

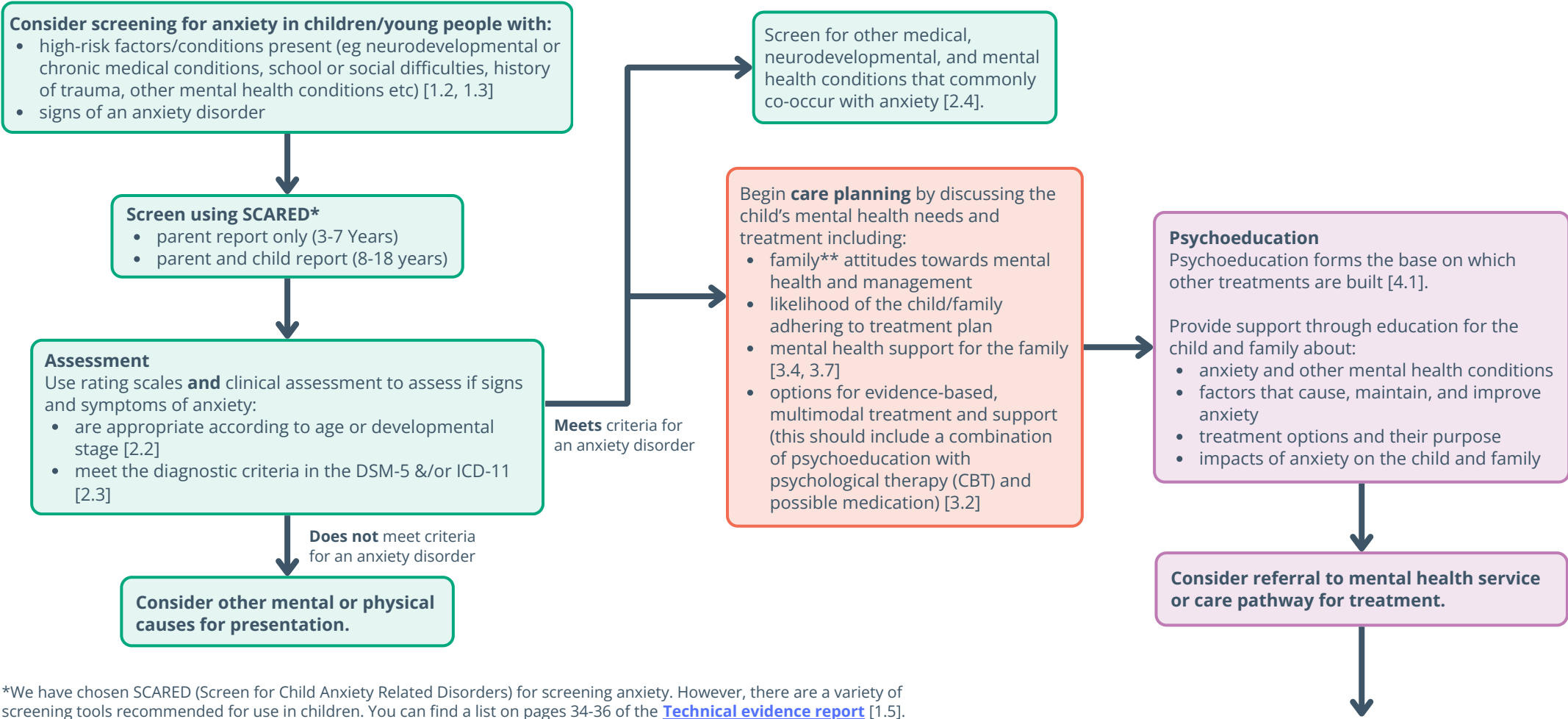
Anxiety quick reference flowchart

Preface

Steps should be taken to ensure that pathways are available within communities, schools, and clinical settings for children, young people and their families** to recognise and raise concerns about anxiety [1.1].

All information in this document is informed directly by the *Evidence-Based Clinical Practice Guideline for Anxiety in Children and Young People, 2024*. Specific recommendation numbers are included in brackets. This document is not intended to be used as sole guidance for decision-making. For more information, clinical context, implementation notes, evidence reports etc, please consult the full document.

Identification, assessment, and care planning



*We have chosen SCARED (Screen for Child Anxiety Related Disorders) for screening anxiety. However, there are a variety of screening tools recommended for use in children. You can find a list on pages 34-36 of the [Technical evidence report](#) [1.5].

**In this context, family is used to refer to the family unit including caregivers, support persons, and those who do not have a direct caring relationship with the child, such as siblings.

Anxiety quick reference flowchart

Treatment and monitoring

Psychoeducation should continue throughout treatment and management.

Psychological therapy

Consider individual needs of the child including:

- age or developmental capacity
- ability to participate in therapy or desire to engage with therapist
- availability of therapies or modalities
- caregiver(s) inadvertently maintaining anxiety
- environmental factors that contribute to anxiety

Chose appropriate therapy:

CBT should usually be offered as first choice and delivered using an evidence-based program [5.1]. There are many modalities of CBT that can be offered according to suitability and availability.

Play-based approaches using CBT concepts could be considered if the child is:

- 8 years or younger [5.9]
- struggling to engage in CBT (eg neurodivergence, intellectual disability etc) [5.8]

ACT could be considered if the young person is:

- 12 years or older [5.7]
- living with a chronic health condition [5.7.1]

Medication could be considered for use in conjunction with psychological therapy if the child's anxiety:

- is too severe to allow the child to engage in psychological therapy
- has led to significantly reduced participation in their community (eg family, school, social events, sports etc)
- is associated with a moderate or greater risk of deliberate self-harm or suicide attempt
- is affecting the wellbeing of a family member [4.3]

If considering medication

Before initiating:

- assess history, other medications, comorbidities etc [6.5]
- discuss potential adverse effects [6.1]
- obtain informed consent [6.1]

Choose medication:

- offer SSRIs first, including if comorbid with OCD, ADHD etc [6.4]
- to reduce the risk of sudden withdrawal-related adverse effects, consider SSRIs with longer half-lives [6.11]

Dosage considerations:

- age-appropriate dosage; start low, go slow [6.2.1]
- titrate dosage gradually [6.3]

If considering medication change:

- change to other SSRI as first option [6.12]
- consider SNRI if SSRI not tolerated/inadequate response, considering safety etc [6.13, 6.13.1]

If discontinuing medication:

- SSRIs are known to have discontinuation symptoms. To minimise, these should be gradually reduced then discontinued [6.10]

Monitor and adjust

Regular and frequent follow up for monitoring of symptoms and adverse effects should happen at all points of care. Treatment should be adjusted according to outcomes [7.1, 7.3].

DSM-5 = Diagnostic and Statistical Manual of Mental Disorders
ICD-11 = International Classification of Diseases
ADHD = Attention deficit hyperactivity disorder
OCD = Obsessive compulsive disorder

CBT = Cognitive Behavioural Therapy
ACT = Acceptance and Commitment Therapy
SSRI = Selective Serotonin Reuptake Inhibitor
SNRI = Serotonin and Norepinephrine Reuptake Inhibitor

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