Even after effective treatment and an improvement in symptoms, people with an anxiety disorder face the possibility that symptoms will re-emerge (relapse). 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 disorder.

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, lifestyle behaviours, self-care, and knowing how to get help from health care professionals when needed.[46] This preparation puts a focus on people's strengths, autonomy, and personal capability. It also empowers people to be involved in their care, affirming their autonomy and decision-making.

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 be concerned and what to do
- 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 how to prevent a relapse and how to manage symptoms when they return. 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 Planners
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: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder who are receiving treatment and who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge
- Percentage of people whose symptoms for an anxiety disorder have been in remission and who relapse within 1 year

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Quality Statement 12: Transitions in Care

People with an anxiety disorder are given appropriate care throughout their lifespan and experience seamless transitions between services and health care professionals, including between care settings and from child and adolescent services to adult services.

Definition

Seamless transition: Consists of a set of actions designed to ensure the safe and effective coordination and continuity of care when people experience a change in health status, health care professional, service, or location (within, between, or across settings). For example, transitions in care can take place when a person moves from hospital to home or from primary care to community care (setting), but also when moving from child and adolescent care to adult care (service). For more information on transitions, please see the *Transitions from Hospital to Home* quality standard.

Source: Advisory committee consensus

Rationale

Seamless transitions require a coordinated approach among knowledgeable and skilled health care professionals who are familiar with the person's clinical status, goals of care, plan of treatment, care plan, and health-information needs. Timely and effective communication is essential to prevent problems that may occur if services and supports are not well integrated. Seamless transitions include appropriate monitoring and follow-up, and they contribute to quality care and prevention of relapse.

What This Quality Statement Means

For People with an Anxiety Disorder
When you change health care professional or type of service (for example, if you return home from being in hospital), your care team should work with you to ensure a smooth transition. The care you receive should be appropriate to your age. This includes making sure that you and any new team members have the right information, and that you receive the services you need.

For Clinicians
Ensure that people moving between health care professionals and services experience coordinated and seamless transitions. This includes providing age-appropriate care across the lifespan and facilitating communication between settings and other related processes.

For Health Services Planners
Ensure that systems, processes, and resources are in place to facilitate communication and information-sharing between health care professionals and services for safe and effective transitions.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with an anxiety disorder who transition between services or health care professionals and who experience a seamless transition
- Percentage of people with an anxiety disorder who transition from child and adolescent services to adult services and who experience a seamless transition

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Appendix 1. Recommendations for Adoption: How the Health Care System Can Support Implementation

To come

Appendix 2. Measurement to Support Improvement

The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with an anxiety disorder. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

To assess equitable delivery of care, you can stratify locally measured indicators by patient socioeconomic and demographic characteristics, such as age, education, gender, income, language, and sex.

Our measurement guide provides more information and concrete steps on how to incorporate measurement into your planning and quality improvement work.

How to Measure Overall Success

Indicators That Can Be Measured Using Provincial Data

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

- Denominator: total number of people with an unscheduled ED visit for an anxiety disorder
- Numerator: number of people in the denominator who did not have a health care visit for mental health and addictions care in the previous 2 years
- Data sources: National Ambulatory Care Reporting System (NACRS), Discharge Abstract Database (DAD), Ontario Health Insurance Plan (OHIP) Claims Database, Ontario Mental Health Reporting System (OMHRS)

Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder

- Denominator: total number of unscheduled ED visits for an anxiety disorder
- Numerator: number of ED visits in the denominator followed within 30 days after leaving the hospital by a repeat unscheduled ED visit related to mental health and addictions
- Data source: NACRS

Indicators That Can Be Measured Using Only Local Data

Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result 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

- Denominator: total number of people suspected to have an anxiety disorder, or who have had a positive screening result 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, and whether they have any associated functional impairment
- Data source: local data collection
- Note: Please see quality statement 2 for more details

Percentage of people with an anxiety disorder for whom cognitive behavioural therapy (CBT) was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders

- Denominator: total number of people with an anxiety disorder for whom CBT was determined to be appropriate
- Numerator: number of people in the denominator who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders
- Data source: local data collection
- Note: Appropriateness of CBT is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach. Please see quality statement 6 for more details on CBT

Percentage of people with an anxiety disorder who report an improvement in their quality of life

- Denominator: total number of people with an anxiety disorder
- Numerator: number of people in the denominator who report an improvement in their quality of life
- Data source: local data collection

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."

- Denominator: total number of people with an anxiety disorder who answer the following question, "The services I have received have helped me deal more effectively with my life's challenges"
- Numerator: number of people in the denominator who "strongly agree"
- Data source: local data collection
- Notes:
    - 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/
    - This indicator is also an area of focus for the Excellence through Quality Improvement Project (EQIP). To find out more, visit http://ontario.cmha.ca/provincial-programs/e-qip-excellence-through-quality-improvement-project/ or https://amho.ca/our-work/e-qip/

Percentage of people with an anxiety disorder who complete CBT and have reliable recovery

- Denominator: total number of people with an anxiety disorder who complete CBT
- Numerator: number of people in the denominator who have reliable recovery
- Data source: local data collection
- Notes:
    - Reliable recovery occurs when a client's score on an anxiety disorder-specific validated severity-rating scale[47]:
        - Is above a clinical cut-off before treatment is initiated and is below the clinical cut-off after treatment is completed (reduction in symptoms); and
        - Changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion
    - Please see quality statement 1 for more information about the scales, and the measurement guide for more information on how to calculate reliable recovery

Percentage of people with an anxiety disorder who complete CBT and have reliable improvement

- Denominator: total number of people with an anxiety disorder who complete CBT
- Numerator: number of people in the denominator who have reliable improvement
- Data source: local data collection
- Notes:
    - Reliable improvement occurs when a client's score on an anxiety disorder-specific validated severity-rating scale changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion[47]
    - Please see quality statement 1 for more information about the scales, and the measurement guide for more information on how to calculate reliable improvement

How to Measure Improvement for Specific Statements

Quality Statement 1: Identification and Appropriate Screening

Percentage of people suspected to have an anxiety disorder who are identified using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales

- Denominator: total number of people suspected to have an anxiety disorder
- Numerator: number of people in the denominator who are identified using (1) a validated screening tool or recognized screening questions and (2) 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 identified 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 identified 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

Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who receive a comprehensive assessment

- Denominator: total number of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder
- Numerator: number of people in the denominator who receive a comprehensive assessment
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Note: Please see quality statement 1 for the definition of people suspected to have an anxiety disorder. This indicator is also included in the section “How to Measure Success”

Percentage of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who have a comprehensive assessment initiated within 8 weeks of the first point of contact

- Denominator: total number of people suspected to have an anxiety disorder, or who have had a positive screening result for an anxiety disorder, who have a comprehensive assessment initiated
- Numerator: number of people in the denominator who have this comprehensive assessment initiated within 8 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: Please see quality statement 1 for the definition of people suspected to have an anxiety disorder

Number of days from when someone suspected to have an anxiety disorder or someone who had a positive screening result for an anxiety disorder has their first point of contact to when a comprehensive assessment is initiated

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when someone suspected to have an anxiety disorder or someone who had a positive screening result for an anxiety disorder has their first point of contact to when a comprehensive assessment is initiated
- Stratify by:
  - Specific phobia
  - Social anxiety disorder
  - Generalized anxiety disorder
  - Panic disorder
  - Agoraphobia
- Data source: local data collection

Quality Statement 3: Support for Family

Percentage of adults with an anxiety disorder who choose to have their family involved in their care and whose family is connected to available resources and supports and provided with psychoeducation by a health care professional

- Denominator: total number of adults with an anxiety disorder who choose to have their family involved in their care
- Numerator: number of people in the denominator whose family is connected to available resources and supports, and provided with psychoeducation by a health care professional
- Data source: local data collection

Percentage of children and adolescents with an anxiety disorder whose family is connected to available resources and supports and provided with psychoeducation by a health care professional

- Denominator: total number of children and adolescents with an anxiety disorder
- Numerator: number of people in the denominator whose family is connected to available resources and supports, and provided with psychoeducation by a health care professional
- Data source: local data collection

Percentage of people with an anxiety disorder whose family is involved in their care and whose family reports feeling supported and informed about anxiety disorders

- Denominator: total number of people with an anxiety disorder whose family is involved in their care
- Numerator: number of people in the denominator whose family reports feeling supported and informed about anxiety disorders
- Data source: local data collection

Quality Statement 4: Stepped-Care Approach

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 who have a treatment plan

- Numerator: number of people in the denominator whose treatment plan follows a stepped-care approach
- Data source: local data collection

Percentage of people with an anxiety disorder who have followed a stepped-care approach to treatment and have shown improvement in symptoms

- 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
- Data source: local data collection
- Notes:
    - A validated severity-rating scale can be used to evaluate improvement in symptoms. Please see quality statement 1 for validated severity-rating scales
    - This indicator is also included in quality statement 9

Quality Statement 5: Self-Help

Percentage of people with an anxiety disorder for whom self-help was determined to be appropriate and who report feeling supported in accessing self-help resources based on their individual needs and preferences

- Denominator: total number of people with an anxiety disorder for whom self-help was determined to be appropriate
- Numerator: number of people in the denominator who report feeling supported 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 (e.g., through a patient survey)
- Note: Appropriateness of self-help is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach

Quality Statement 6: Cognitive Behavioural Therapy

Percentage of people with an anxiety disorder for whom CBT was determined to be appropriate and who receive disorder-specific CBT delivered by a health care professional with expertise in anxiety disorders

- Denominator: total number of people with an anxiety disorder for whom CBT was determined to be appropriate
- Numerator: number of people in the denominator who receive disorder-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
- Note: Appropriateness of CBT is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach. This indicator is also included in the section “How to Measure Success”

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

Local availability of CBT programs given by trained and certified health care professionals

- Data source: local data collection

Quality Statement 7: Pharmacological Treatment

Percentage of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, who receive pharmacological treatment based on their specific anxiety disorder

- Denominator: total number of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate
- Numerator: number of people in the denominator who receive pharmacological treatment based on their specific anxiety disorder
- Stratify by:
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Notes:
    - Appropriateness of pharmacological treatment is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach
    - Specific phobia is excluded from the stratification because medication plays no role or a minimal role in the treatment
    - Pharmacological treatment is not routinely offered to treat social anxiety disorder in children and adolescents
    - Please see clinical practice guidelines for further guidance on disorder-specific pharmacological treatment

Percentage of people with an anxiety disorder who are offered pharmacological treatment for their specific anxiety disorder and who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects

- Denominator: total number of people with an anxiety disorder who are offered pharmacological treatment for their specific anxiety disorder

- Numerator: number of people in the denominator who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects
- Data source: local data collection

Quality Statement 8: Monitoring

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 in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician

- 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 in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician
- Data source: local data collection
- Note: Please see quality statement 1 for validated severity-rating scales

Percentage of people with an anxiety disorder who are receiving pharmacotherapy and whose disorder is not yet stabilized who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician

- Denominator: total number of people with an anxiety disorder who are receiving pharmacotherapy and whose disorder is not yet stabilized
- Numerator: number of people in the denominator who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Note: Please see quality statement 1 for validated severity-rating scales

Percentage of people with an anxiety disorder who are in remission and who receive follow-up by a health care professional at least once within 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 follow-up by a health care professional at least once within 12 months
- Data source: local data collection

Quality Statement 9: Support for Initial Treatment Response

Percentage of people with an anxiety disorder who are not responding to initial treatment and who are reassessed by a health care professional before being offered other treatment options

- Denominator: total number of people with an anxiety disorder who are not responding to initial treatment
- Numerator: number of people in the denominator who are reassessed by a health care professional before being offered other treatment options
- 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 who are not responding to initial treatment and are reassessed who have a treatment plan that follows a stepped-care approach

- Denominator: total number of people with an anxiety disorder who are not responding to initial treatment and are reassessed
- Numerator: number of people in the denominator who have a treatment plan that follows a stepped-care approach
- 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 who have followed a stepped-care approach to treatment who have shown improvement in symptoms

- 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
- Data source: local data collection
- Notes:
    - A validated severity-rating scale can be used to evaluate improvement in symptoms. Please see quality statement 1 for validated severity-rating scales
    - This indicator is also included in quality statement 4

Quality Statement 10: Specialized Expertise in Anxiety Disorders

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

Quality Statement 11: Relapse Prevention

Percentage of people with an anxiety disorder who are receiving treatment and who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge

- Denominator: total number of people with an anxiety disorder who are receiving treatment
- Numerator: number of people in the denominator who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge
- Data source: local data collection

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

Quality Statement 12: Transitions in Care

Percentage of people with an anxiety disorder who transition between services or health care professionals and who experience a seamless transition

- Denominator: total number of people with an anxiety disorder who transition between services or health care professionals
- Numerator: number of people in the denominator who experience a seamless transition
- Potential stratification: by type of transition
- Data source: local data collection

Percentage of people with an anxiety disorder who transition from child and adolescent services to adult services and who experience a seamless transition

- Denominator: total number of people with an anxiety disorder who transition from child and adolescent services to adult services
- Numerator: number of people in the denominator who experience a seamless transition
- Data source: local data collection

Appendix 3. Glossary

Caregiver: 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.”

Culturally appropriate: An approach that incorporates cultural or faith traditions, values, and beliefs; uses the person’s preferred language; adapts culture-specific advice; and incorporates the person’s wishes to involve family and or community members.[48]

Family: The people closest to a person in terms of knowledge, care, and affection; 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.

Health care professionals: Regulated professionals, such as social workers, psychotherapists, nurses, nurse practitioners, physicians, psychologists, occupational therapists, and pharmacists.

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We focus on making health care more effective, efficient and affordable through a legislative mandate of:

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- Finding the best evidence of what works, and
- Translating this evidence into clinical standards; recommendations to health care professionals and funders; and tools that health care providers can easily put into practice to make improvements.

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