

## Appendix 1 Process used for developing the guidelines.

These guidelines have been developed using the following process:

1. Assembly of a working party of a range of experts in the area of anxiety disorders and primary mental health, including representation from; Māori, Pacific Islands, consumers, psychologists, psychiatrists, general practitioners, and a practice nurse.
2. Developing a draft of the perceived key components in the assessment, and diagnosis of anxiety disorders, with specific sections sent to named individuals for review.
3. Analysis of the literature to develop evidence tables for key decision points specifically in the areas of treatment, i.e., psychological vs. pharmacological (and the specific treatments within each broad area). (See next section for a discussion of how this was conducted).
4. Incorporation of the evidence tables into the draft, and into the key decision points.
5. Extensive peer review. Comments from resulting submissions were considered by the entire working party, and the document updated accordingly.

### Literature review

The medical and psychological literature from 1992-1998 was reviewed by searching MEDLINE, EMBASE, PSYCLIT, the Cochrane library, and the Internet using the following key words; anxiety disorders, generalized/generalised anxiety disorder, panic, stress, social, social anxiety, adjustment, post traumatic stress, obsessive compulsive disorder(s), social, specific phobia(s), agoraphobia, treatment, therapy, randomized/randomised control trials, meta-analysis, meta-analytic, case series. References from selected articles and reviews were also examined.

Two reviewers (with backgrounds in psychological research) extracted information from articles and assigned them to categories of evidence (see below).

Where possible, the 'Number Needed to Treat' figure was calculated, to help ascertain treatment effect. The expert opinion of selected members of the working party was used to judge the clinical significance of findings in the literature. (An additional meeting of psychiatrists was convened to establish agreement on pharmacological recommendations)

### Basic evidence grading strategy

Grade of evidence	Description	Comment
A1	Randomised controlled trials with double blind placebo control	RCT's can control for selection bias
A2	Randomised controlled trials without double blind placebo control	Patients are randomly assigned to treatment and control groups, but both experimenter (and often the patient) are aware of which treatment they are receiving, which may generate bias.
B	<ul style="list-style-type: none"><li>• non-randomised controlled trials (incl.: non-randomised historical cohort studies)</li><li>• other studies with non-experimental designs (e.g., population based studies)</li></ul>	Comparisons are made between patients who did and did not receive the intervention. Selection bias may result from unrecognised or recognised or inappropriate comparisons over time. Only through randomisation can unknown selection bias be controlled.
C	Case series	The reader is informed of the outcomes for a group of patients. May provide useful information about clinical course and prognosis but can only hint at efficacy.
D	Expert opinion	Is used to inform when there is a lack of robust scientific evidence on particular cases where sound decisions still need to be made. In this case it reflects accumulated clinical wisdom by people who are experienced in the field.

## Methodological issues in grading evidence

There are two fundamental issues to be aware of when considering the evidence grading strategy that has been employed in developing this guideline:

1. although the majority of evidence considered in the evidence tables is Grade A1 or A2, it is evidence that has been taken from specialist services in the secondary and tertiary sectors. There is a dearth of evidence for the treatment of anxiety disorders in primary care. Some studies of interventions in primary care have been conducted in other countries, but the extent to which findings may be generalised to the New Zealand context is arguable. Where evidence is reported, it has been moderated by expert opinion as to its relevance to the primary care sector in New Zealand.

2. the psychological research cited as evidence falls into Grade A2 evidence as it is not possible to provide 'double-blind' psychological interventions, in which neither the client nor the therapist knows which intervention is being delivered.

In addition to the explicitly evidence-based treatment recommendations, the guideline also recommends best practice based on expert opinion about the process of recognition, assessment and treatment of anxiety disorders. (Grade D evidence)