Identifying and treating anxiety in general practice

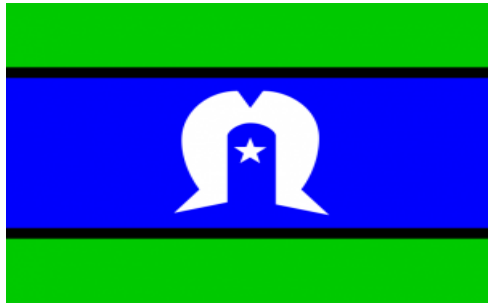
Wednesday 15 May 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network and Clarity Health Care would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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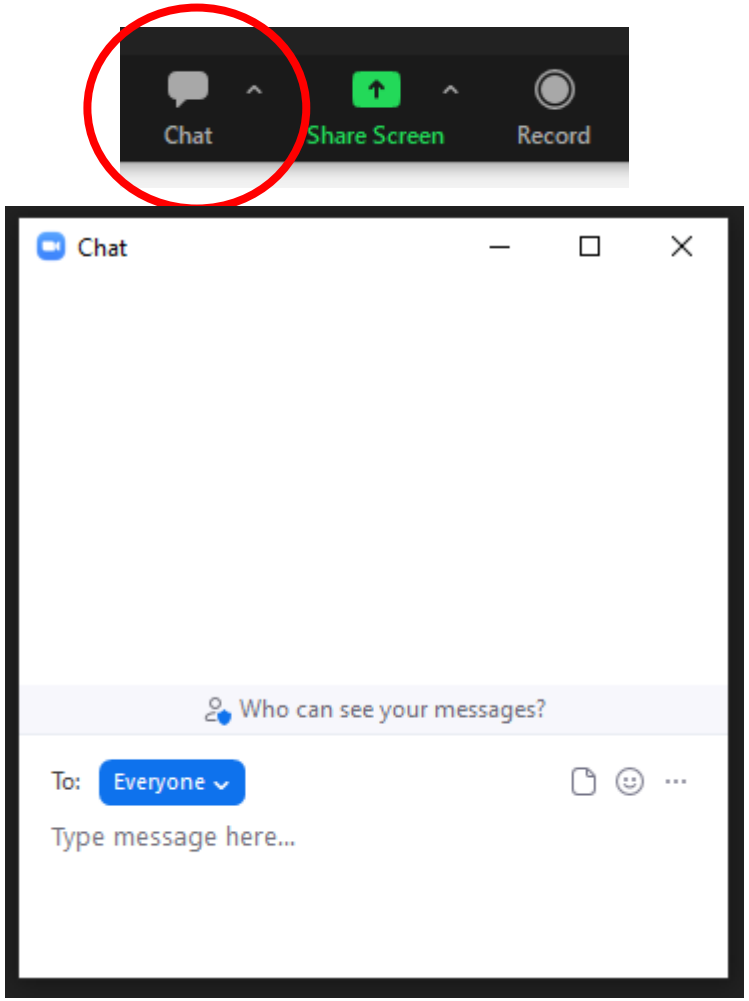

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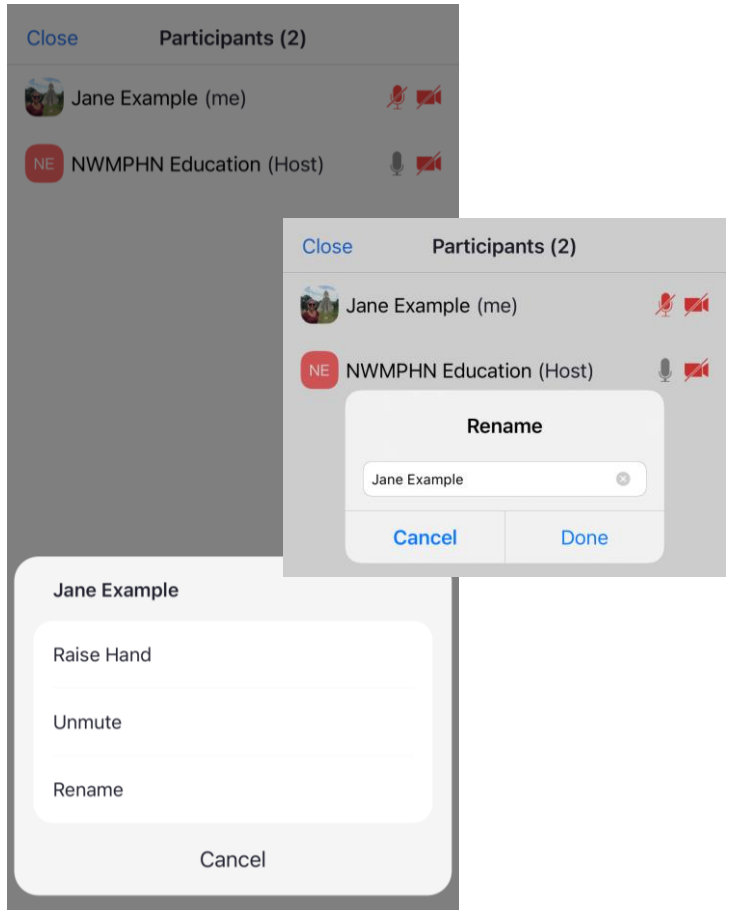

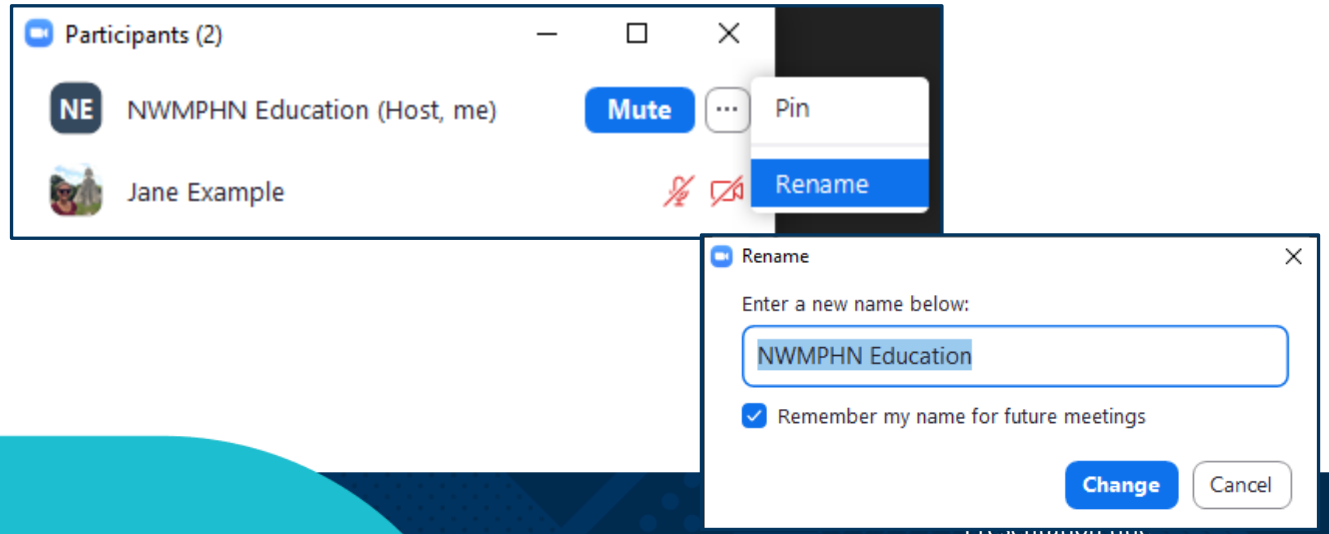

Speakers

Parwana Nawabi, Clinical Director, Senior Psychologist & Family Therapist - Clarity Health Care

- Parwana Nawabi is Clarity Health Care's Clinical Director and a senior psychologist and family therapist.
- She has extensive experience working with individuals and families across the lifespan. She works from an attachment-based and trauma-informed lens and has a special interest in working with a range of mood and anxiety disorders, interpersonal difficulties, grief, life transitions and adverse childhood experiences with a special interest in PTSD and complex PTSD.
- Parwana has held various clinical and leading positions across acute mental health, psychotherapeutic and holistic therapeutic teams.

Dr Matthew Warden, Psychiatrist - Clarity Health Care

- Dr Matthew Warden brings significant experience across public and private mental health services in Australia and the UK.
- His previous roles include Director of Acute Inpatient Services, ECT and MHA governance at St Vincent's Hospital, Melbourne; Consultant Psychiatrist in the Hobart and Southern Districts Community Mental Health Team, Tasmania; and a member of the Mental Health Act Tribunal in Tasmania. Dr Warden has also held academic roles with the University of Melbourne.
- Matthew obtained his MBBS in 1995, his MRC Psych in 2000 and his Diploma of Mental Health Law at Northumbria University, UK, in 2004.

Agenda

Introduction and housekeeping	5 minutes
Education component: Identifying and treating anxiety in general practice *Dr. Matthew Warden*	45 minutes
Evidence Based Treatment for Anxiety	15 minutes
Reflection on complex cases of anxiety and Q&A	15 minutes
NWMPHN Referral and Access team	5 minutes
Conclusion	5 minutes

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Identifying and treating anxiety in general practice

Dr Matthew Warden

Anxiety

What is anxiety?

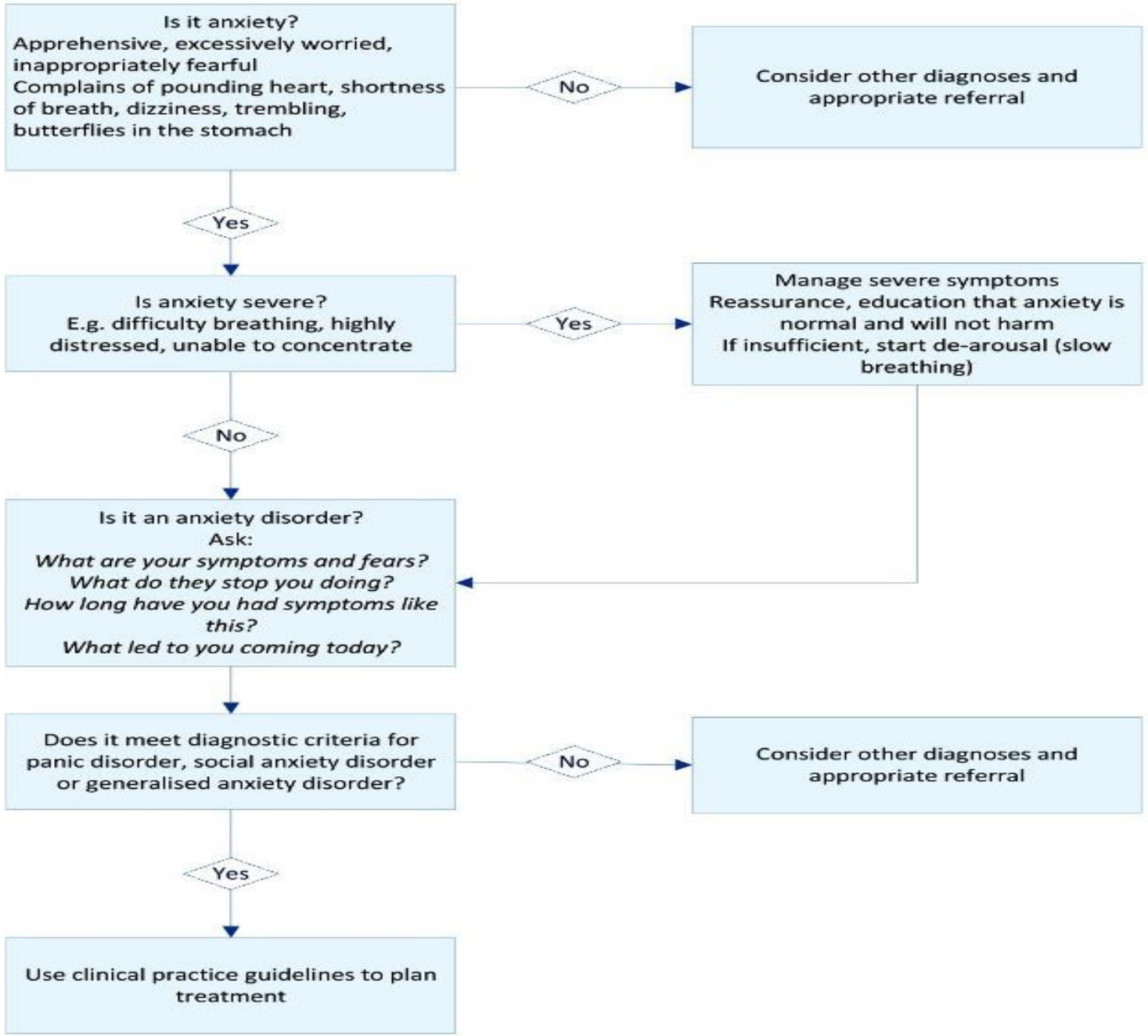
- Anxiety is normal and can be good for us
- Moderate levels of anxiety make us alert and improve performance
- High anxiety can reduce a person's capacity to think plan and do complex tasks that also need attention in difficult situations
- Anxiety disorders involve unhelpful thinking patterns
- The primary consideration is the level of severity and functional impairment that anxiety causes
- Most people have minor transient symptoms from time to time which require no intervention

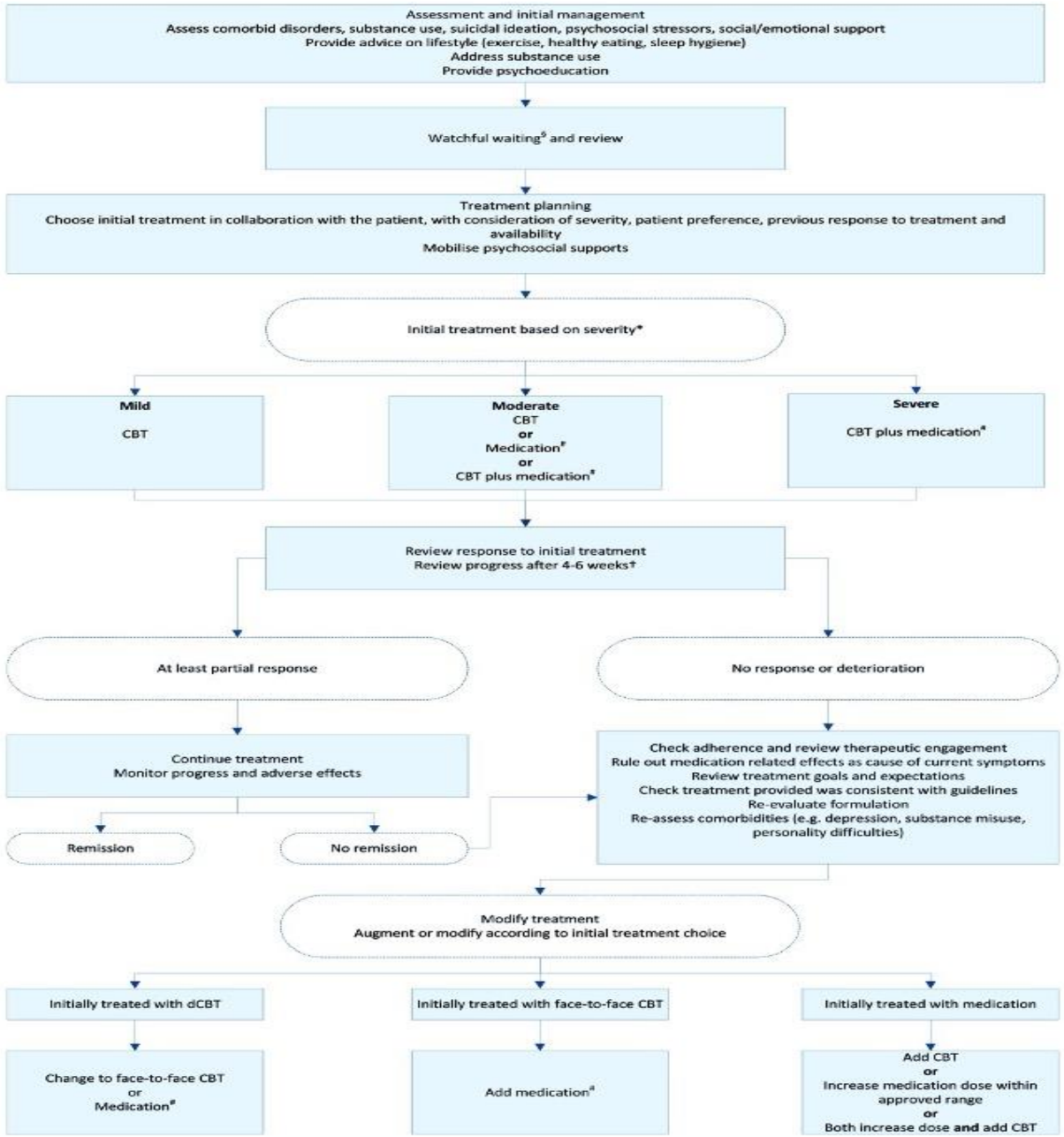
Normal v. Pathological

- No clear demarcation
- Unrealistic or excessive
- Warrants treatment when it interferes with normal living and when it is felt to be distressing and persistent

Classification

- Cardinal part of most neurotic illnesses (stress related)
- Very commonly seen as a part of a depressive picture
- Can be part of almost any diagnosis
- Learning theory & avoidance


Is it anxiety?
Apprehensive, excessively worried, inappropriately fearful
Complains of pounding heart, shortness of breath, dizziness, trembling, butterflies in the stomach
No
Consider other diagnoses and appropriate referral
Yes
Is anxiety severe?
E.g. difficulty breathing, highly distressed, unable to concentrate
Yes
Manage severe symptoms
Reassurance, education that anxiety is normal and will not harm
If insufficient, start de-arousal (slow breathing)
No
Is it an anxiety disorder?
Ask:
What are your symptoms and fears?
What do they stop you doing?
How long have you had symptoms like this?
What led to you coming today?
Does it meet diagnostic criteria for panic disorder, social anxiety disorder or generalised anxiety disorder?
No
Consider other diagnoses and appropriate referral
Yes
Use clinical practice guidelines to plan treatment


Assessment and initial management
Assess comorbid disorders, substance use, suicidal ideation, psychosocial stressors, social/emotional support
Provide advice on lifestyle (exercise, healthy eating, sleep hygiene)
Address substance use
Provide psychoeducation
Watchful waiting[§] and review
Treatment planning
Choose initial treatment in collaboration with the patient, with consideration of severity, patient preference, previous response to treatment and availability
Mobilise psychosocial supports
Initial treatment based on severity*
Mild
CBT
Moderate
CBT
or
Medication[¶]
or
CBT plus medication[¶]
Severe
CBT plus medication[¶]
Review response to initial treatment
Review progress after 4-6 weeks†
At least partial response
No response or deterioration
Continue treatment
Monitor progress and adverse effects
Remission
No remission
Check adherence and review therapeutic engagement
Rule out medication related effects as cause of current symptoms
Review treatment goals and expectations
Check treatment provided was consistent with guidelines
Re-evaluate formulation
Re-assess comorbidities (e.g. depression, substance misuse, personality difficulties)
Modify treatment
Augment or modify according to initial treatment choice
Initially treated with dCBT
Initially treated with face-to-face CBT
Initially treated with medication
Change to face-to-face CBT
or
Medication[¶]
Add medication[¶]
Add CBT
or
Increase medication dose within approved range
or
Both increase dose and add CBT

Common anxiety illnesses

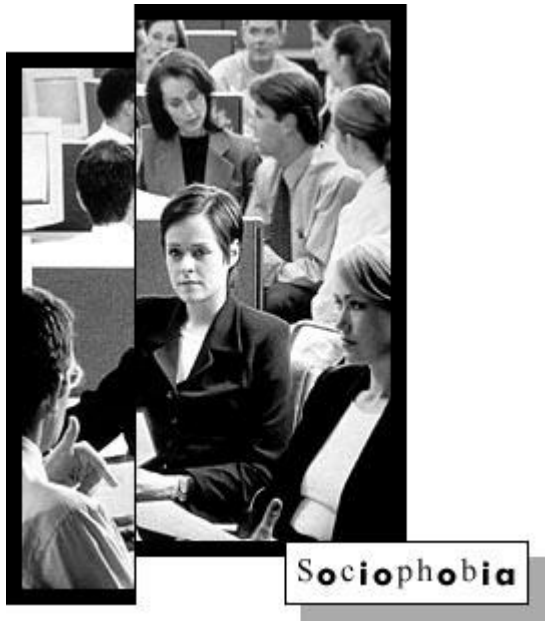
- Phobic disorders
- Agoraphobia / Panic disorder
- Generalised anxiety disorder
- OCD/ BDD
- PTSD
- Mixed disorders

Phobic disorders

- Restricted to specific situations
- May lead to panic
- Preparedness
- Exposure and anxiety management
- Prevalence 10%

Social Phobia

- Fear of scrutiny by others
- Avoidance of social situations
- Adolescence
- Exposure & anxiety management
- Alcohol

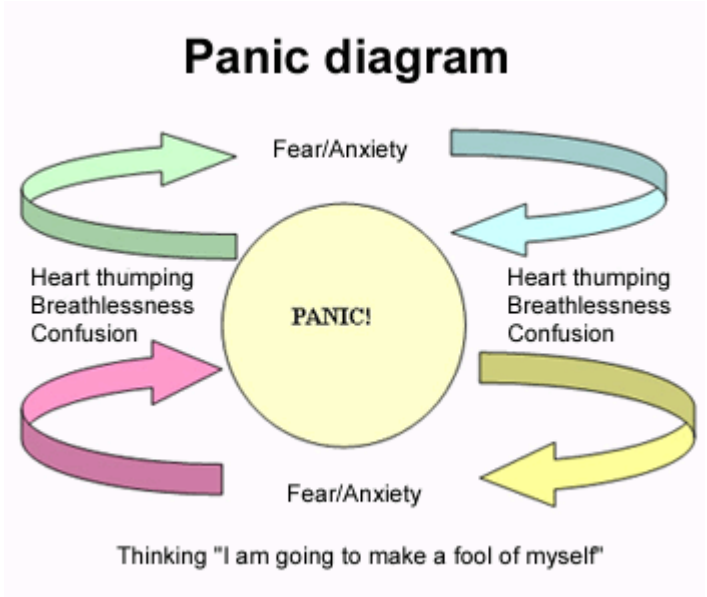


Agoraphobia

- Public places, crowds etc
- Housebound
- Panic attacks
- CBT and antidepressants
- Often lifelong

Panic Disorder

- Recurrent severe anxiety attacks
- Not restricted to a particular situation
- Somatic symptoms
- CBT / antidepressants



Generalised anxiety disorder

- Generalised and persistent
- Free floating
- Somatic symptoms
- Initial insomnia
- Alcohol
- Relaxation techniques

Treatment of GAD

Focus of the intervention	Nature of the intervention
STEP 4: Complex treatment-refractory generalised anxiety disorder (GAD) and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment	Choice of a high-intensity psychological intervention (cognitive behavioural therapy [CBT]/applied relaxation) or a drug treatment
STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care	Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups
STEP 1: All known and suspected presentations of GAD	Identification and assessment; education about GAD and treatment options; active monitoring

Drug treatment of GAD

- Consider drug treatment at stage 3
- Avoid benzodiazepines in general practice
- Offer SSRI (avoid drugs with high risk of discontinuation syndrome)
- Consider Pregabalin as second line
- Do not use antipsychotics in general practice

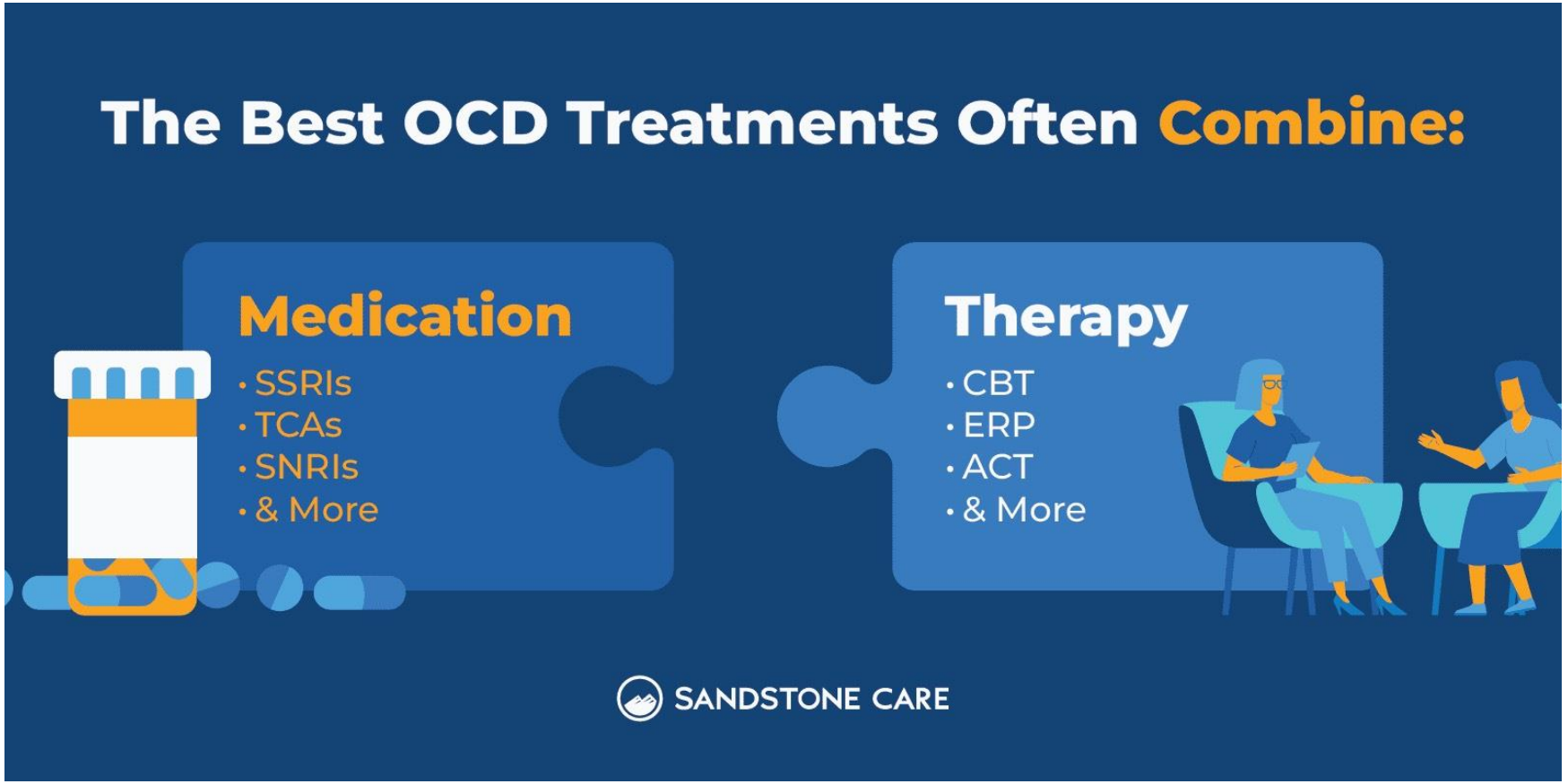
OCD

- Obsessions and/or compulsions
- Owned
- Resisted
- Distressing
- Overlap with depression and schizophreni
- Hard to treat

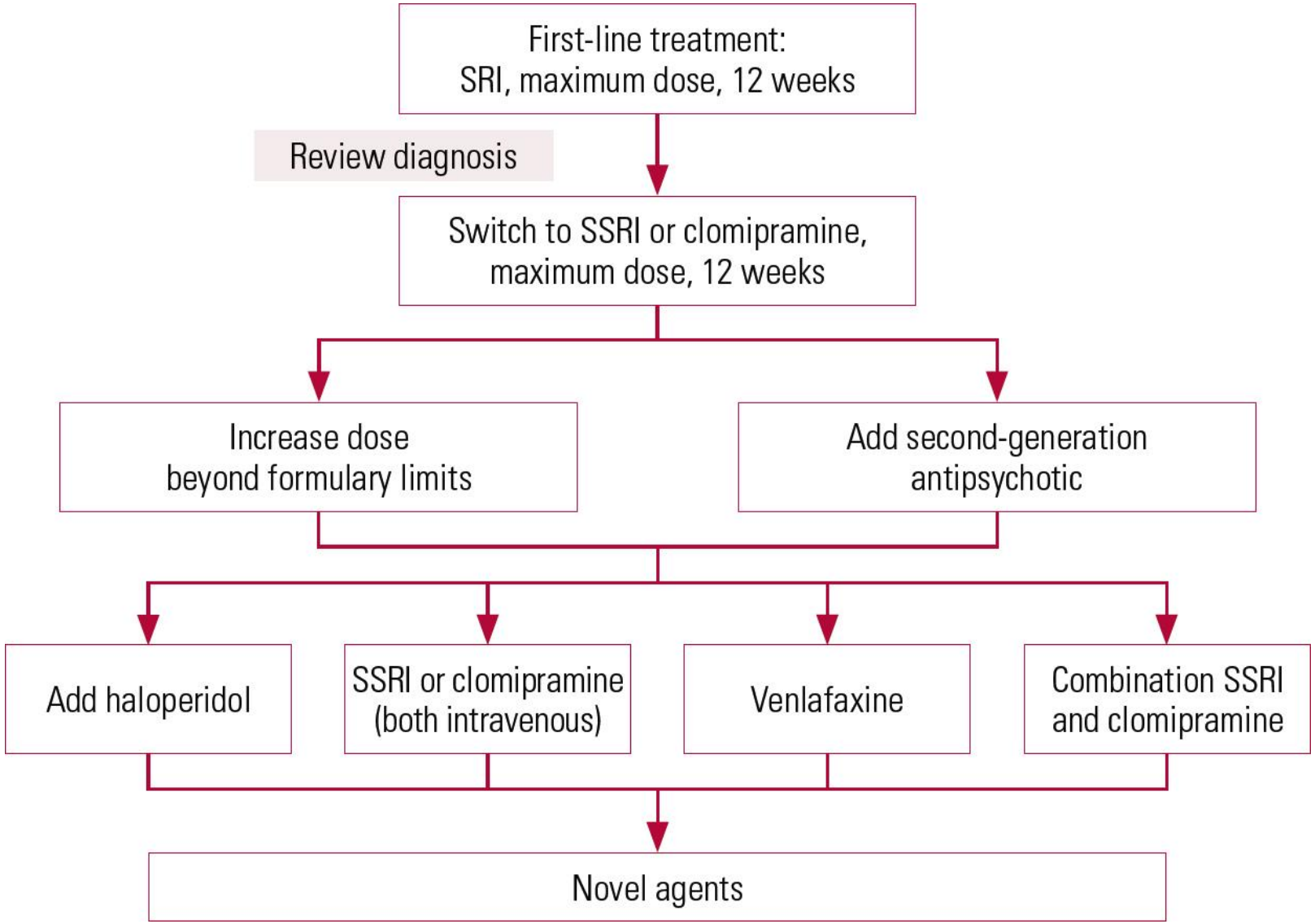
OCD

- Onset in early life
- Prevalence 2%
- SSRIs
- CBT/ ERP etc
- DBS

OCD Treatment



	SSRIs	TCAs	Benzo-diazepines	Others
Acute efficacy	Citalopram Fluoxetine Fluvoxamine Paroxetine Sertraline Escitalopram	Clomipramine Imipramine	Clonazepam (?)	Cognitive–behavioural therapy
Long-term efficacy	Fluoxetine Sertraline	Clomipramine		Cognitive–behavioural therapy
Relapse prevention	Fluoxetine Paroxetine Sertraline Escitalopram			
Enhances psychological treatment	Fluvoxamine	Clomipramine		
After non-response				Another SSRI or add haloperidol, risperidone, quetiapine, olanzapine or aripiprazole to SRI


First-line treatment:
SRI, maximum dose, 12 weeks
Review diagnosis
Switch to SSRI or clomipramine,
maximum dose, 12 weeks
Increase dose
beyond formulary limits
Add second-generation
antipsychotic
Add haloperidol
SSRI or clomipramine
(both intravenous)
Venlafaxine
Combination SSRI
and clomipramine
Novel agents

PTSD

- Delayed response to exceptional situation
- Outside normal experiences
- Flashbacks
- Avoidance
- Autonomic arousal
- Drug/ alcohol abuse
- EMDR

Table 2

Treatment Options for PTSD

Drug	Place in Therapy	Dosing Range (mg)	Common Side Effects
SSRIs	1st line/(++) for avoidance and hyperarousal/(+) for reexperiencing	Fluoxetine: 20–80 Sertraline*: 50–200 Paroxetine*: 20–60 Citalopram: 20–40 Escitalopram: 10–20	Sexual dysfunction, sedation, appetite changes, headache, increased nervousness if dose started too high
TCAs	2nd, 3rd line/(+) for avoidance and hyperarousal	Imipramine: 25–250; Amitriptyline: 25–250	Sexual dysfunction, anticholinergic, sedation, cardiovascular
MAOIs	3rd line/(+) for avoidance and hyperarousal	Phenelzine: 30–90	Dietary restrictions, hypertension, sexual dysfunction
SNRIs	2nd line	Venlafaxine XR: 75–300	Gastrointestinal, sexual dysfunction, mild increase in heart rate/blood pressure
Nefazodone	2nd line/(+) for nightmares/sleep	200–600	Black box warning for hepatotoxicity
Atypical antipsychotics	2nd-line addition to antidepressant/(++) for nightmares and reexperiencing	Risperidone: 0.25–2 Olanzapine: 2.5–10 Quetiapine: 25–100 Ziprasidone: 40–160 Aripiprazole: 2.5–20	Weight gain, metabolic syndrome, akathisia, dystonic reactions
Alpha-1 receptor antagonists	2nd-line addition to antidepressant/(++) for nightmares/sleep/(+) for overall symptoms	Prazosin: 1–10	Dizziness, orthostatic hypotension, drowsiness
Propranolol	Prevention of future symptoms if given within hours of event; not widely used	40 mg 3–4x/day x 7–10 days	Bradycardia, hypotension, dizziness
Anticonvulsants	2nd, 3rd line, best with comorbid bipolar disorder	Doses not well studied	Vary by drug

** FDA approved for PTSD. SSRIs: selective serotonin reuptake inhibitors; (++): evidence is positive; (+): good evidence but not as strong; TCAs: tricyclic antidepressants; MAOIs: monoamine oxidase inhibitors; SNRIs: serotonin/norepinephrine reuptake inhibitors.*

2

Evidence Based Interventions for anxiety disorders

Parwana Nawabi

Psychological Treatment for anxiety disorders

Generalised Anxiety Disorder (GAD)

Panic Disorder

Social Anxiety Disorder

Obsessive Compulsive Disorder (OCD)

Acute Stress Disorder

Posttraumatic Stress Disorder (PTSD)

Generalised Anxiety Disorder (GAD)

GAD involves persistent and excessive worry that interferes with daily activities. This ongoing worry and tension may be accompanied by physical symptoms, such as restlessness, feeling on edge or easily fatigued, difficulty concentrating, muscle tension or problems sleeping. Often the worries focus on everyday things

Treatment: Cognitive Behaviour Therapy (CBT). Consistent, systematic challenging of the thoughts and modification of behaviour through exposure.

Panic Disorder

Two types of panic attacks:

Expected- followed after a particular cue or trigger e.g. being in a plane
Unexpected- do not have an identifiable cue or trigger and can occur at any time, even if the person is in a calm state or asleep.

Symptoms:
Palpitations, pounding heart or rapid heart rate, sweating, Trembling or shaking Feeling of shortness of breath or smothering sensations, Chest pain, Feeling dizzy, light-headed or faint, Feeling of choking, Numbness or tingling Chills or hot flashes.

Diagnosis:
For a diagnosis of panic disorder, a person must experience at least one unexpected panic attack followed by one month or more of: ongoing concern or worry regarding the experience of further panic attacks or their consequences; and/or changes in behaviour in order to prevent further attacks from happening, for example, the person may avoid situations where they fear a panic attack could occur, such as public transport.

Social Anxiety Disorder

A person with social anxiety disorder has significant anxiety and discomfort about being embarrassed, humiliated, rejected or looked down on in social interactions. People with this disorder will try to avoid the situation or endure it with great anxiety. Common examples are extreme fear of public speaking, meeting new people or eating/drinking in public. The fear or anxiety causes problems with daily functioning and lasts at least six months.

Treatment:

CBT specifically psychoeducation, cognitive restructuring, interpersonal psychotherapy, thought reframing, exposure and homework tasks

Acute Stress Disorder (ASD)

Acute stress disorder occurs in reaction to a traumatic event, However, the symptoms occur between three days and one month after the event. People with acute stress disorder may relive the trauma, have flashbacks or nightmares and may feel numb or detached from themselves. These symptoms cause major distress and problems in their daily lives. About half of people with acute stress disorder go on to have PTSD. Acute stress disorder has been diagnosed in 19%-50% of individuals that experience interpersonal violence (e.g., rape, assault, intimate partner violence)

Post Traumatic Stress Disorder (PTSD)

Post traumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances. An individual may experience this as emotionally or physically harmful or life-threatening and may affect mental, physical, social, and/or spiritual well-being. Examples include natural disasters, serious accidents, terrorist acts, war/combat, rape/sexual assault, historical trauma, intimate partner violence and bullying

•Trauma-focused cognitive behaviour therapy (TF-CBT) — This involves working through memories of the trauma in a safe and structured environment, trying to change unhelpful beliefs and thoughts and gradual exposure to triggers that make you anxious.
•Prolonged exposure (PE) — A type of talking therapy, which involves retelling your trauma memories until they become less distressing.
•Cognitive processing therapy (CPT) — A type of CBT, which focuses on people who are stuck in their thoughts about trauma.
•Eye movement desensitisation and reprocessing (EMDR) — This involves working through memories of the trauma while going through a series of eye movements.

Obsessive Compulsive Disorder (OCD)

Disorder in which people have recurring, unwanted thoughts, ideas or sensations (obsessions). To get rid of the thoughts, they feel driven to do something repetitively (compulsions). The repetitive behaviours, such as hand washing/cleaning, checking on things, and mental acts like (counting) or other activities, can significantly interfere with a person's daily activities and social interactions.

Treatment:
One effective treatment is a type of cognitive behavioral therapy (CBT) known as exposure and response prevention (ERP). During treatment sessions, patients are exposed to feared situations or images that focus on their obsessions. Although it is standard to start with those that only lead to mild or moderate symptoms, initially the treatment often causes increased anxiety. Patients are instructed to avoid performing their usual compulsive behaviors (known as response prevention). By staying in a feared situation without anything terrible happening, patients learn that their fearful thoughts are just thoughts. People learn that they can cope with their thoughts without relying on ritualistic behaviors, and their anxiety decreases over time. Using evidence-based guidelines, therapists and patients typically collaborate to develop an exposure plan that gradually moves from lower anxiety situations to higher anxiety situations. Exposures are performed both in treatment sessions and at home. Some people with OCD may not agree to participate in CBT because of the initial anxiety it evokes, but it is the most powerful tool available for treating many types of OCD.

HealthPathways Melbourne

Identifying and treating anxiety in general practice

15th May 2024

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

Anxiety in Children Relevant and Referral Pathways

Relevant Pathways

Anxiety in Adults

Anxiety in Children and Adolescents

Anxiety, Distress, and Agitation in Palliative Care

Alcohol and Other Drugs

Child and Youth Mental Health

LGBTIQA+ Mental Health

Medications for Depression and Anxiety (Pregnancy and Breastfeeding)

Pregnancy and Postpartum Mental Health

Psychosis

Self-harm

Suicide Prevention

Referral Pathways

Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)

Adult Mental Health Service Referrals

Child and Adolescent Eating Disorders Specialised Referral

Child and Youth Mental Health Support Services

Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)

Paediatric Psychology and Counselling Referral

Perinatal Mental Health Referrals

Transgender Health and Gender Diversity Referral

Anxiety in Children Related Pathways

Related Pathways

Carer Support - Mental Health

Depression in Children and Adolescents

Depression in Adults

Depression in Older Adults

Medications for Depression in Adults

Medications for Depression in Older Adults

E-Mental Health Services

GP Mental Health Treatment Plan

Mental Health Community Support Services

Bipolar Disorder

Practical Prescribing Guide

Safe Script

HealthPathways Melbourne

Dementia Education

Enabling EDIE Virtual Reality Training

Immersive, in-person, workshop suitable for General Practitioners and Practice Nurses who provide support to people living with dementia and for their carers.

Location

Dementia Australia, 155 Oak Street, Parkville, VIC, 3052

When

Session 1 for GPs Monday 20 May, 7 - 8:30 pm

Session 2 for Practice Nurses Monday 27 May, 10 am - 1 pm

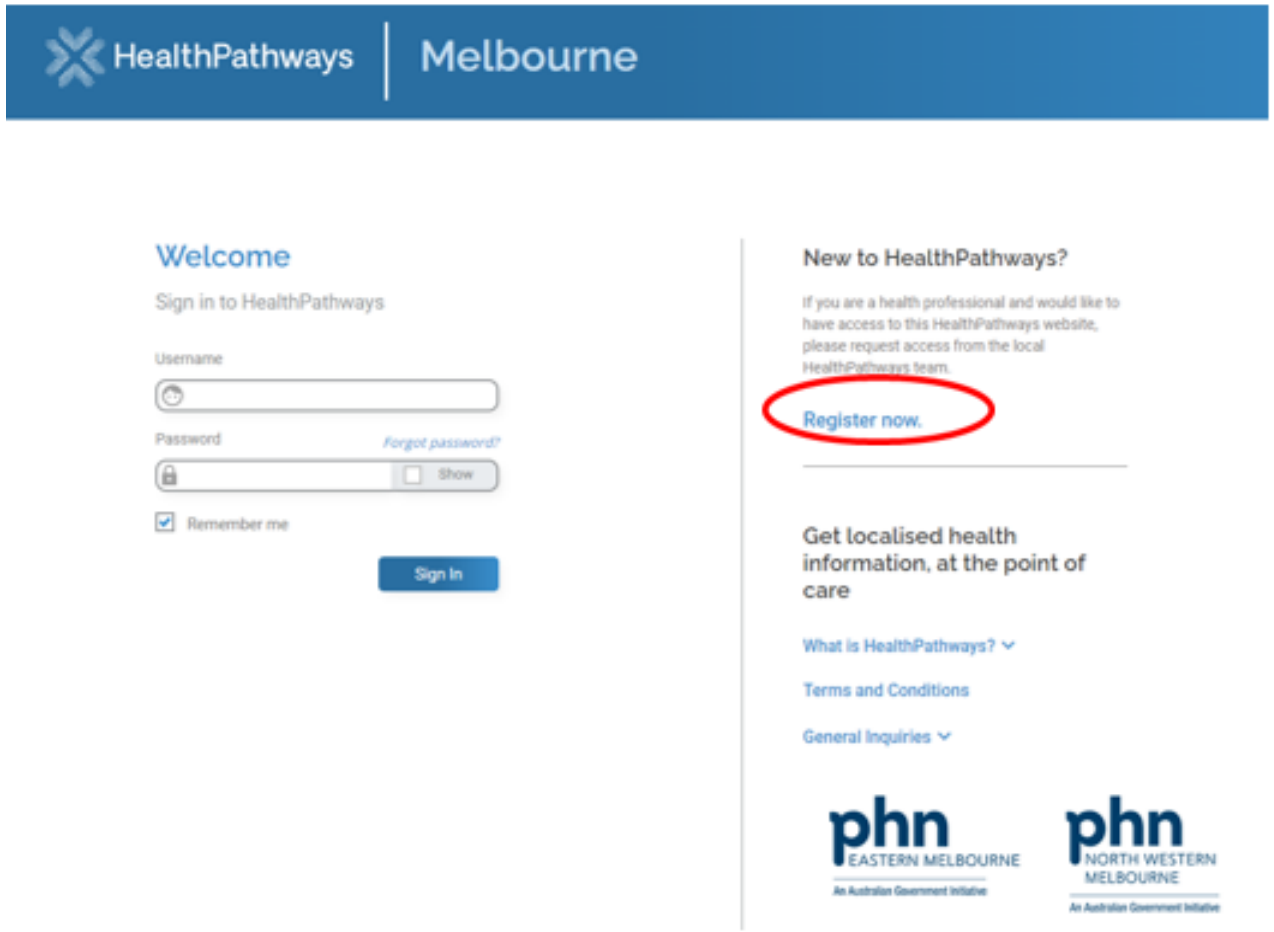
Register your interest now

Limited places available

Disclaimer: This session involves the use of Virtual Reality technology. Read the disclaimer here.

CPD points are not available for this education opportunity.

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

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3

Reflection on complex cases of anxiety

Dr Matthew Warden

Parwana Nawabi

4

NWMPHN Referral and Access team

Paulette Belcastro

Referral and Access Team for Head to Health and CAREinMIND Services

Our response promotes a person-centred approach, matching people with available supports according to their specific mental Health needs.
Service navigation is undertaken through our Referral and Access team, that consists of experienced Mental Health Clinicians. The team can assist to link people in with mental health services within the NWMPHN catchment.
Services range from suicide prevention (not crisis care), targeted therapeutic intervention and even care co-ordination for people who are experiencing chronic and complex mental illness who can be managed in the community.
PLEASE NOTE: We are not equipped to manage patients in crisis. Referrals should be made to Psych Triage in these instances.

NWMPHN mental health services are designed to improve access to mental health support for people who cannot easily access services due to financial constraints and for people from priority populations.

You can refer using the Referral Form which can be found on the PHN website and can be downloaded in a variety of formats and into your systems.
The more information you provide about a patient's current presentation and reason for referral, the faster and more accurate the navigation into services.
Information can include the history of mental illness, potential triggers, current stressors as well as any Dx.
These forms have been designed so that you can bill Medicare for Mental Health Care Plan.

If your patient is not ready to talk or engage in therapy, then they can be given the Head to Health number – 1800 595 212. The patient can then call when they are ready. At this time, they will then undertake an Intake Assessment and linked in with appropriate mental health services.

Paid CPD training for GPs

NWMPHN are providing training for GPs, mental health clinicians and nurses interested in learning about the Initial Assessment and Referral Decision Support Tool (IAR-DST).

The IAR-DST provides a standardised, evidence-based and objective approach to assist GPs and mental health clinicians with mental health care recommendations.

- 2 RACGP Education Activity CPD hours
- Online or face-to-face at your practice
- $300 GP incentive payment

The tool is designed to provide advice relating to initial assessment and intake, across 8 diagnostic domains:

- symptom severity and distress
- risk of harm
- impact on functioning
- impact of co-existing conditions
- treatment and recovery history
- social and environmental stressors
- family and other supports
- engagement and motivation.

Register your interest for IAR training

Discussions

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/