Responses to Public Consultation Feedback

Public and targeted consultation was undertaken on the draft guideline for a period of 18 days, commencing 6 – 29 September 2023.

Individuals and organisations were invited to provide feedback on the contents of the document via email. The draft guideline was publicly available for download and review, and an online feedback form provided.

During the development process, an advisory group discussed individuals and organisations that should be invited to participate to ensure that feedback was well-rounded, and all perspectives were included.

Individuals contacted included healthcare professionals such as paediatricians, child psychologists, and child psychiatrists, who had direct clinical experience working with children and adolescents facing anxiety disorders. Additionally, psychosocial support workers, social workers, and nurses, who often played an essential role in identifying and addressing anxiety-related issues, were also contacted.

Organisations that were invited included professional clinical organisations, medical education organisations, mental health research bodies, government support bodies, First Nations health organisations, and community and social support groups.

Anonymous feedback and responses can be reviewed in the table below.

Notes for reading this feedback and responses:

- feedback is organised by guideline section depending on the specificity of the comment
- recommendation numbers might have changed in the final published version of this guideline, therefore some comments referring to specific recommendations may now be associated with a different recommendation number.
- all feedback was discussed among guideline developers and responses reflect the decision to incorporate the feedback into the final document.

General comments			
Respondent	**Type of respondent**	**Comment**	**Response to comment**
Anonymous [2]	Individual – Professional Experience (Clinical Psychology)	Some anxiety a normal part of development at some point for most young people – make a statement about this early? Doc reads from the start as if anxiety = pathology	Thank you for pointing this out. Context has been added throughout to acknowledge that anxiety is normal and can be developmentally appropriate but may be diagnosed as a disorder when it impacts on a child or young person's ability to fully participate in life.
Anonymous [2]	Individual – Professional Experience (Clinical Psychology)	Doc is heavy on acronyms – affects readability	Acronyms throughout the document have refined and those necessary have been summarised in a table at the beginning of the document. We hope this helps the readability.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	There are many acronyms that clinicians are required to hold in their heads throughout the document.	See earlier comment: Acronyms throughout the document have refined and those necessary have been summarised in a table at the beginning of the document. We hope this helps the readability.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	There are several recommendations that I was unclear about why consensus was reached such as starting with Individual CBT; starting medication to increase engagement.	These statements were made from discussions among the GDG, who considered the evidence and clinical experience to make recommendations and statements. The wording has been adjusted to reflect this in the clinical context sections.

Anonymous [3]	Individual – Professional Experience (Nursing)	This is a dense document. I commend the contributors on the robust approach taken to developing this document. I am concerned that in pitching this as a Clinical Practice Guideline, many clinicians may approach it expecting a very condensed set of recommendations that they can apply to a pressing clinical situation, which is not really found in this document. I wonder therefore if there is a way to present a condensed version of the key recommendations (possibly in a table) to enable clinicians to quickly find the information they're seeking, and if they so choose, then proceed to read the more in-depth description and ranking of the evidence. Many recommendation papers I've been involved in developing (not related to MH care) take this approach - essentially creating an Executive Summary of the content. I make this suggestion as I'm assuming your motivation to develop this guideline is to offer clinicians access to robust guidance re the assessment and management of anxiety...but if clinicians find its size too overwhelming, they might not engage with it, which would be big shame.	To help with readability we a summary table of all recommendations has been included at the beginning of the document, as per your suggestion. We hope to develop flowcharts for an easily digestible, visual representation of the recommendations in the near future.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	How do these compare to the guidelines and fit in with the guidelines provided by the ANZ college of psychiatrists for anxiety in children. Should these now supersede the earlier guidelines?	Before beginning this process, our team undertook a systematic search for existing guidelines to address anxiety in children. The search returned no guidelines that met the benchmark criteria to be adopted, however a guideline developed by NICE (2018) was identified and helped to inform the steps for identifying and prioritising key areas to include. While RANZCP does have a clinical practice guideline for anxiety in adults there is not a clinical practice guideline nor a position statement on anxiety in children and adolescents.

Anonymous [4]	Organisation – Professional Experience (Disability Support)	I was asked to review the document from the perspective of Psychosocial Policy and the NDIS. From this perspective there is no substantive comments that I could make related to this guideline draft. I did note that the discussion and guidance related to the use of assessment tools and the contexts that are optimum for their application and this could have some information that is useful to the NDIA eligibility, access and planning teams. Better understanding and appreciation of the approaches that clinicians take to a assess levels of function is useful in weighing their relevance to guide decisions. The guideline highlights that assessment of anxiety cannot be done well through questionnaires and that skilled clinical questioning is required, emphasising the importance of the qualified practitioner in the process. From a psychosocial support perspective a few points in the document to consider are: - that anxiety commonly co-occurs with other mental health conditions. In some cases anxiety conditions may be overshadowed in treatment plans by more severe and low prevalence disorders so once again assessment for, and treatment of anxiety should be considered where required for people with complex psychosocial need. - psychological supports are currently commonly provided to NDIS recipients, with a particular focus on sessional supports to build a participants' capacity to access community and achieve goals. This guideline could assist in considering the evidence base to improve the appropriateness of psychological therapy/intervention.	We are happy to hear that the document might be useful information to your colleagues. As per your advice, we have added several sentences throughout the documents to acknowledge the importance of psychosocial support, as well as emphasising the comorbidities than often come with an anxiety diagnosis. We have also created a new recommendation emphasising that anxiety commonly co-occurs and may be overshadowed by more severe, less prevalent conditions, and these patients also need to be assessed for anxiety where possible
Anonymous [1]	Individual – Professional Experience (Clinical	The document suggests that the guidelines should be delivered in a culturally sensitive way. I question whether this is possible when consultations with First Nations people do not seem to have occurred. Instead, the approach of these guidelines is in essence culturally insensitive as they have not	We appreciate your concern about the cultural sensitivity of these guidelines. In an ideal scenario, extensive consultation with First Nations people would have occurred. The development and consultation phases did involve

	Researcher in Child Anxiety)	met the minimum standard of what would be considered culturally sensitive which includes consultation.	Aboriginal and Torres Strait Islander organisations, however there were limitations in time and persons available to dedicate to this process. We acknowledge this as a significant limitation. In the future, we hope to develop specific resources for vulnerable populations including Aboriginal and Torres Strait Islander persons as well as those with culturally and linguistically diverse backgrounds.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	The current guidelines are written in a way that would indicate the recommendations are relevant for school screening. This is not the question that was posed in this review but could be interpreted as being applicable to universal school screening. I do not believe that Australian schools are currently equipped to be able to integrate universal screening. It is not a clinical setting and schools are not set up to handle sensitive clinical data in the same way as a primary care setting (e.g., GP.) I think this distinction needs to be made before schools introduce screening as a safe process, in the absence of ANY studies that have been conducted on evaluating harm. I am in the process of finishing a study using mental health screening in schools and examining stigma changes with some very interesting (and concerning) preliminary findings about increased stigma.	The GDG agrees with this and have removed references to school settings. Also included is context for screening, which should include clinical interviews and not be done on mass.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	The guidelines are now already 18 months behind the literature. This would not be acceptable for a published MA or SR which is recommended to be published within 6 months of the data extraction. I understand the time it takes to deliver such a guideline. But could an update be provided, an addition review, to check the literature for new findings that would modify the guidelines?	We are aware that the original literature searches began almost 18 months ago. This does have the potential to be a significant limitation of the document. In order to ensure the evidence is up to date, we have run an update of the searches as of October 2023 there has been no new evidence that would change the recommendations.

Specific Comments by section			
Introduction			
Respondent	**Type of respondent**	**Comment**	**Response to comment**
Anonymous [2]	Individual – Professional Experience (Clinical Psychology)	Infant section – in or out, don't half do it… infant anxiety can't be reduced to one page, so what's there is not particularly helpful and I suspect a little patronising. Better to just say it's beyond scope rather than have something half-baked in there?	Our team agreed that the infant mental health and anxiety section was too brief and provided insufficient information to provide that sort of advice. The text has been simplified to note the limitations in the evidence and instead linked to an Australian government website with more information and further resources.
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	I wonder when we talk about types of anxiety disorders (beginning page 8) whether we can say something about the high rates of comorbidity we see in the anxiety disorder space?	Our team agreed that comorbidity is an important factor to consider and have added the wording "It is also important to recognise that anxiety commonly co-occurs with other mental health conditions" in the section on types of anxiety disorders to make this clear. There is also discussion of this in the identification and assessment sections of the document.
Anonymous [6]	Organisation – Professional Experience (Medical)	Treatments in the guideline are more general and not focused towards specific disorders. Perhaps consider listing more generalised symptoms or noting this. Also noting where developmentally appropriate?	We have added sentences in the Psychological Therapy, Medication, and Making Initial Treatment Choices sections to clarify that the treatments in this guideline are more general and not focused on specific disorders, in line with your comments.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	I can see the rationale for including information about anxiety disorder symptoms; to increase children's access to evidence-based care, given the lack of evidence-based care provision in Australia (Gandhi et al., 2023). However, the list of anxiety disorders is incomplete and adds another set of criteria that the clinician has to be familiar with. It is not clear why several of the anxiety disorders are excluded such as	We appreciate your view that we should have added more anxiety disorders to the list of disorders our guideline applies to, however as the DSM treats OCD and PTSD separately, we have chosen not to include these here. We have added a paragraph explaining our rationale for this: "While the recommendations for assessment and

		Specific fears; Selective mutism. Also the majority of the child anxiety literature has included both OCD and PTSD in RCTs. It is unclear why these disorders are also excluded, when the treatment recommendations are very often the same.	management are, in the main, generic and not disorder specific, this Guideline is focussed on those disorders classified in the Anxiety Disorders chapter of the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5). We do not cover either obsessive compulsive disorder (OCD) or trauma and stressor related disorders for which the evidence base suggests different approaches are appropriate. We also did not specifically look for evidence around selective mutism."
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	6-12 months of age: I question whether there is evidence to suggest that 6 months old have the cognitive ability to worry. Would the word "fear" be more appropriate here. Although there has been little published on worry in infants, the models that are available discussing the cognitive requirements for worry would indicate that this is not an ability that 6 months old will have. Fear yes. They can anticipate basic events (separation; feeding, comfort) but can 6 month olds worry. The section on infants appears to be discussing developmental changes in infants in fear/anxiety but then it refers to "the traumatic event" p.8. What traumatic event is being referred to here? It is possible that this whole section is referring to infants who have experienced trauma but it is unclear.	This section was removed due to lack of clarity and scope.
Identification and assessment			
Anonymous [7]	Individual – Professional Experience (Leader in	I was concerned that the assessment section is rather weak and too reliant on the US prevention taskforce guidelines which focussed on community and school screening rather than clinical practice. There are other very widely used youth anxiety assessment measures that need to be considered. I	This is something that the GDG discussed thoroughly. The evidence in this area is quite varied due to the number of measures available and was insufficient to provide recommendations for specific measures. In light of this, we have

	Anxiety and Depression in Young People Research)	have a conflict of interest here, of course, although no financial interest in saying this as the scale is free to download, but one of the most widely used and evidence-based assessment tools internationally is Australian (the Spence Children's Anxiety Scale). It is also used in the Royal Children's Hospital, Melbourne. See www.scaswebsite.com. The scale is translated into around 30 languages and has been validated in multiple studies by other researchers . It has versions for Parents, Children, and Preschoolers (Parents). It also has subscale scores (aligned with DSM anxiety subtypes) in addition to total scores. It has been widely used in both school-based screening and in clinical case assessment. There is a short-form see Reardon et al 2017. I attach a further review on child anxiety assessment tools that I did for Child and Adolescent Mental Health in 2019. There is also another review that is broader: Etkin RG, Shimshoni Y, Lebowitz ER, Silverman WK. Using Evaluative Criteria to Review Youth Anxiety Measures, Part I: Self-Report. J Clin Child Adolesc Psychol. 2021 Jan-Feb;50(1):58-76. doi: 10.1080/15374416.2020.1802736. Epub 2020 Sep 11. PMID: 32915074; PMCID: PMC7914129. The SCAS is also included in recommended tools in the Am Acad Child Adol Psychiatry clin guidelines (attached).	removed the table of recommended measures by the USPTS review to reduce confusion. And have suggested the use of appropriate validated measures that are accessible in each context. Also noting that some are more effective for different ages/developmental stages (ie preschool)
Anonymous [8]	Individual – Professional Experience (Developmental Psychology)	"Autism spectrum disorder/autism spectrum condition (ASD)" would read better as "Autism Spectrum Disorder (ASD)/autism spectrum condition". I recall we had also discussed putting in a clarifier here about terminology preferred by different groups (similar to like the statement in the Autism diagnostic guidelines). I'm wondering if there is a reason this was not included.	This wording has been adjusted "autism spectrum disorder/autism spectrum condition (ASD)" to "autism spectrum disorder/autism spectrum condition" and have added a note that "this guideline endeavours to use inclusive terminology while also acknowledging the need to include some terms that align with international

			diagnostic classification standards. However, we acknowledge that each community may have their own preferences regarding terminology. Individuals should take care to respect these preferences" in the section relating to how to use the guideline.
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	I also wonder whether on page 11 at 1.4 we can highlight behavioural difficulties as anxiety commonly underlies oppositional presentations, meltdowns, and the like?	We have adjusted recommendation 1.4 to "oppositional defiant disorder and other challenging behaviours" to reflect your suggestion to highlight behavioural difficulties.
Anonymous [8]	Individual – Professional Experience (Developmental Psychology	The term "Neurodevelopmental neurodivergent disorders" is not appropriate to use. The neuroaffirming movement often uses "neurodivergent" but it is not necessarily well defined in the literature, and would not be paired with "disorder" as the neuroaffirming movement generally rejects the notion of disorder. I suggest we use neurodevelopmental disorders but I wonder what the lived experience advisors would recommend and if this has gotten confused somewhere in the process of combing professional and lived experience feedback.	The term "neurodevelopmental neurodivergent disorders" is inappropriate in this context. As such we have adjusted it to "neurodevelopmental disorders" in line with advice. See our response to your previous feedback for the inclusive terminology disclaimer we have added to the document.
Anonymous [8]	Individual – Professional Experience (Developmental Psychology	I am surprised about the EBR recommendation to use screening measures (and to use the specific ones listed) as the sample for development and testing those screeners sometimes excludes children with conditions listed in CCR our children with particular conditions who need screening. I also notice the list does not include the RCADS – is there a reason the RCADS is not listed? The more universal screeners that cover anxiety (e.g. Child Behaviour Checklist, Developmental Behaviour Checklist) are also not included	As above: This is something that the GDG discussed thoroughly. The evidence in this area is quite varied due to the number of measures available. The evidence to recommend RCADS above other measures was not sufficient to produce a recommendation, though we recognise that it is widely available and used in this context. In light of this, we have suggested the use of appropriate validated measures that are

		and I wonder if this needs comment in the guidelines as to why. Apologies if we did cover this in the meeting as it was a complex process to get our heads around.	accessible in each context. Also noting that some are more effective for different ages/developmental stages (ie preschool)
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in Young People Research)	On page 15 the report states "evidence is insufficient on screening for anxiety in children 7 years or younger". I concur, but your guidelines are not about screening, they are about clinical assessment and parent report on very young and 3-7 year old is important and there is plenty of evidence. The Preschool Anxiety Scale (Spence and Rapee) is widely used for this purpose. Again, free download from www.scaswebsite.com. There is also a teacher version. Translated into multiple languages, and numerous evidence-based academic papers from other research groups.	The guidelines do discuss screening as well as assessment. To make this and the distinction between the them more clear we have separated the recommendations into 'identification' (1) and 'assessment' (2) recommendation tables and changed the wording in the introduction of this section to explain and reflect this. We do agree that clinical assessment for children uner 8 is important and have added discussion of the importance of clinical assessment/interview in addition to using instruments.
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in Young People Research)	In the Clinical Context component of assessment (p15), perhaps the point could be made a bit more strongly that clinicians should not just rely on self-report tools, and the need for an evidence-based clinical interview eg Anxiety Disorders Interview Schedule for Children ADIS-C parent and/or child versions. This is probably the most widely used child anxiety interview and it would be good to mention it.	A section has been added to the clinical context in assessment to emphasise that clinicians should not just rely on self-report tools and the need for evidence-based clinical interviews: "Clinicians could consider using a structured approach to interviews. Examples in generic interview such as the KIDDIE-SADS or Developmental and Wellbeing Assessment (DAWBA) and anxiety specific interviews such as Anxiety Disorders Interview Schedule for Children which has both parent and child versions."
Anonymous [8]	Individual – Professional Experience (Developmental Psychology	I understood there was going to be at an additional literature review as to conditions with a high prevalence rate of anxiety to inform the conditions for which screening is recommended –as I can't see mention of it I'm wondering if this was actioned.	This was done, and we have changed the wording in the clinical context section to reflect this: "The evidence review for groups at high risk of anxiety was supplemented with a table of conditions that are known to have a higher prevalence of anxiety,

			which can be found in the technical evidence report".
Anonymous [10]	Organisation - Professional Experience (Mental Health Foundation)	The guidelines are extremely well written, with evidence well synthesized for clinicians, considering of priority groups and the importance of family involvement. This will be a valuable addition to the literature, providing practical evidenced based recommendations to clinicians working with children and young people experiencing anxiety. We did have one minor consideration from page 17 and whether there could be a note for clinicians when working with family is not possible, or when factors contraindicate family involvement (such as domestic violence).	Thank you for this important consideration. We have added a clause to recommendation 2.5: "Wherever possible*, clinicians should work closely with families and engage parents and caregivers in treatment plans, regardless of whether psychological or medical treatment (or a combination) is chosen. *There are situations where family involvement is not appropriate such as domestic violence or a history of abuse". We have also added a few sentences throughout the document that encourage the clinician to think about whether involving the family is an appropriate or safe to do in that circumstance.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	I don't think the list of screening measures is useful. It excludes the most widely used measures in Australia for anxiety. I examined the Viswathan paper in more detail to understand why the Spence Children's anxiety scale were excluded and I can't see why the Spence and RCADS were excluded from this list. There have been other reviews (outside the US) with international teams that have conducted extensive review that includes lived experience consultation. See the ICHOM International consensus on a standard s...er, and post-traumatic stress disorder (ichom.org) that recommended the RCADS-25 (which includes SCAS items) Standard Sets – ICHOM Connect. I cannot see a GP in Australia giving an 8 year old a 41 item measure in their	After review, this table has been removed.

		practice. There are no Australian norms as far as I can see. Children rarely present for one anxiety disorder so the only recommendation provided is the SCARED. So the disorder specific measures recommended are unlikely to be useful when most children present with more than one disorder.	
Care planning			
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in Young People Research)	On page 17, Point 2.2. "Clinicians should offer multimodal treatment and support. In this context multimodal refers to a combination of psychoeducation with specific psychological therapies and possibly medication treatment. ", I thought to rephrase to state "Clinicians should offer evidence-based, multimodal treatment and support. In this context multimodal refers to a combination of psychoeducation with specific psychological therapies and possibly medication treatment in exceptional circumstances (such as if there is a need for acute severe symptom reduction associated with high levels of functional impairment)". The Am Ac Ch & Adol Psychiatry guidelines make this point (see attached doc)	This wording adjusted has been adjusted.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	Great to see parents included here in the care planning. There is inconsistent evidence of the value of parent inclusion for child outcomes. There may also be cases when parent involvement is not helpful so this should be discussed also, especially in adolescence. Who is engaged in treatment will also depend on the developmental stage/age of the young person.	As above, wording has been added and adjusted at the beginning of the care planning section to reflect this.
Making initial treatment choices			
Anonymous [1]	Individual –	"In this instance, the GDG concurred that medication may be used to reduce anxiety symptoms enough to support optimal engagement in psychological therapy". Is there evidence that	The wording has been changed to "were in agreement that in their clinical experience, medication may sometimes reduce anxiety

	Professional Experience (Clinical Researcher in Child Anxiety)	this would reduce symptoms more quickly? I am unaware of this evidence that would indicate it would improve engagement.	symptoms enough to support optimal engagement in psychological therapy" in order to make the clinical consensus aspect of this statement clearer.
Psychological therapy			
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	Several recommendations are concerning. Although I like the clear demarcation in the process of the recommendations based on evidence versus clinical intuition, this line is becomes extremely blurred within the document and recommendations made. As a result I question the capacity this guideline has to improve outcomes. Many clinicians in Australia adopting alternative treatments could find a recommendation in this document to support their current approach. Given the way clinicians rarely have time to read the fine print, I am concerned about the high level recommendations. For example, ACT is recommended as a treatment to be used for children with anxiety. This is in the absence of positive evidence. There have now been multiple studies showing that mindfulness interventions can lead to increases in anxiety symptoms, and have particularly worse outcomes for younger children. Yet mindfulness interventions are regularly used particularly in school settings. Clinicians and educators love delivering them but recommending these strategies reduces the potential that therapist would deliver what is considered the most active ingredient in therapy for anxiety disorders and that is exposure therapy. There are a number of reviews and experimental studies that show the more exposure that is used, the better the outcomes for the child and family. The more different types of strategies and approaches that are used will dilute the active ingredients. There is evidence of a	To address these concerns the following has been adjusted: Our team did agree with the reviewer that the evidence from the school based trials (population based not focussed on those with a disorder) showed increased anxiety and depression and this was pretty clear in the well-designed study. References to school setting have been removed. Wording has been added to acknowledge the emerging nature of ACT and proper use in clinical settings. Some recommendations regarding play therapy have been removed and remaining recommendations referring to play therapy have been reworded to reflect "play based approaches with cognitive behavioural concepts". Clinical context and implementation sections have also been adjusted to reflect this.

		large school-based trial with early teens in the UK showing that mindfulness actually increases anxiety and depressive symptoms in kids already at risk compared to treatment as usual. The most concerning recommendation is: Play therapy could be considered for remission of anxiety diagnosis in children and young people aged 8 and under. I don't object to the earlier statement about "play based approaches could be used to explore CB concepts". However, the statement about "play therapy" (different to play based CB approaches) comes in the absence of a single positive study to show its efficacy. A recent review my team conducted confirmed the lack of evidence particularly for younger children (Hudson et al., 2023). Play therapy should be removed from the guidelines.	
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in Young People Research)	In the treatment recommendations section, (Point 4.4) perhaps you could add a sentence stating that digital interventions can be used as an alternative or adjunct to face to face clinical therapy, or as an element of a stepped-care approach. You note Brave-Online and Cool-kids in the evidence base as examples here.	We have created an additional CCP (4.4.1) with this point.
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in Young People Research)	For online interventions you suggest only for ages 8 plus, but there are parent-delivered, evidence-based programs for anxiety treatment in younger children. See Donovan et al., (2014) for RCT. (Beh Research and Ther, vol 58, 24-35.). This program can be accessed free of charge in Australia via the braveonline website. I was not involved in that study, so no conflict of interest. https://www.sciencedirect.com/science/article/abs/pii/S00057967140006 2X	The age recommendation for this has been removed and a statement for age appropriate interventions to reflect this.

Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	On page 4.9 I can see that play therapy is recommended for children under 8 years, however what we had talked about was recommending CBT as a first line intervention with play therapy recommended for children who had not engaged well in this (which I can see is recommendation 4.8). Based on the available research I think it would be preferrable to just have recommendation 4.8.	Some recommendations regarding play therapy have been removed and remaining recommendations referring to play therapy have been reworded to reflect "play based approaches with cognitive behavioural concepts". Clinical context and implementation sections have also been adjusted to reflect this.
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	I wondered if we should also cut out 4.9.1 on page 25 given that we have said that procedural anxiety is out of scope.	Agree, have removed this recommendation.
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	I would suggest we cut "For engagement purposes let the child lead the play" out of the Implementation notes on page 34. While many play therapists will be child led at times and this is a central aspect of child centred play therapy it is not necessarily part of the cognitive behavioural play therapy.	Agree, this text has been removed.
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	There is in my opinion too much emphasis on the network meta-analysis conducted by Zhoua and colleagues. This analysis prioritises self-report which is not what the field considers the best source of evidence (Creswell, et al., 2020). I struggled to understand why the findings of this study were preferenced over the same analyses conducted within the more recognised Cochrane review which is far more comprehensive and more recent. There are a number of recommendations that are at odds with the rest of the field. This is primarily due to the preferencing of child report.	It would be biased of us to make recommendations based on the rest of the field rather than based on the evidence. The GDG, have made the recs based on the evidence and with the knowledge of the rest of the field. The James Cochrane review is the sole source of evidence for CBT v waitlist/no treatment, treatment as usual (TAU) or attention control in this guideline. It is summarised and referenced in the first paragraph of the evidence summary for CBT in the guideline (also

			described/analysed/assessed further in technical report). We did not use Zhou for this key comparison of whether CBT on the whole is effective. This is used to inform all recommendations about CBT. The Zhou review was used to compare types/formats of CBT, which James review did not do as comprehensively as Zhou. The evidence summaries for the comparisons of different types does seem long because there are so many comparisons (ie. individual CBT, group CBT, etc.)
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	[I was] asked if I could have a look over, specifically at the ACT and play therapy pieces, which I had been involved in as part of the guidelines group though which have been further developed since that time. The section on ACT looks really good.	Thank you for your comment.
Anonymous [6]	Organisational – Professional Experience (Medical)	Should acknowledge that psychoeducation is an ongoing process, not a one off exercise. Is likely going to have to continue through treatments.	A new CCR (4.1) has been added to the 'making initial treatment choices' section detailing this.
Anonymous [5]	Individual – Professional Experience (Clinical Psychology)	I wonder if the comment "however was insufficient evidence on which to make a recommendation" may be a bit confusing given there are recommendations listed on page 25 around play therapy? I appreciate this might be about the strength of the recommendation though wonder if it is worth clarifying? Play therapy is a non-directive approach that particularly engages younger children at their developmental level. It allows for symbolic expression of emotions and	Have edited the wording here to clarify there was insufficient evidence on which to make an *evidence-based* recommendation.

		experiences. Children can learn to regulate their emotions through play therapy. (My thinking around this is that because play therapy is an umbrella term for a number of different play based therapies, we probably need something broader here. For example, not all play therapy relies on creative play or on children expressing their story through play).	
Anonymous [1]	Individual – Professional Experience (Clinical Researcher in Child Anxiety)	There are a number of recommendations for the clinician to consider tailoring the treatment. "When considering psychological therapy for children/young people experiencing anxiety, clinicians should: • Consider the developmental age and stage of the child • Include parents or caregivers in therapy where and when appropriate • Consider the feasibility of the child/young person and their family's capacity to participate in the full course of sessions of psychological therapy • Consider alternatives if wait lists mean lengthy delays to accessing care • Consider alternatives if cost of therapy is a barrier to access for a child/young person and their family Ensure they have appropriate training and experience before using specific therapies for a course of treatment, e.g. play therapy." It is not clear how these decisions impact on the clinician's decision making.	These statements are made to ensure that treatments are appropriate to the specific needs of the child and their family, including cultural appropriateness, developmental stage, stigma, cost, and access to care.
Medication			
Anonymous [7]	Individual – Professional Experience (Leader in Anxiety and Depression in	In the medication section, I felt that the first point should be that medication should not be the first choice for treatment except in exceptional circumstances (such as if there is a need for acute severe symptom reduction associated with high levels of functional impairment), and that the first treatment choice should be that with the greatest evidence-base, namely cognitive behaviour therapy.	Have adjusted the wording at the beginning of this section to reflect this.

	Young People Research)		
Anonymous [6]	Organisational – Professional Experience (Clinical Practice Guideline Committee)	Consider Including information about proper training for prescribing and should be done by someone that is going to be following up. From Etg: "if pharmacotherapy is used, it is ideally started by a clinician with expertise in using psychotropics in children."	Have adjusted the wording at the beginning of this section to include this point.
Anonymous [6]	Organisational – Professional Experience (Clinical Practice Guideline Committee)	If including starting doses, should also include maximum and titration doses?	Our team feel it is safer not to include these specifically, given variations in tolerability. However, we have added a sentence about being careful to consider these factors in prescribing correct doses: “Doses dependent on tolerability, age and other factors, so should take care in providing current doses”.
Anonymous [9]	Individual – Professional Experience (Specialist Pharmacy – Mental Health)	Where Choice and Medication is listed in history section (under assessment) it implies that it can tell you about drug interactions - it can't. This should definitely be fed back. My preferred drug interaction database is Lexicomp available via UpToDate. Just need to link to one that everyone can access (free). AMS, MIMS and lexicom get updated more regularly.	We have linked to the Lexicomp database: https://www.uptodate.com/drug-interactions/#di-druglist
Anonymous [9]	Individual – Professional Experience (Specialist	I would definitely mention in the side effect section that anxiety can worsen before it improves.	We have added this to recommendation 5.8 about side effects: “when initiating an SSRI, anxiety symptoms can worsen before improving”.

	Pharmacy – Mental Health)		
Anonymous [6]	Organisational – Professional Experience (Medical)	Recommendation 5.9: Younger than what age? Evidence for increased risk <12 yo, also higher rates in cohort 7 and under? Should specify to avoid confusion.	We have adjusted the wording to “children and young people”.
Anonymous [9]	Individual – Professional Experience (Specialist Pharmacy – Mental Health)	Pharmacogenomic testing can be considered for patients who poorly tolerate treatment.	This is out of scope and a too specific for the general recommendations in this guideline.