National Institute for Health and Clinical Excellence

Social Anxiety Disorder
Guideline Consultation Comments Table
11 December 2012 - 5 February 2013

Type (NB this is for internal purposes – remove before posting on web)

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website when the guideline is published.
PR = Peer Reviewers or Experts. These comments and responses will be posted on the NICE website when the guideline is published.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.

No	Type	Stakeholder	ON o	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1	SH	Department of Health	1				No comment	Thank you for considering the guideline.
2	SH	British Psychological Society	1		General		The Society believes that the guideline is very strong and a model of content and structure. The Society welcomes the extensive, detailed and well presented analysis of the data on the assessment and management of social anxiety disorder. The classification of treatments on the whole is appropriate and makes the necessary distinctions between types of cognitive and behavioural interventions. The report does however, label one treatment as "Attention Training", and it should be noted that this is a misleading label for the treatment concerned which was developed by Bogel and colleagues. Their treatment is in fact called Task Concentration Training, and should not be confused with Attention Training (ATT: Wells, 1990) which has not been systematically investigated as a treatment for social phobia. The report usefully distinguishes avoidant personality (APD) and social anxiety disorder. Given the high level of overlap in the symptoms of these two presentations it would be helpful to comment on the effects of APD on treatment outcomes where this data is available in the trials analysed. Further, if possible, it would be of use to clinicians if the guidelines could identify whether the presence of APD requires any adjustments in the delivery of Cognitive Therapy, and if there is any indication of the effects of pharmacotherapy in the APD subgroup	Thank you for the comment, the description of BOGELS2006 has been revised The GDG did consider whether recommendations could be made along the lines you suggest but as the data about avoidant personality disorder are extremely limited, they were considered insufficient to make recommendations about modifying treatments.

3	ER	Expert reviewer	29		General		G*ENERAL* COMMENT In summary, I recommend that the analyses and reported results for the social phobic sub-samples of general CBT studies of children with primary Soc Ph be limited to:- 1. clinic-based studies (as there are just not enough people in the internet and bibliotherapy groups to draw conclusions). The report should mention that work is ongoing to evaluate internet and self help approaches but to date there are insufficient studies and sample sizes to enable conclusions to be drawn about effectiveness 2. to diagnostic events and CSR (not generic self report measures that examine a range of anxiety symptoms rather than soc phobia per se) 3. samples where social anxiety is the primary presenting disorder.	Thank you for your comments. To follow our protocol, we are obliged to report the existing studies. You are correct that there were few participants in many studies. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these very serious limitations in the data. In line with your suggestions, only children with primary social anxiety were included and only social anxiety measures were analysed.
4	ER	Expert reviewer	29		General		It would make sense to initially merge the individual and group-based studies and then only separate these out if the sample sizes give strong power to enable valid results I also suggest that the sample sizes be boosted by including data from the large scale trials of the Kendall et al team and other major research groups. This would provide sufficient power to draw conclusions at least about clinic-based general CBT programs (and perhaps group vs individual treatment). Again analyses should be limited to those outlined above. Effect sizes should be reported only for the merged data set, rather than separately reporting individual studies unless the sample sizes are extensive. The confidence intervals are just too large to make sense otherwise.	We agree and have revised the group / individual analyses. We requested data from the Kendall team and others, but they were not able to provide outcomes for children with social anxiety. As above, all effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE (Appendix 19). When making recommendations, the GDG considered these very serious limitations in the data.
5	ER	Expert reviewer	29		General		The report can then specify where the data were obtained from. The section about recommendations for research should then highlight the insufficiency in evidence and types of studies that are needed for the future in order to draw valid conclusions about impact of CBT (general and specific) treatments for social anxiety disorder in children and adolescents	Thank you, the recommendations have been revised the following this and other comments.
6	SH	Lilly UK/Eli Lilly & Co Ltd	1		general		Thank you for the opportunity to comment in the NICE draft guideline for social anxiety disorder. We have no comments to make.	Thank you for considering the guideline.
7	S	Selective	1	Bot	Gene	Ge	To summarise SMIRA's position:	Thank you for the feedback. The scope does

	H	Mutism Information & Research Association (SMIRA)		h	ral	neral	What evidence we have at present) points to the value of very early intervention with selective mutism, (Toppelberg, 2005; Keen et al, 2008) which often begins at the nursery stage. Young children who simply remain silent in specific situations do not necessarily suffer from full- blown Social Anxiety Disorders. Appropriate intervention in conjunction with the school and family has been shown to restore their confidence and ability to function in challenging situations (Cline & Baldwin 2004). If Selective Mutism were to be seen as inevitably linked to SAD even from the outset, several difficulties would be likely to arise. 1.We doubt whether it would be seen as possible to provide treatment at the optimal age, as very young children would not be candidates for medication and cannot engage in talking therapies. 2. A major training investment would be required, as few psychologists or psychiatrists currently claim to have expertise in Selective Mutism.	include selective mutism only in the context of social anxiety disorder, and therefore we do are unable to make wider recommendations about this condition. The guideline makes no recommendation for medication and suggests parental involvement for young children in receipt of psychological interventions (note the lower age limit is 4 years or above.)
8	S H	Selective Mutism Information & Research Association (SMIRA)	1	Both	General	General	3.Funding might not be made available for treatment by professionals such as speech and language therapists, specialist teachers and the members of autism-outreach teams who are currently becoming able to demonstrate, success with selectively mute children and who are engaged in sharing and developing this expertise. There may well be an association between certain types of mutism and SAD, but it is misleading and potentially damaging to the treatment of the child to regard the two conditions as inseparable.	Thank you for the feedback, the scope only includes selective mutism in the context of social anxiety disorder, and clinical guidelines do not make funding directives.

9	SH	Selective Mutism Information & Research Association (SMIRA)	11	Both	General	General	Final comments SMIRA contributed to the DSM 5 consultation and opposed the proposal to subsume SM under SAD, some of the reasons for this have been included in this document. We are happy to send a copy of our response to the DSM consultation on request. We would welcome a separate NICE guideline for the assessment and treatment of SM following a consensus based care pathway of good practice (Keen et al, 2008), or a section devoted to Selective Mutism in the NICE Guidelines for Anxiety Disorders. Meanwhile, it is relevant to include SM in the guidelines for SAD as there is a high rate of co-morbidity, and reluctance to speak affects the assessment of both SAD and SM.	Thank you for the feedback. The guideline does not consider the wider issues of the diagnosis of selective mutism but we will draw your suggestion on care pathways to the attention of NICE.
10	SH	Selective Mutism Information & Research Association (SMIRA)	12	Both	General	General	References: Anstendig KD (1999). Is selective mutism an anxiety disorder? Rethinking its DSM-IV classification. J Anxiety Disorders;13(4):417–434. Bergman, Piacentini & McCracken (2002), Prevalence and Description of Selective Mutism in a School-Based Sample, Journal of the American Academy of Child & Adolescent Psychiatry, 41(8) 938–946 Bernstein B (2009). Anxiety disorder, social phobia, and selective mutism. E-Medicine: Medscape Bernstein et al (2012), Paediatric Social Phobia and Selective Mutism, Medscape http://emedicine.medscape.com/article/917147 Bögels SM et al (2010), Social Anxiety Disorder: Questions and Answers for the DSM-V. Depression and Anxiety, 27: 168-189 Busse, R.T. & Downey, J. (2011). Selective mutism: A three-tiered approach to prevention and intervention. Contemporary School Psychology (15). Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. T. (2004). Child anxiety in primary care:Prevalent but untreated. Depression and anxiety, 20, 155−164. Cline, T. & Baldwin, S. (2004). Selective Mutism in Children (2nd edition). London, England: Whurr Publishers Ltd. Cohan SL, Chavira DA, Stein MB (2006). Practitioner review: psychosocial interventions for children with selective mutism: a critical evaluation of the literature from 1990–2005. J Child Psychology Psychiatry 47:1085–1097. Cohan, L., Chavira, D., Shipon-Blum, E., Hitchcock, C., Roesch, S., Stein, M. (2008). Refining the classification of children with selective mutism: A latent profile analysis. Journal of Clinical Child & Adolescent Psychology, 37(4). Crundwell, R.M.A. (2006). Identifying and teaching children with selective mutism. Teaching Exceptional Children, 38, 48-54. Cunningham et al (2006). Social phobia, anxiety, oppositional behavior, social skills, and self-concept in children with specific selective mutism, generalized selective mutism, and community controls. European Child and Adolescent Psychiatry. 15:245–255. Dummit et al (1997), Systematic	Thank you for these references.

							Assessment of 50 children with Selective Mutism. Journal of the American Academy of Child and Adolescent Psychiatry, 36 (5), 653-660 Elizur Y, Perednik R (2003) Prevalence and Description of Selective Mutism in Immigrant and Native Families: A Controlled Study. Journal of the American Academy of Child and Adolescent Psychiatry, 42 (12): 1451-9. Ford et al (1998), Selective Mutism: Phenomenological Characteristics, School Psychology Quarterly. 13/3, Publisher: Guilford Publications, Pages: 192-227 Garcia-Coll, C., Kagan, J. and Resnick, J (1984), Behavioural inhibition in young children. Child Development, 55, 1005-1019. Johnson and Wintgens (2001). The Selective Mutism Resource Manual, Speechmark Publications, Milton Keynes. Johnson and Wintgens (2013), Selective mutism: specific phobia rather than social anxiety disorder? The importance of accurate conceptualisation for effective clinical management. Occasional paper, Assocation for Child and Adolescent Mental Health – in press Keen, Fonseca and Wintgens (2008). 'Selective Mutism: A consensus based care pathway of good Practice' Archives of Disease in Childhood, vol./is. 93/10 (838-844) Kristensen H (2000). Selective mutism and comorbidity with developmental disorder/delay, anxiety disorder, and elimination disorder. Journal of the American Academy of Child & Ad Kearney, C (2010). Helping Children with Selective Mutism and Their Parents: A Guide for School-Based Professionals. Oxford University Press Inc. Kristensen, H (2001). Multiple informants report of emotional and behavioural problems in a nation-wide sample of selective mute children and controls. European Child & Adolescent Psychiatry. 10:135–142. Adolescent Psychiatry.39:249–256. Kearney, C (2010). Helping Children with Selective Mutism and Their Parents: A Guide for School-Based Professionals. Oxford University Press Inc. Kristensen, H (2001). Multiple informants report of emotional and behavioural problems in a nation-wide sample of selective mute children and controls. European Child & Adolescent Psychiatry. 10:135–142. Kumpulainen, K. (2002). Phenomenology and treatment of selective mutism. CNS Drugs, 16(3), 175-180. Manassis, K., Fung, D., Tannock, R., Sloman, L., Fiksenbaum, L., & McInnes, A. (2003). Characterizing selective mutism: Is it more than social anxiety? Depression and Anxiety, 18,153-161 Manassis K. (2009). Silent suffering: understanding and treating children with selective mutism. Expert Review Neurotherapeutics. 9(2):235-43 Masgutova, S. and Akhmatova, N. (2004), Manual: Integration of Dynamic and Postural Reflexes Into the Whole Body Movement System. McHolm A, Cunningham C and Vanier M (2005). Helping Your Child with Selective	

							Mutism: Practical Steps to Overcome a Fear of Speaking, New Harbinger Publications. Melfsen S, Walitza S, Warnke (2006), A. The extent of social anxiety in combination with mental disorders. Eur Child Adolesc Psychiatry. 15(2):111–117. Omdal, H. and Galloway, D. (2008), Could Selective Mutism be Re-conceptualised as a Specific Phobia of Expressive Speech? An Exploratory Post-hoc Study. Child and Adolescent Mental Health, 13: 74–81. Remschmidt H., Poller M., Herpetz-Dahlmann B., Hennighausen K., and Gutenbrunner C. 2001 A follow up study of 45 patients with elective mutism. European Archives of Psychiatry and Clinical Neuroscience. 251 284-296 Roe, V (2011), Silent Voices: Listening to Young People with Selective Mutism. Paper presented at the British Educational Research Association Annual Conference. Available online from the British Education Index at http://www.leeds.ac.uk/educol/documents/203095.pdf. Schwartz et al (2006), Selective Mutism: Are Primary Care Physicians Missing the Silence? Clinical Pediatrics, 45/1 (43-48) Sharkey L, Mc Nicholas F. (2006), Female monozygotic twins with selective mutism--a case report. J Dev Behav Pediatr. 27(2):129-33. [Medline]. Shipon-Blum, E. (2007). When the words just won't come out: Understanding selective mutism. http://www.selectivemutism.org/resources/library/index_html/ sm-general-information/ Stein M.B. et al (2011). A Common Genetic Variant in the Neurexin Superfamily Member CNTNAP2 Is Associated with Increased Risk for Selective Mutism and Social Anxiety-Related Traits, BIOL PSYCHIATRY; 69:825–831 Steinhausen et al (2006), A long-term outcome study of selective mutism in childhood, Journal of Child Psychology and Psychiatry 47:7, pp 751–756 Stone, B.P., Kratochwill, T.R., Sladezcek, I., & Serlin, R.C. (2002). Treatment of selective mutism: A best-evidence synthesis. School Psychology Quarterly, 17, 168-190. Toppelberg, C. O., Tabors, Patten, Coggins, Alissa, Lum, Kirk and Burger, Claudia (2005) ' Differential Diagnosis of Selective Mutism in Bilingual Children.' Journal of the American Academy of Child and Adolescent Psychiatry 44, 6, 592-595 Vecchio, J. & Kearney, C. (2005). Selective mutism in children: Comparison to youths with and without anxiety disorders. Journal of Psychopathology and behavioral assessment, 27(1). Viana AG, Beidel DC, Rabian B (2009). Selective mutism: a review and integration of the last 15 years. Clin Psychol Rev. 29(1):57-67. Wong, P, (2010). Selective Mutism: A Review of Etiology, Comorbidities, and Treatment, Psychiatry (Edgmont). 7(3): 23–31. Yeganeh R, Beidel DC, Turner SM, et al (2003). Clinical distinctions	

							between selective mutism and social phobia: an investigation of childhood psychopathology. J Am Acad Child Adolesc Psychiatry. 42(9):1069–1075. Yeganeh R, Beidel DC, Turner SM (2006). Selective mutism: more than social anxiety? Depression and Anxiety, 23(3):117–123.	
11	SH	British Medical Association	1	Full	General	General	We are concerned that by issuing a clinical guideline NICE risks medicalising a phobia and treating social phobias differently from other phobic anxiety.	Thank you for your comment. Social anxiety disorder, specific phobias, and agoraphobia form distinct diagnostic categories in DSM and ICD and are covered in NICE guidance. For each disorder, clinicians should consider specifics when they identify cases, conduct assessments, and select treatments. It is therefore appropriate to provide guidance on the treatment of this common, debilitating, and distinct condition.
12	SH	South London and Maudsley NHS Foundation Trust	1	FULL	General	General	This guidance is very welcome given the high rates of social anxiety disorder in the population and the existence of effective treatments. The guidance is valuable in highlighting the impact of social anxiety on work, education, relationships etc, and its current under-detection. There are 3 aspects covered in this guidance – SAD in adults, SAD in children, and CCBT for specific phobias. This last section seems a strange addition to this overall guidance and its impact and recommendations are likely to get lost. It makes more sense for these to be removed into a separate report. The main recommendations for treating SAD are eminently sensible and expected: to offer individual CBT specifically developed for SAD. It is important that it has been clearly stated that generic CBT is less effective and not recommended. The guidance also provides an important element of patient choice, including pharmacological treatment and other psychological therapies, if CBT has been offered and declined. While welcoming the guidance and agreeing with the recommendations it is unclear why a network meta-analysis / model is used to compare treatments, rather than other more standard meta-analyses that have been used in other NICE guidance documents.	Thank you for the positive feedback. A network analysis was used because this was the best way to estimate relative effects of three or more interventions by making use of as much data as possible under the assumption that effects are transitive. The NCCMH were commissioned by NICE to include a review of cCBT for specific phobias within this guideline as a partial update of TA97.

13	PR	Expert reviewer	4	FULL	General	General	There are a number of references to the effectiveness of treatments as determined in the context of RCTs or other similar evaluations. However, this is not the typical (or best) terminology. Outcomes in RCTs are said to index 'efficacy.' The term 'effectiveness' is often reserved for evaluation of the utility of a treatment under less controlled, potentially more externally valid, conditions, as might be the case when a treatment showed as efficacious in an RCT is applied in a working mental health clinic by line clinicians and the outcomes are then evaluated.	Thank you for your comment. We have amended the guideline to ensure that this terminology has been used appropriately.
14	PR	Expert reviewer	5	FULL	general	general	A limitation of the comparisons between modalities of treatment, that I did not see discussed, is that they assume that studies of each modality enrolled similar subjects with similar severity of SAD. However, it seems unlikely, for example, that patients willing to take the risks of study treatment with an MAOI were in general the same in respect to severity and treatment-refractoriness as those volunteering for a self-help study. While I doubt sufficient evidence exists to document such differences, it should be noted as a prominent caveat in these comparisons and in the cost effectiveness analysis.	Thank you. We agree that the available evidence is insufficient to identify systematic differences in severity across studies. In section 6.5.1 (*Indirectness*) we identify this as a limitation. We raise it again in section 6.10.2 (*Discussion - limitations of cost effectiveness analysis*). Statistically, the network analysis was very consistent. We found no empirical evidence of heterogeneity of this kind, but the data were too limited to conclude that there is an absence of true heterogeneity.
15	SH	The College of Mental Health Pharmacy	1	FULL	General comment	General comment	The College welcomes these guidelines which will help clarify prescribing decisions in this persistent and distressing disorder.	We are grateful for the positive feedback about the recommendations in this guideline, and we acknowledge the complexities of psychotropic prescribing.
16	SH	The College of Mental Health Pharmacy	2	FULL	General comment	General comment	We are disappointed that a lead mental health pharmacist was not appointed to the guidelines development group given the complexities of psychotropic prescribing.	The guideline group (as detailed in the agreed scope) included experts from a wide range of disciplines, including a psychiatrist with expertise in psychopharmacology.
17	ER	Expert reviewer	5	FULL	????	18	*Line 7:* Again may be worth pointing out that these differences may simply reflect a difference in degree.	Thank you – we have added this.
18	SH	South London and Maudsley NHS	2	FULL	1.1.2	7	Important that the responsibility of clinician responsibility in exercising clinical judgement and consultation with service user/carers has been highlighted. Presume carers are more relevant in considering under 18s	Thank you. We agree that the role of carers and family members change across the lifespan and recommendation 1.1.10 reflects this.

		Foundation Trust						
19	SH	British Association for Behavioural & Cognitive Psychotherapies	1	Full	1.1.2	8	It would be very helpful to particularly emphasise that because of the considerable variability in the number and type of feared social situations and range of feared outcomes, the clinical guideline recommendations are not readily applicable	Thank you for this comment, clinical guidelines are designed to support professional judgement and the recommendations are developed by the GDG with this mind. It will be for individual clinicians to take account of the settings in which problems arise when developing a collaborative treatment plan.
20	SH	British Association for Behavioural & Cognitive Psychotherapies	2	Full	2.1.1	13	Although somewhat stated, it is useful to acknowledge that people with social anxiety disorder fear or worry about showing signs of anxiety/symptoms of anxiety	Thank you for the comment – we have added this.
21	SH	South London and Maudsley NHS Foundation Trust	3	FULL	2.1.1	13	Helpful distinction between clinical and non clinical social anxiety, and adult and child presentations	Thank you for your comment.
22	ER	Expert reviewer	1	FULL	2.1.3	15	*Line 11:* Yonkers? suggests that treatment or not makes little difference to persistence.	We have revised to say “naturally unremitting”
23	SH	British Association for Behavioural & Cognitive Psychotherapies	3	Full	2.1.4	15	Please specify what type (e.g. health, therapeutic etc) of “poorer outcomes” are predicted	Thank you – we have revised.
24	ER	Expert reviewer	2	FULL	2.1.4	16	Line 14: There is actually little or no evidence about causal relationships. SAD precedes dep and subst because it starts earlier, but this does not mean one causes or leads to the other.	Thank you for your comment, but we don’t think that the text to which you refer implies more than the data support.
25	ER	Expert reviewer	3	FULL	2.1.4	16	Line 20: No - this is correlational! May indicate common relationship - especially likely a general genetic link.	Thank you for your comment, with which we agree. We have removed the statement about causation.
26	ER	Expert reviewer	4	FULL	2.1.4	16	*Line 32:* May be worth making the point that many experts view these are really the same basic disorder with APD simply being a more severe version.	Thank you – we have added this.

27	SH	The National Autistic Society	1	FULL	2.1.4	17	There is increasing evidence to suggest that the 1% of people in the general population who have autistic spectrum disorders (ASD)[1] have higher rates of anxiety and mood related symptomatology (Rescorla, 1986; Russell & Sofronoff, 2005; Szatmari et al., 1995; Tantam, 1988), including social anxiety (Green et al., 2000) than the rest of the general population. In a review White et al. (2009) found that the prevalence rates of anxiety disorders (in children) ranged from 11-84% in an ASD population. The possible reasons behind the great range might be due to the population age range, the methods applied in measuring anxiety and the diagnostic subtypes (AS, HFA etc). Children with ASD have difficulties tolerating new situations (including new people) and certain sensory experiences. Their reactions may include extreme distress, and anxiety (Mayes & Calhoun, 1999, 2011). Therefore it is not surprising when comparing children with ASD and typically developing children that the occurrence and/or intensity of the anxiety symptoms are higher for the ASD population (Gillott et al., 2011; Bellini, 2004). Contributing to the anxiety are intense and odd fears, and at a frequency of 40% in children with autism (Mayes, 2012; Mayes et al., 2012), this is significantly higher than for children without autism where it lays at 0–5%. In terms of the nature of anxiety studies involving adolescents suggest that up to 45% of those with AS may have significant difficulties with either generalised anxiety or specific phobias (Green et al., 2000). A recent study of adults with ASD (Gillott & Standen, 2007) found that this population is nearly three times more anxious than people with intellectual disabilities, and they are more likely to have difficulties across a range of anxiety disorders, including social anxiety, e.g. panic disorder and generalised anxiety disorder.	Thank you for the thoughtful comments. Unfortunately, however, including these issues are beyond the scope of the current guideline. The current autism guidelines and the *Autism in Children and Young People* guideline that is due for publication summer 2013 address some of these issues.

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28	SH	The National Autistic Society	1	FULL	2.1.4	17	In view of these figures practitioners should take into account that individuals with ASD are particularly vulnerable to stress and anxiety, be it due to their restricted repertoire of appropriate coping mechanisms (Groden et al., 2001) or to their reduced ability to recognize thoughts and feelings both in themselves and others (Baron- Cohen & Jolliffe, 1997; Baron- Cohen et al., 1999). Finally co-morbidity with additional psychiatric disorders is common for people with ASD. Ghazziudin et al. (1995) observed that psychiatric disorders go unrecognized in many individuals with AS/HFA as they can be challenging for clinicians to recognize. The most frequent co-morbid conditions, apart from anxiety, are depression, OCD, bipolar disorders and ADHD (Mazzone et al. 2012). OCD symptoms in adults with ASD tend to differ from those in a typical population including more repetitive ordering, hoarding, telling/asking, and repeated touching, and with fewer of their obsessive thoughts being aggressive, sexual, or religious in nature (McDougle and colleagues (1995). An epidemiological study by Ghaziuddin et al., (1994) suggested that approximately 1 in 68 persons with an ASD also meet criteria for an additional diagnosis of OCD but this may be an under-estimate. Practitioners also should note that 20% of individuals with OCD have coexisting autistic traits (Bejerot et al., 2001), and biological links between the disorders have been hypothesized (Gross-Isseroff et al., 2001). There are very few studies yet of (modified) cognitive behavioural therapy offered as treatment for social anxiety in children and adults with AS. However it is important to note that effectiveness may not be the same as for people without ASD. References Baron-Cohen, S., et al. (1999). Recognition of faux pas in normally developing children and children with autism and Asperger syndrome or high functioning autism. Journal of Autism (1997). and Developmental Disorders, 29, 407-418. Baron-Cohen, S., Jolliffe, T. Another advanced theory test of theory of mind: Evidence from very high functioning adults with autism or Aspergers syndrome. Journal of Child Psychology and Psychiatry, 38, 813-822. Bejerot, S., Nylander, L. & Lindström, E. (2001). Autistic traits in obsessive–compulsive disorder. Nordic Journal of Psychiatry, 55, 169–176.	Again we are grateful for your thoughtful comments. But this guideline is limited by its the scope of the current guideline. The current autism guidelines and the *Autism in Children and Young People* guideline that is due for publication summer 2013 address the issue to some extent but as pointed out above are limited by the available evidence.

							Bellini, S. (2004). Social skills deficits and anxiety in high- functioning adolescents with autism spectrum disorder. Focus on Autism and Other Developmental Disabilities, 19, 78-86. Ghaziuddin, M. , Tsai, L. & Ghaziuddin, N. (1994). Comorbidity of Autistic Disorder in Children and Adolescents. European Child & Adolescent Psychiatry, 1, 209–13. Ghaziuddin, M., Leininger, L. & Tsai, L. (1995). Thought disorder in Asperger syndrome: Comparison with high-functioning autism. Journal of Autism and Developmental Disorders, 3,311–317. Gillott, A. & Standen, P.J. (2007) Levels of anxiety and stress in adults with autism. Journal of Intellectual Disabilities, 11, 359-370. Gillott, A., Furniss, F., Walter, A. (2001). Anxiety in high- functioning children with autism. Autism, 5, 277-286. Green, J., et al. (2000). Social and psychiatric functioning in adolescents with Asperger syndrome compared with conduct disorder. Journal of Autism and DevelopmentalDisorders, 30, 279-293. Groden J, et al. (2001). The development of a stress survey schedule for persons with autism and other developmental disabilities. Journal of Autism and Developmental Disorders, 31, 207-217.Gross-Isseroff, R., Hermesh, H. & Weizman, A. (2001). Obsessive compulsive behaviour in autism—towards an autistic-obsessive compulsive syndrome? World Journal of Biological Psychiatry, 2, 193–197. Mayes, S. D. (2012). Checklist for Autism Spectrum Disorder. Wood Dale, IL: Stoelting. Mayes, S. D., & Calhoun, S. L. (1999). Symptoms of autism in young children and correspondence with the DSM. Infants and Young Children, 12, 90–97. Mayes, S. D., & Calhoun, S. L. (2011). Impact of IQ, age, SES, gender, and race on autistic symptoms. Research in Autism Spectrum Disorders, 5, 749–757. Mayes, S. D., Calhoun, S. L., Mayes, R. D., & Molitoris, S. (2012). Autism and ADHD: Overlapping and discriminating symptoms. Research in Autism Spectrum Disorders, 6, 277–285. Mazzone, L., Ruta, L. & Reale, L. (2012). Psychiatric cormobidities in asperger syndrome and hight functioning autism: diagnostic challenges. Annals of General Psychiatry, 11, 1-13. McDougle, C. , Kresch, L . , Goodman, W.K. & Naylor, S . T. (1995). A Case- Controlled Study of Repetitive Thoughts and Behavior in Adults with Autistic Disorder and Obsessive-Compulsive Disorder. American Journal of Psychiatry, 152, 772- 777. NICE clinica guidelines (2011). Autism: recognition, referral and diagnosis of children and young people on the autism spectrum. http://www.nice.org.uk/nicemedia/live/13572/56424/56424.pdf Rescorla, L.A. (1986). Preschool psychiatric disorders: Diagnostic classification and symptom patterns. Journal of the American Academy of Child and Adolescent Psychiatry, 25, 162-169.	

							Russell, E. & Sofronoff, K. (2005). Anxiety and social worries in children with Asperger syndrome. Austrailian and New Zealand Journal of Psychiatry, 39, 633-638. Szatmari, P. et al. (1995). Asperger syndrome and autism: Differences in behaviour, cognition and adaptive functioning. Journal of the American Academy of Child and Adolescent Psychiatry, 34, 1662-1670. Tantam, D. (1988) Lifelong eccentricity and social isolation. Part 2: Asperger syndrome or schizoid personality disorder. British Journal of Psychiatry, 153, 783-791. White, S.W., Oswal, D., Ollendick T. & Scahill L. (2009). Anxiety in children and adolescents with autism spectrum disorders. Clinical Psychology Review, 29, 216-229	
29	S H	Selective Mutism Information & Research Association (SMIRA)	3	FU LL	2.1.4	17, 1-4	Prevalence of Selective Mutism The full version states that mutism is 'rare'. Viana et al (2009) indeed describe SM as 'a rare childhood disorder' but this is misleading. Lisa Camposano (2011) summarises that: "Recent studies suggest that selective mutism may occur in .7 to 2% of early elementary students, although many researchers agree that these prevalence rates may be underrepresented due to the lack of knowledge of the disorder (Cunningham, McHolm, & Boyle, 2006; Lescano, 2008; Schwartz et al., 2006; Sharkey, McNicholas, Barry, Begley,& Ahern, 2007)." Even taking the most conservative of these estimates, 0.7% amounts to 1 in 150 children in the primary school age-range. This concurs with Manassis's observation that 'Although SM is considered rare, one or more children with SM can be found in most elementary schools.' This conservative estimate makes SM as common as autism. It is essential for every GP and teacher to be fully aware of its existence and the need for intervention as, unlike autism, it can be fully resolved if tackled early (Toppelberg, 2005; Schwartz et al., 2006; Busse and Downey, 2011).	Thank you for these comments. In light of your comments this section has been rewritten as follows: *"In some people, social anxiety can be expressed as selective mutism, however as selective mutism does not always reflect social anxiety, more detailed assessment is always required*".

30	S H	Selective Mutism Information & Research Association (SMIRA)	3	FU LL	2.1.4	17, 1-4	Describing SM as 'rare' will continue to marginalise the condition and discourage the prioritisation of awareness-raising amongst practitioners in health and education. We therefore suggest that either 'although rare' is removed altogether, *OR* that 2.1.4 is qualified as follows: 2.1.4 What other mental health problems tend to be associated with social anxiety disorder? Selective mutism, although rare in the SAD population, is also often associated with a diagnosis of social anxiety disorder	Thank you, this section has been revised in light of your comments.
31	S H	Selective Mutism Information & Research Association (SMIRA)	4	FU LL	2.1.4	17, 1-4	Social Anxiety Disorder and Selective Mutism: Comorbidity The full version states that mutism is often associated with SAD, particularly in younger children. This is unsubstantiated and we suggest that 'particularly in younger children' is removed *or* changed (see end of this section). Bögels et al (2010) conducted a very similar review of selective mutism, largely based on Viana et al's paper, and state: "Rather than a distinct disorder, an alternative conceptualization of SM is that it *may* be a developmentally specific, *young child* variant of SAD. That is, not speaking *might* be a more natural form of social avoidance for younger children than for older children and adults" (our italics). However, viewing SM as 'an extreme variant of social anxiety disorder, particularly in younger children', is very different from the statement in 2.1.4, that SM is often associated with a diagnosis of SAD, particularly in younger children. . In fact, SM is more often associated with a diagnosis of SAD in older children and adults. Social anxiety levels tend to increase as children get older and do not "grow out of" selective mutism (Steinhausen et al, 2006). Without early intervention, older children and adolescents with SM are at risk of developing SAD and other psychopathology (Schwartz et al, 2006, Kumpulainen, 2002, Steinhausen et al, 2006, Shipon-Blum, 2007) with poorest outcomes for adults suffering from both SM and anxiety disorders such as SAD (Remschmidt et al, 2001; Steinhausen et al, 2006). There are strong indications in the literature (more references in next section) that SM exists *without* SAD in young children, and that they are distinct, but overlapping conditions. In practice, young children with SM often demonstrate *minimal*	Thank you, this section has been revised in light of your comments.

							social anxiety when they are allowed to gesture or write, rather than speak (Yeganeh et al, 2003; Omdal and Galloway, 2008; Sharkey and Nicholas, 2006), indicating that their anxiety is linked specifically to the *act* of speaking; rather than the wider social context and the effect they are having on other people. Some authors suggest that this is a small subset of the SM population, but it appears to have far more to do with environmental factors and the way the SM is handled by others (Cline and Baldwin, 2004). This is not to say that young children do not experience social anxiety. Indeed, the only consistent finding in the literature, is that children with SM experience high levels of anxiety in specific social situations, at times when they are expected (or believe they are expected) to speak. But it is essential to understand that this is not the same as having social anxiety disorder, when an individual's lack of speech is due to fear of embarrassment or humiliation. SM is increasingly linked in the literature to an actual 'freezing' of the articulatory muscles and inability to speak, accompanied by extreme anxiety (Masgutova and Akhmatova, 2004; Garcia-Coll et al, 1984; Johnson and Wintgens, 2001). If children anticipate these distressing sensations when expected to speak, it is natural for them to experience social anxiety until the pressure to speak is removed and to try to avoid being in that position. In this respect SM has far more in common with stammering than SAD, and it is of note that children who avoid speaking because they are embarrassed about their stammer are excluded from the DSM IV definition of social phobia. We therefore propose a modification to 2.1.4. page 17, lines 1-4 as follows: 2.1.4 What other mental health problems tend to be associated with social anxiety disorder? Selective mutism is also often associated with a diagnosis of social anxiety disorder, particularly in older children and adults.	

32	SH	Selective Mutism Information & Research Association (SMIRA)	5	FULL	2.1.4	17, 1-4	Ensuring appropriate management of selective mutism (1) As already stated, the full version cites the hypothesis that mutism is an extreme variant of SAD, referencing Viana et al, 2009. However, in the same review, Viana et al conclude that although there is an association between SM and SAD, further investigation is needed to elucidate the nature of this relationship. Arguments *against* subsuming SM within SAD include the differences in mean age of onset, self-reported anxiety levels, response to cognitive and behavioural interventions, and longterm prognosis (Manassis et al., 2003; Melfsen et al, 2006; Yeganeh et al, 2003, 2006; Omdal and Galloway, 2008; Stein et al, 2011). The suggestion that SM is a variant of SAD is only one view and not universally accepted. A view that is more compatible with the presentation and effective treatment of SM, is that it may be regarded as a specific phobia of expressive speech (Omdal and Galloway, 2008; Johnson and Wintgens, 2001). Of particular concern to SMIRA therefore, is the risk that, in the absence of a separate NICE Guideline for SM, practitioners will look to the SAD Guideline, see that SM is viewed as a variant of SAD and assume that the assessment and treatment recommendations apply to both SAD *and* SM. Despite considerable overlap, effective treatments for SM and SAD are significantly different, particularly for younger children. Based on the outcome of single-case experimental studies, behavioural interventions in the form of contingency management, shaping, stimulus fading and systematic desensitisation appear efficacious for SM (Stone et al, 2002; Cline and Baldwin, 2004; Cohan et al, 2006; Bogels et al, 2010; Roe V, 2011). Treatment manuals written by experienced clinicians with large caseloads of children with SM, employ the same behavioural methods and recommend programmes of parent/staff education to ensure the SM is not maintained through the reactions of others, combined with graded exposure to the source of the child's fear (allowing others to hear their voice) in small manageable steps (Kearney C, 2010; Johnson and Wintgens, 2001; Cunningham, 2004). In contrast with the NICE guideline recommendations, these behavioural programmes almost invariably necessitate working with children on an *individual* basis initially, and children are systematically helped to work towards talking in groups. Starting	Thank you for your comment. Unfortunately, we are unable to make any treatment recommendations that are not specific to social anxiety disorder as these would be outside the agreed scope of the guideline.

							with groupwork as is suggested on page 44, line 3, would have a negative effect on young children with SM. The efficacy of cognitive interventions for SM is less clear (Cohan et al, 2006; Stone et al, 2002; Cline and Baldwin, 2004) particularly for young children . We therefore propose the following addition to ensure that additional or alternative interventions for SM are considered and explored: 2.1.4 What other mental health problems tend to be associated with social anxiety disorder? Selective mutism is also often associated with a diagnosis of social anxiety disorder, particularly in older children and adults and is viewed by some as an extreme variant of social anxiety disorder (Viana et al., 2009). However, while there is some overlap with recommendations for SAD, specific interventions for selective mutism are recommended but beyond the scope of these guidelines.	
33	SH	Selective Mutism Information & Research Association (SMIRA)	2	FULL	2.1.4.	17, lines 1-4	Mutism or Selective Mutism? The full version cites the hypothesis that mutism is an extreme variant of social anxiety disorder (SAD) and references Viana et al., 2009. Throughout Viana's review, the term *selective mutism* is used, rather than *mutism*, and this should be upheld within the NICE guideline to avoid confusion with partial or total mutism which may occur as part of post-traumatic stress disorder.	Thank you, this has been revised in light of your comments.
34	SH	British Association for Behavioural & Cognitive Psychotherapies	4	Full	2.1.5	17	It would be useful to highlight the primary distinctions between social anxiety disorder and shyness	Thank you – we have revised.
35	SH	British Association for Performing Arts Medicine	1	FULL	2.1.5	17	For some performers, performance anxiety can lead to to the abandonment of a career or a change of career.	Thank you – we have added this point.
36	P	Expert	1	FU	2.1.6	18	This section describes the generalized and non-generalized	Thank you – we have removed the discussion

	R	reviewer		LL			subtypes. For what it is worth, the DSM-V will drop this distinction. What is currently called generalized SAD will simply be SAD; however, a performance type will be specified for persons whose fears fall only in that domain. Also, it is stated that a subtype of persons with SAD and risk prone behavior has been suggested, and there is in fact a bit of research on the topic. However, it is limited to 3-4 papers, and thus the evidence base is quite insufficient to warrant the suggested inclusion of subtyping in this manner at this time.	of "risk prone". Thank you also for the comment about the generalised and non-generalised subtypes. The guideline simply reflects current nosology, and most of the data relate to the broader condition, as detailed throughout.
37	E R	Expert reviewer	6	FU LL	2.2.1	18	*Line 23:* But they are also more likely to have a variety of other disorders including other anxiety and depression. Ie the genes are probably broad ones.	Thank you – we have added this point.
38	S H	British Association for Performing Arts Medicine	2	FU LL	2.3.2		For many performers, stigma is attached to admitting to having performance anxiety and some sufferers fail to seek treatment for this reason.	Thank you – we have added this point.
39	P R	Expert reviewer	2	FU LL	2.3.2	19	At the end of this section, there is a listing of some potential reasons why people with SAD do not seek treatment. Missing from this list is the fear that they may be negatively evaluated by service providers for having their fears and anxieties. See Olfson et al. (*American Journal of Psychiatry*, 2000).	Thank you – we have added this point.
40	P R	Expert reviewer	3	FU LL	2.3.3	21	It is stated that almost any psychological treatment will have substantial non-specific effects for SAD. This might be generally true. However, it is not uncommon to see this effect shattered because the sufferer is afraid to admit to the service provider the specific nature of his/her fear, and this may abort the otherwise beneficial effects of the therapeutic relationship implied in this passage.	Thank you for your comment. We have revised the text to clarify that we are talking about therapies in which it is clear to the therapist and patient that social anxiety disorder is the main focus of treatment.
41	S H	British Association for Behavioural & Cognitive Psychotherapies	5	Full	2.3.4	22	The different forms of subtle or covert avoidance behaviours need to be referred to as safety-seeking behaviours earlier on in the guideline	Thank you for your comment. We have revised the text to cover safety seeking behaviours. We have also mentioned these behaviours in several other places in the guideline, including in the chapter on assessment.
42	P R	Expert reviewer	5	FU LL	2.3.4	22	It is stated that social skills training is based on the notion that persons are anxious in social situations partly because they are uncertain how to behave. This is a degree or two off the mark.	Thank you – we have added this.

							Rather social skills training is premised on the notion that persons with social anxiety are deficient in their social behavioral repertoires and need to enhance these repertoires in order to behave successfully and realize positive outcomes in their interactions with others. These two positions are quite different – it is certain that all persons with SAD are uncertain how they should behave; however, it is not at all clear that their behavior is in all cases socially deficient.	
43	SH	British Association for Behavioural & Cognitive Psychotherapies	6	Full	2.3.4	23	There are conceptual as well as practical differences between external attention focusing and task focused attention so these should not be confused	Thank you. We have revised.
44	SH	South London and Maudsley NHS Foundation Trust	4	FULL	2.3.4	24	The report should be more specific in describing Mindfulness Based Cognitive Therapy rather than the rather general term “mindfulness” which simply describes a particular state of awareness rather than a specific practice/intervention.	Thank you for your comment. Mindfulness Based Cognitive Therapy and Mindfulness Based Stress Reduction were both included and the text has been revised to reflect this.
45	SH	British Association for Behavioural & Cognitive Psychotherapies	7	Full	2.3.4	25	Reference is made to medication, rather than (and correctly) meditation, techniques	Thank you for pointing this typo out, this has been amended.
46	PR	Expert reviewer	6	FULL	2.3.4	25	Line 15, ‘medication’ should be ‘meditation’.	Thank you for pointing this typo out, this has been amended.
47	ER	Expert reviewer	7	FULL	2.3.4	25	*Line 15:* I think you mean meditation!	Thank you for pointing this typo out, this has been amended.
48	PR	Expert reviewer	1	FULL	2.3.5	25	line 18: refers to “three classes of medicines”, the first of which is “antidepressants”. But it would be more accurate and consistent to list (or at least allude to) the 4 separate classes of antidepressants rather than to lump them here.	Thank you. We have revised this section.
49	PR	Expert reviewer	7	FULL	2.3.5	26	This section speaks rather highly of the efficacy of moclobemide. It is my reading of the literature that this is not truly the case, that it is efficacious only at high doses, and inconsistently at that. Traditional MAOIs have efficacy to be sure, but moclobemide does not.	Thank you for the comment; we have amended this section in light of your and other comments.

							Brofaromine, a reversible inhibitor on MAO-A, looked to be quite efficacious in early trials, but the pharmaceutical company ceased worldwide production many years ago.	
50	PR	Expert reviewer	8	FULL	2.3.5	27	It is worthwhile and important to mention that an additional issue in the use of benzodiazepines is that their ability to reduce anxiety in the short term may complicate the conduct of exposure treatments by preventing the patient from experiencing sufficinet anxiety evocation on initial exposure to the feared situation. Although not studied in SAD, studies in panic disorder/agoraphobia suggest greater relapse in patients taking benzodiazepines (specifically alprazolam) in conjunction with exposure compared to exposure alone, especially if they attribute their initial gains to the medication.	Thank you for the comment; we have amended this section in light of your and other comments
51	SH	British Association for Performing Arts Medicine	3	FULL	2.4	27	Costs to the Depts of Health, Social Services and Dept Employment, etc stem from the loss of a career and the need to register as unemployed.	Thank you for your comment. Section 2.4 does discuss costs to the health services, productivity losses and state benefits associated with the presence of social anxiety. We have added a sentence to emphasise the lower employment rates associated with social anxiety. Section 2.1.5, which discusses the impact of social anxiety on people's lives, also provides some details regarding work-related issues.
52	ER	Expert reviewer	1	FULL	3.7	59	The statement that adult recommendations will be reused for children if evidence is not available is of dubious validity and should be treated with considerable caution.	Thank you for the comment, this is not what we intended to suggest and we have revised the section to clarify our intentions.
53	SH	South London and Maudsley NHS Foundation Trust	5	FULL	4.1 & general	64 & onwards	Very good summary of obstacles to accessing care. Excellent principles of care.	Thank you for your comments.
54	SH	British Association for Behavioural & Cognitive Psychotherapies	8	Full	4.3	67	For a number of people with social anxiety disorder, performance problems occur and more anxiety levels are experienced with one, rather than more than one person present, as they tend to find these situations more difficult to conceal their symptoms or manage their perceived distorted appearance	Thank you for your comment, this section has been revised and the phrase "particularly when more than one person is present" removed.
55	E	Expert	8	FU	4.3	67	*Second bullet under 'relationship problems':* or that their	Thank you for your comment .The text has

	R	reviewer		LL			professional will evaluate them negatively.	been revised to read: "or *fear that they are going to let down or displease their healthcare professional, or that their healthcare professional will evaluate then negatively*"
56	PR	Expert reviewer	10	FULL	4.6	75-76	The phrase "the concern that the social anxiety disorder may impact on their ability to fully benefit from the intervention offered" seems quite unusual when one is discussing treatment for social anxiety disorder itself.	Thank you for the comment, this section has been revised.
57	ER	Expert reviewer	6	FULL	4.7	74-79	Somewhere in this section there needs to be a recommendation about finding ways to increase access of young people to treatment given that majority of young people with anxiety disorders (and presumably social phobia) do not receive professional clinical therapy (Essau et al.). Chapter 2 notes that most children with social phobia do not get referred to CAMHS. What methods are effective in improving uptake of and engagement with interventions for children and adolescents with social anxiety disorder? Need to examine ways to increase access to treatment for this population. How might school-based services and online, therapist or parent guided approaches assist?	Thank you for this comment. We have amended the recommendations on case identification in light of your and other comments (1.4.1.-1.4.5) and we would draw your attention to recommendations 1.1.6 to 1.1.8 which address the issue of engaging young people in treatment.
58	SH	South London and Maudsley NHS Foundation Trust	6	FULL	4.7	76-79	Comprehensive and clear principles of working with people with social phobia and carers/parents	Thank you for your comment.
59	ER	Expert reviewer	4	FULL	4.7.2	77-79	This section should pay greater heed to the role of school-based services given the increased likelihood of detection and attendance for intervention.	Thank you for this comment, recommendations are based on the available evidence and in recommendation 1.1.7 (revised recommendation 1.1.6) reference is made to the importance of maintaining links with schools.
60	ER	Expert reviewer	5	FULL	4.7.3	79	Should mention the need for intervention that focusses on changing parenting behaviour if it Full promotes or maintains social anxiety, and to increase parent behaviour that supports effective implementation of therapy, particularly in the younger age range. Enhancing parenting skills is not really mentioned here.	We have revised recommendations on parenting in light of this and other comments.
61	ER	Expert reviewer	7	FULL	4.7.4	79	4.7.4 Research recommendation Given the paucity of research relating the RCTs for child social anxiety disorders – this section needs to emphasize the importance of more RCTs specifically with this population, with sufficient power	Thank you – this has been revised.

							to draw conclusions and with interventions designed specifically for social phobia.	
62	PR	Expert reviewer	12	FULL	5.2.1	83	The description of the clinical utility of case identification instruments strikes me as unrealistic. Given that there is a reasonable desire for the instrument to be very brief (no more than 12 items), it is simply not plausible that the level of detail provided may "contribute to the identification of further assessment needs and therefore be potentially useful for care planning and for referral to treatment." It is fine to expect that a screening instrument should screen, that is, suggest the presence of a disorder and flag the need for further assessment, but nothing more.	Thank you for the comment. Thank you for the comment, this section has been revised to read: "*The instrument should be feasible and implementable in a routine clinical care. The instrument should contribute to the identification of further assessment needs and inform decisions about referral to other services."*
63	ER	Expert reviewer	17	FULL	5.2.2	84	*Two studies evaluated the Mini-SPIN:* Three? Seeley-Wait, E., Abbott, M. J., & Rapee, R. M. (2009). Psychometric properties of the mini-SPIN. *The Primary Care Companion to the Journal of Clinical Psychiatry, 11*(5), 231-236.	Thank you. We have added this study to the review.
64	PR	Expert reviewer	13	FULL	5.2.2	88	It is noted that there are few studies of each instrument for case identification (2 for the Mini-SPIN, one for all others). There are, however, at least a few other studies of the Mini-SPIN, although these studies may or may not meet the specific criteria set forth. See: de Lima Osório, F. L., Crippa, J. A. S., & Loureiro, S. R. (2010). Further Study of the Psychometric Qualities of a Brief Screening Tool for Social Phobia (MINI SPIN) Applied to Clinical and Nonclinical Samples. *Perspectives in Psychiatric Care, 46*(4), 266-278. de Lima Osório, F., Crippa, J. A., & Loureiro, S. R. (2007). A study of the discriminative validity of a screening tool (MINI-SPIN) for social anxiety disorder applied to Brazilian university students. [10.1016/j.eurpsy.2007.01.003]. *European Psychiatry, 22*(4), 239-243. Wilson, I. (2005). Screening for social anxiety disorder in first year university students. *Australian Family Physician, 34*(11), 983-984.	Thank you for the references. One of these meets the inclusion criteria (de Lima Osório 2007) and we have added it. The filter for identifying studies of diagnostic test accuracy in electronic databases excluded this study. This is a known problem with such filters (e.g. Mann and Gilbody *Systematic Reviews* 2012, **1**:9;
65	ER	Expert reviewer	19	FULL	5.4.2	94	I find this surprising. The SIAS has the highest retest reliability (which is most important for monitoring of symtpoms) and is one of the shorter scales. Seemingly better than the LSAS and far shorter than the SPAI when subitems are taken into account.	Thank you for this comment. The GDG considered the SIAS/SPS were designed to be used together but, in combination, these are too lengthy and too difficult to recommend them in routine clinical practice. We have revised accordingly.
66	ER	Expert reviewer	9	FULL	Table 9	95	Characteristics of adult assessment instruments:- Need to be clear that the Spence et al 2000 paper was with children… not adults. Perhaps doesn't fit here, or a note should be made in the table.	Thank you for the comment. This has been revised accordingly.

67	ER	Expert reviewer	20	FULL	5.4.2	95	*Table 9, FNE:* Is this right?? FNE was developed by Watson & Friend I think - around 1979?	Thank you for the comment, this has been revised.
68	ER	Expert reviewer	21	FULL	5.4.2	95	*Table 9, SAD:* As above - SADS and FNE are companion scales.	Thank you for the comment, this has been revised.
69	ER	Expert reviewer	22	FULL	5.4.2	95	Table 9, SPAI-SP: As far as i know, this scale has many sub-items and so is far longer than 32 items. I would personally never use this to monitor tx due to its length.	Thank you for your comment. We have decided to remove the SPAI from our recommendations, as its length and the potential complications regarding scoring bring into question its usefulness for monitoring symptoms.
70	ER	Expert reviewer	12	FULL	5.5	100 - 104	Needs some recommendations for research re validation of existing diagnostic instruments and assessment questionnaires for identification of social anx disorder in children/adolescents.	Thank you for your comment. The GDG agrees with the need for further work in this area but have not included a recommendation because we are limited in the number of recommendations we can make and those included were deemed to have a higher priority by the GDG.
71	ER	Expert reviewer	11	FULL	5.5.2	102	Assessment should include an examination of maintaining or causal factors in the home, school and social environment, such as parenting behaviours that promote and support anxious behaviours, and peer victimisation at schools.	Thank you. We have included a new recommendation to address this comment.
72	SH	South London and Maudsley NHS Foundation Trust	8	FULL	5/general	general	Simple and easy to follow suggestions for screening and identifying social anxiety set out.	Thank you for your comments.
73	PR	Expert reviewer	2	FULL	6.2.1	104	The statement, “Benzodiazepines have also been used but their long-term use is actively discouraged,” is not consistent with what is in my opinion a more accurate statement on p.27, line 11, that “they should be considered as part of the options available when other treatments have failed. A 2-year follow-up study of an RCT of clonazepam recorded that some people carried on using it intermittently and effectively.”	Thank you for your comment. The text has been revised and the recommendation on the use of benzodiazepines has been changed in light of stakeholder feedback.
74	ER	Expert reviewer	1	FULL	6.3.1	105	- page 105: why do you consider St John's wort as an homeopathic drug? It is usually prescribed at 600 to 900 (or even more) mg/day. Anyway, in the first paragraph about pharmacological interventions, instead of homeopathic drugs I would rather mention cognitive	Thank you for your comment. The text has been revised as you suggest.

							enhancers among "other drugs", as you report a full paragraph about them a few lines below.	
75	PR	Expert reviewer	18	FULL	6.3.1	106	Reprise of earlier comment in regards to moclobemide	Thank you for your comment. Comments about efficacy have been removed from this introductory section.
76	PR	Expert reviewer	19	FULL	6.3.1	107	Cognitive enhancers like D-cycloserine have been described in published studies for SAD treatment only to enhance abbreviated artifically constrained exposure treatments for public speaking fears related to SAD. In this circumstance, there has been a significant effect in two studies compared to psychosocial treatment (CBT) only. However, a paper now in press by Hofmann's group at Boston University suggests rather minimal effects of DCS as an adjunctive treatment to a full and broad-spectrum CBT treatment.	Thank you for your comment. The text has been revised to read: "*Cognitive enhancers D-cycloserine is a partial agonist of the NMDA-associated glycine site. They have been tested as adjuncts to psychological interventions*."
77	PR	Expert reviewer	20	FULL	6.3.2	107	Here and elsewhere the statement is made that the principle underlying exposure therapy is habituation. This is a narrow and inaccurate focus. I do not argue that habituation is irrelevant, although my own opinion is that it is not central in the treatment of SAD, but rather that it is only one of several possible mechanisms. In my view, a better candidate is the provision through experience of disconfirmatory information that may undermine the service user's expectations for the outcomes or consequences of feared social situations. Habituation is a poor candidate mechanism in social anxiety because of the dynamically changing nature of social situations.	Thank you, the text has been revised in light of your comment.
78	PR	Expert reviewer	21	FULL	6.3.2	107	Reprise of earlier comment about social skills training	Thank you, the text has been revised in light of your comment.
79	PR	Expert reviewer	22	FULL	6.3.2	107	The emphasis here, especially as indicated in the statement beginning with "More recently,..." marks an equation between the Clark-Wells model of treatment and all variations of CBT. This is not justified, although I have no argument with the efficacy and utility of that approach. This statement is simply not true for all CBT variants in its specific wording.	Thank you, the text has been revised in light of your comment.
80	ER	Expert reviewer	24	FULL	6.3.2	107	*Exposure in vivo:* Not necessarily. Exposure involves encouraging the person to face the situation they fear. It is usually conducted within an hierarchy, but not necessarily.	Thank you, the text has been revised in light of your comments.
81	ER	Expert reviewer	25	FULL	6.3.2	107	*A guiding principle is the assumption that repeated exposure leads to habituation:* Not at all - this is a very old fashioned and out-moded view of the possible mechanism of exposure. More recent views (and I am	Thank you, the text has been revised in light of your comments.

							talking the past 15 years) suggest that exposure works by teaching the person new information about the likelihood of negative outcomes. See: Mitchell, C. J., De Houwer, J., & Lovibond, P. F. (2009). The propositional nature of human associative learning. *Behavioral and Brain Sciences, 32*(2), 183-198. Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*(1), 5-27.	
82	SH	British Association for Behavioural & Cognitive Psychotherapies	13	Full	6.3.2	108	Please refer to Comment Order Number 7: *Reference is made to medication, rather than (and correctly) meditation, techniques*	Thank you for pointing this typo out, this has been amended.
83	SH	Social Anxiety West (SA West)	17	FULL	6.3.2	108	Although mindfulness did originate from the Buddhist tradition, it is important to emphasise that the mindfulness-based therapies used in Western cultures to treat conditions such as depression, stress and anxiety are completely secular and contain no references to Buddhism. Ideally this section should highlight that there are two different types of mindfulness-based therapies: MBSR and MBCT.	Thank you for your comment. We have revised the text in light of your comment
84	PR	Expert reviewer	23	FULL	6.3.2	108	CT is clearly the Clark-Wells package. Again, with no disrespect to the important work that this represents, this package appears to be the only one that is singled out for attention, and I question the basis for doing so.	Thank you for this comment. The text here is not intended to endorse any particular treatment model – that will be based on a review of the evidence - but to provide an introduction and overview of the various models.
85	SH	British Association for Counselling and Psychotherapy	1	FULL	6.3.2 6.7.11	109 119, 146	The studies described elsewhere in the Full Guideline and Appendices as “Supportive psychotherapy” use a variety of treatments, including Lipsitz 2008 (“psychodynamic supportive therapy following Pinsker”) and two non bona fide treatments: Cottraux 2000 (6 X 30 min sessions of empathic counselling), and Knijnik 2004 (psychoeducation and sharing groups). This means that there is no body of literature corresponding to the description on p. 109. Perhaps this should noted there.	Thank you for your comment. First, we wish to clarify that two interventions (supportive therapy and psychodynamic psychotherapy) were treated separately in our analysis. **Supportive Therapy** Supportive Therapy in the network meta-analysis includes different types of interventions that the authors saw as primarily supportive interventions. However, there are

								other forms of supportive psychotherapy that have not yet been evaluated in RCTs with social anxiety disorder populations. Therefore, we have revised and now use the term "Supportive Therapy" or to avoid confusion with the unevaluated variants. We have also revised the description, and this now reads "*Supportive therapy uses techniques that aim to enable patients to feel comfortable in discussing their personal experiences in the context of the patient-therapist relationship*." Regarding the effects of the interventions, Lipsitz 2008 assigned 34 people to supportive therapy. In Cottraux 2000, 28 people were assigned to supportive therapy. It is not possible to report heterogeneity in a pairwise analysis because the studies make different comparisons (compared with CBT and Interpersonal Psychotherapy); however, these trials find no good evidence that ST and IPT have different effects (Lipsitz 2008) and very low quality evidence that CBT is superior to ST (Cottraux 2000). The small number of participants assigned to ST in the two trials making different comparisons with somewhat different results resulted in considerable uncertainty about the true effects of this intervention, which were small at best, and this is reflected in the size of the confidence intervals, the text of the guideline, and the GDG's decision not to recommend it. Other supportive therapies exist but have not been evaluated in clinical trials, so they were not included in this analysis. **Psychodynamic Psychotherapy**

								We included three examples of psychodynamic psychotherapy, Emmelkamp 2006, Knijnik 2004 and Leichsenring 2012. The intervention in Knijnik 2004 is described as “psychodynamic group therapy”, and the study finds no difference between this and an attention-matched control. This effect is consistent with the effects in the two studies that BACP considers credible, including the largest study of psychodynamic psychotherapy (Leichsenring 2012). The latter study accounts for much of the overall effect estimate, and it suggests that psychodynamic psychotherapy is not as effective as CBT Having carefully considered the results again, we are confident that excluding any of these studies from the analysis would have no meaningful effect of the outcomes or the recommendations of the GDG. The largest study is also the most promising, and its results are consistent with the results of the network analysis.
86	SH	South London and Maudsley NHS Foundation Trust	9	FULL	6.3.3	109	Exercise is mentioned as an intervention for social anxiety. The guidance should say more here about how it helps/the rationale for its use as this is given for all other interventions described.	Thank you, we have revised the text. It now reads “*Exercise is a physical activity that is planned, structured, and repetitive and aims to improve or maintain of physical fitness. It may improve mood generally, provide opportunities to interact with others, or function as a form of exposure (e.g. for people with a fear of blushing or sweating).”*
87	ER	Expert reviewer	2	FULL	6.5	113	- page 113: how many unpublished studies have been included in the review?	Most studies were published in part. We wrote to authors and requested additional information for almost every trial in the review, and we received additional information, including unpublished outcome data, for published and unpublished studies alike.
88	ER	Expert reviewer	3	FULL	6.5	117	- page 117 (table 13): I would compare treatments with placebo, rather than with waiting list. This approach would be more clinically	Thank you, it is important that the comparator for the network is one that is valid for all

							sound (in clinical practice we do not prescribe placebo, but we can decide to wait a bit before prescribing a drug). Moreover, in Figure 6 (as it is now on page 121) all treatments and even placebo are better than waiting list 8difficult to interpret from a clinical point of view). I suggest to use placebo pill as comparator	treatments. The Guideline Development Group took the view that for all treatments one is interested in knowing whether having the treatment is better than not having the treatment. The wait-list comparator addresses this question. It is, of course, also important to know whether a treatment shows specific effects in the sense that its effectiveness exceeds the improvements once might expect for non-specific components of that class of treatment (i.e. placebo effect). Section 2.3.3 of the Full Guideline emphasizes that treatments should be superior to both no treatment and placebo. Superiority to placebo is essential in the case of drugs (because of the potential side effects and health risks of active medication). It is also highly desirable in the case of psychological treatments (perhaps especially so in the case of social phobia as just seeing a therapist is exposure and potentially helpful. See Section 2.3.3, page 21, lines 8-27). The network analysis does allow one to assess the extent to which drugs and psychological therapies separate from the two placebo conditions. When reviewing the effects of any treatment the GDG considered a number of comparison in addition to the primary comparison of waitlist to inform their decisions.
89	E R	Expert reviewer	4	FU LL	6.5	121	- page 121 (Figure 6): what does "psychological placebo" mean from a clinical perspective? Does it mean that the patients are receiving an unstructured and unspecific care? If so, why don't we use another wording (to call it "placebo" might be confusing for readers)	This category includes a variety of interventions that control for procedures that are common to most psychological therapies (and hence "non-specific"). Some offer a credible rationale, generate an (equal) expectation of improvement, provide structured homework, etc. So everything except for the unique features of the "active" therapy. This is why the GDG considered "psychological placebo" an appropriate term.

90	ER	Expert reviewer	5	FULL	6.5	121	- Figure 6 is very interesting but, as far as I can understand, it reports only efficacy data. Why don't you report also acceptability (all cause dropout rate) or tolerability (dropouts due to side events) in a forest plot? Ayway, I would add the corresponding ORs and CIs in a column on the right side of the figure - in the Lancet MTMs we also reported MTM results in a table. It is easier to read and you can have the punctual comparative estimate. I did a similar thing for treatment of depression in Clinical Evidence. - Does it make sens to present the first analysis with different forms of similar psychotherapies merged together (i.e. CBT) and then split them into different types. One option would be to group all individual CBT together and all group CBT together	Thank you. It should have been possible to report tolerability, but in contrast to the Cipriani analysis, which was restricted to studies that reported both efficacy and tolerability, this analysis did not exclude studies that failed to report tolerability, and this is missing from some included studies. Additionally, dropout is not reported across pharmacological and psychological studies in a manner that allows comparison throughout the network. With regard to your second point: In principle this is possible, but such are the number of comparisons that the table would become very large and so fail to provide any readable summary The current order of presentation accurately reflects the way in which the GDG sequenced its analysis of the data; the GDG began with class effects (as you suggest) then proceeded to the effects of individual interventions.
91	PR	Expert reviewer	24	FULL	6.5.1	120	I did not take a magnifying glass to the table and look for every study that should have been included. I was curious, however, as to why the study by Blomhoff et al. (2001) and its follow-up (Haug et al., 2003) which examine the combination of sertraline and exposure were not included in the block of combination trials. It appears from text of the section on sertraline on p.131 that the exposure treatment in this trial was considered a nuisance effect of exposure instructions. However, the physicians who administered the exposure treatment received fairly extensive treatment in how to do so. How well they did it is an open question.	Thank you. The GDG considered treating the combination separately and combining the group receiving exposure instructions in Blomhoff 2001 with participants receiving exposure in vivo in other studies; however, the GDG concluded that this was not sufficiently active to include as exposure in vivo. Furthermore, other pharmacological studies (including the Clark 2003 trial of fluoxetine) gave exposure instructions. The GDG determined that the comparison of (i) exposure instructions plus placebo versus (ii) exposure instructions plus sertraline was effectively a comparison of sertraline versus placebo, and this was consistent with the treatment of other pharmacological trials. Furthermore, the combinations of medication

								and psychological therapy that were examined are those that used a drug and a psychological therapy that were each examined on their own in the network meta-analysis. The exposure used in Blomhoff et al. (2011) did not meet this criterion as it was essentially self-exposure instructions. At no time did the therapists do any within session exposure work (role-plays or out-of -office assignments) with the patient. Such work would have been required for the study to have been eligible for inclusion in the "exposure in vivo" category.
92	ER	Expert reviewer	6	FULL	6.5	122	- I was thinking of putting pair-wise results (like Table 14) in the Appendix	Thank you. Due to the size of the network, there are about 1000 effects with confidence intervals. Because the effects are consistent regardless of comparator, the information can be seen in the comparison versus waitlist and we have decided not to add further appendices to this large document.
93	SH	British Association for Behavioural & Cognitive Psychotherapies	14	Full	Table 14	122	Please refer to Comment Order Number 6 and note that in the Bogels (2006) study applied relaxation was compared against task concentration training and not attention training as these procedures are conceptually and practically different from each other	Thank you for the comment, the description of BOGELS2006 has been revised. The GDG did consider whether recommendations could be made along the lines you suggest but as the data about avoidant personality disorder are extremely limited, they were considered insufficient to make recommendations about modifying treatments.
94	ER	Expert reviewer	7	FULL	6.6	125	- Paragraph 6.6 onwards: it is a bit strange to read tha almost all intervention were better than waiting list. Which is the clinical bottom line? - did you try also to rank treatments/interventions?	Thank you. As previously described the GDG took the view that waitlist allowed for the most comprehensive comparison but other comparator e.g. pill placebos and attentional controls were also taken into account in developing the recommendations. Interventions were ranked in the clinical analysis, but these were not the main consideration for the GDG's assessment of efficacy. Rankings for the cost-effectiveness analysis are presented and were considered

								by the GDG (Table 20).
95	PR	Expert reviewer	25	FULL	6.6.3	126	In the analysis of depression effects of MAOIs, it is not specified whether there were trial exclusion criteria related to depression, especially major depressive disorder. I know that this was the case for some of the trials, but I do not know this for all. Such an exclusion is reasonable when one wants to examine the effects of drug on SAD independent of its effects on depression (MDD), but it also makes it much more difficult to demonstrate a depression effect. This comment may apply to other classes of drug as well.	Thank you for the comment, which we have now addressed in the Overall Clinical Summary (6.11.1).
96	PR	Expert reviewer	26	FULL	6.6.3	127	VERSIANI1992 is widely viewed in the field as a trial with effect sizes that are outliers and is thus viewed with skepticism. To the extent that conclusions are based on the potential skewing of effects based on this study, they should be viewed quite cautiously.	Thank you for the comment about this study involving MAOIs. The GDG considered a number of factors in addition to the average effect of each intervention, and MAOIs were not recommended as first pharmacological interventions for reasons described in the text (including cost-effectiveness, side effects, etc.).
97	SH	South London and Maudsley NHS Foundation Trust	10	FULL	6.7	general	Good that the distinction between different types of CBT are made clear (e.g. Clark and Wells protocol, Heimberg manual).	Thank you for your comment.
98	ER	Expert reviewer	26	FULL	6.7.2	142	*None of the trials reported quality of life outcome:* Actually RAPEE2009 reports on the Life Interference Scale - a 6-item measure of interference from social anxiety in the individual's life (significant correlation with SF-12).	Thank you for your comment. The GDG considered quality of life and functioning as different outcomes that are correlated with each other and with symptoms of social anxiety.
99	ER	Expert reviewer	13	FULL	6.7.12	146 - 147	Self-help without support These sections are misleading and suggest that the report's authors do not understand what is involved in online delivery of therapy. This section predominantly relates to online or computer-delivered therapy either on a fully self-help or therapist led/assisted basis. Certainly with the therapist assisted version it should not be regarded as self-help just because the clinical therapy content is delivered using a computer or the internet. Many internet delivered interventions are interactive in terms of communication with the therapist. I suggest that this section is retitled self-help and computer delivered interventions with and without therapist support. Bibliotherapy needs to be clearly distinguished from internet	Thank you for the comment. Section 6.3.2 has been revised to explain that "*Although computerised interventions have the potential to be interactive and individualised, those that have been tested in clinical trials for people with social anxiety are, for the most part, relatively fixed programmes*."

							delivery which is much more interactive in terms of delivery of therapy content. There are now sufficient studies with adult populations to provide a meaningful analysis of online interventions.	
100	SH	British Association for Performing Arts Medicine	4	FULL	6.9	149	Why isn't there a section on specific interventions for the performance related sub-group?	Thank you, but we did look at performance related interventions – see summary in section 6.11.3. The scope only included performance anxiety in the context of social anxiety disorder, and there is very little evidence about this population.
101	SH	British Association for Behavioural & Cognitive Psychotherapies	15	Full	6.9.2	149	Please refer to Comment Order Numbers 6 and 14 *Comment 6: There are conceptual as well as practical differences between external attention focusing and task focused attention so these should not be confused* *Comment 14: Please refer to Comment Order Number 6 and note that in the Bogels (2006) study applied relaxation was compared against task concentration training and not attention training as these procedures are conceptually and practically different from each other*	Thank you, the recommendations have been revised the following this and other comments.
102	PR	Expert reviewer	27	FULL	6.9.2	149 - 150	This comment applies to several passages in this chapter, although not the full document (thus not listed as "general"). In the report of the BOGELS2008 trial, there are two conditions, but there is only one SMD reported for post-treatment and one for follow-up. Is this summed across the two treatment conditions or does it represent an incomplete reporting? This is very unclear.	Thank you. These are both 2-arm studies and it is only possible to calculate one between-group effect.
103	PR	Expert reviewer	28	FULL	6.9.3	150	This comment applies to several passages in this chapter, although not the full document (thus not listed as "general"). In examination of the CONNOR2005 trial, which compared paroxetine with botulinum toxin injections to paroxetine with placebo injections, the SMD is apparently derived from a comparison of the two conditions and not to wait list. This is not always clear. It is also the case that the phrasing that "[t]here was no evidence of an effect on symptoms of social anxiety at post-treatment" or something similar is commonly used. However, this sort of statement is not justified based on the comparison that is reported. The fact that there is no difference between two conditions does not rule out the possibility that both have a significant effect against control conditions. In the CONNOR 2005 trial, for example, although one condition included a placebo, both included paroxetine, so there was no inactive condition.	Thank you for your comment. We have revised to say there was no evidence of a differential effect. Participants in both groups in CONNOR2005 received paroxetine. Random assignment was between botulinum toxin and placebo. There was no evidence of an effect of botulinum toxin.

104	SH	South London and Maudsley NHS Foundation Trust	11	FULL	6.10	189	Very important that although pharmacological treatments may appear more cost effective in the short term, specific forms of individual CBT are more cost effective over the longer term	Thank you for your comment.
105	SH	TOP UK Triumph Over Phobia	1	FULL	6.11.2	190	TOP UK welcomes the report that the strongest evidence for large and sustained benefits in the treatment of social anxiety in adults was the use of psychological interventions	Thank you for your comment.
106	SH	British Association for Behavioural & Cognitive Psychotherapies	16	Full	6.11.3	190	Please refer to Comment Order Numbers 6 and 14 *Comment 6: There are conceptual as well as practical differences between external attention focusing and task focused attention so these should not be confused* *Comment 14: Please refer to Comment Order Number 6 and note that in the Bogels (2006) study applied relaxation was compared against task concentration training and not attention training as these procedures are conceptually and practically different from each other*	Thank you for the comment, this has been revised.
107	SH	British Medical Association	4	Full	6.12	192	We are concerned by the recommendation of expensive patented drugs (escitalopram or fluvoxamine) for treatment of a phobia, as other drugs which are generically available do have a license for this condition. Instead we would argue that phobias need evidence based treatment and the use of psychological therapies has been proved to be effective and helpful.	Thank you for your comment. Recommendations were based on best available evidence on clinical and cost effectiveness, considering also side effects. Drugs have been recommended for people who decline cognitive behavioural interventions and express a preference for pharmacological treatments. The choice of drugs recommended is based on clinical and cost effectiveness evidence, also considering their side effect profile, as discussed in section 6.12. Drug cost is not considered per se (a patented expensive drug may be cost-effective if it is very effective, and a generic drug may not be, if it is less efficacious than other available). Both escitalopram and fluvoxamine were shown to be among the most effective and cost-effective drugs, but the GDG did note important side effects of fluvoxamine. Of the drugs considered in the guideline based on

								available evidence, drugs indicated for social anxiety are (BNF, February 2013): moclobemide, paroxetine, sertraline and venlafaxine. As discussed in section 6.12, the GDG had concerns regarding the use of paroxetine and venlafaxine (and of other drugs as well, e.g. phenelzine) due to their side effect profile. Moclobemide was shown to be one of the least effective and cost-effective drugs. The recommendation has been revised in light of comments and updated clinical and economic analysis.
108	PR	Expert reviewer	29	FULL	6.12	193	I am puzzled by the judgment that group CBT is a treatment into which it is difficult to recruit patients. Clearly, there are patients who will not accept this option, but it has never been a problem in my many years of experience to fill groups. In fact, since we have focused more recently on individual treatment development and, because one cannot do everything, we have down-sized our group treatment program, we make frequent referrals to other providers for persons interested in the group treatment option. I suspect as well, although it is beyond the scope of this guideline, that a treatment that combines individual and group methods in the same protocol may have great potential.	Thank you for this comment. We have removed the point about filling groups as the main reasons for recommending individual CBT are its greater clinical efficacy and cost effectiveness. We have emphasised this point in recommendation 1.3.3 of the NICE guideline.
109	SH	South London and Maudsley NHS Foundation Trust	12	FULL	6.12 & general	198 & general	Important that facilitated CBT-based self help is recommended as second line treatment as a direct alternative to people who decline individual CBT. It is not recommended as a low intensity treatment from which people can be stepped up. Group CBT only recommended for children and adolescents.	Thank you for this comment. Following your and other comments, the GDG decided to significantly revise the recommendations for child CBT.
110	PR	Expert reviewer	33	FULL	7	All	I am surprised that there was little inclusion of the individual CBT interventions done by Kendall's group at Temple University. Some of his studies, but not his major RCTs, were included. These are studies of mixed anxiety diagnostic samples, and in some children with SAD did not do as well as children with other anxiety disorders, but in others there was not an effect of diagnosis. Children with SAD improved and maintained their improvements over follow-ups to seven years. I believe this undermines to a significant degree the low esteem in which individual CBT administered to mixed diagnosis samples is given in the current recommendations.	Thank you. We requested data from the Kendall team and others, but they were not able to provide outcomes for children with social anxiety.
111	P	Expert	3	FU	7	All	One could argue that it is premature to deliver guidelines for youth	Thank you for this comment. We agree that the

	R	reviewer	4	LL			treatment of SAD at this time given that the literature base is minimal.	data is very limited but the GDG decided to produce a small number of recommendations. We have also made a number of research recommendations to address these major limitations in the field
112	E R	Expert reviewer	15	FU LL	7.1-2	203 - 225	I found this section of great concern and I question the methodology used, the way in which the results are reported and the conclusions drawn. There is no way that such an approach would be considered acceptable in producing clinical guidelines for adults. There are some major problems in taking subsamples of social anxiety disorder children/adolescents and then drawing conclusions about impact on social phobia specifically when the measures being included in the analysis include more generic measures that are not specifically designed to measure social phobia and the samples sizes are small. If one were to design a study to examine the impact of general anxiety interventions upon social phobia then one would design that study accordingly, with social phobia measures and adequate samples sizes. While it makes sense to examine impact on social phobia clients selected from within broader trials that included a range of anxiety disorders, this only makes sense where there are multiple studies that generate a large enough sample size that provides sufficient power to examine clinical outcomes in a valid way. It doesn't makes sense to take specific studies on their own where there are very small sample sizes and then report these results in tables or the body of the text and attempt to draw conclusions. Also, the results and effect sizes should only be reported for clinically validated measures of social anxiety, such as the clinician severity rating from the standardized clinical interviews (reported in most studies) – not from generic questionnaire measures completed by parent and/or child that include a range of anxiety problems. Given that the vast majority of studies made use of clinician severity ratings in the diagnostic measure, and this should have been given for the social phobia diagnosis) then this would be a more appropriate indicator of impact on social anxiety. This would be preferable to using a range of generic anxiety measures that assess a range of other disorders rather than tapping into socially specific changes in anxiety. (Any analysis and reporting of subgroups of social phobics from generic programs based on questionnaire data should only be included if they used social anxiety specific assessment measures,	Thank you. We have significantly revised this section and revised the presentation of the data of group and individual CBT, which we think addresses your concerns. We share your concerns about the size of populations in many of the trials but that is precisely why we used meta-analytic techniques. However, the data are still limited and, as a consequence, we have been very cautious in generating our small number of recommendations. We requested data from the Kendall team and others, but they were not able to provide outcomes for children with social anxiety.

							and not anxiety in general or a range of anxiety problems. Also, assuming that social phobia specific questionnaire measures are used, then it is really important that parent measures of social anxiety are included, in addition to child report. I was also concerned in this section that if it is considered appropriate to draw conclusions about the treatment of social phobia based on RCTs of generic anxiety programs using subsamples, then why does the review not include the very important large scale RCTs from the USA (eg. Kendall et al.) or others such as Barrett et al, Cobham, and other UK research groups. It does not seem appropriate to select a small number of such studies. Please see also my comments about Table 24 as many of these issues should be included in the overall concerns with the approach used.	
113	ER	Expert reviewer	27	FULL	7.1.2	205	*This is based on the suggestion that the negative expectations and evaluations that are characteristic of social anxiety disorder may have resulted from a history of poor performance and negative outcomes in social situations (for example, (Rapee & Heimberg, 1997)):* There are also possible developmental differences. It has been argued that, while adults with SAD don't actually lack social skills, children might do so due to a decreased opportunity to engage socially (Rapee & Spence, 2004).	Thank you for your comment. This section has now been amended.
114	ER	Expert reviewer	14	FULL	7.1.2	206	Points (ii) Parent-support , p206. This should read parent skills training, rather than parent support, as the focus was on development of parenting skills to support the therapy process. The studies did actually include parent education also. I suggest merging points (i) and (ii) and re-label as parent education and parenting skills… as the content is very similar. Point (iv) in this section should also reference Cobham et al, as this was the key paper that examined treating parents own anxiety. Re the comment about lack of comparisons between general and specific treatments for social anxiety disorder in young people… this is correct. You might be interested to know that we are in the middle of just such a trial! Too late for this report though.	Thank you for your comment. This has been left largely unchanged, as the GDG wished to distinguish between programmes such as that of Beidel et al., and Coping Cat, which give parents quite brief psycho-education, from those such as Spence et al., where parents are more heavily engaged in supporting the child's therapy, and where the parents get considerable guidance in behaviour and anxiety management. However, the title of ii has been changed to '*Parent Education and Skills'* The Cobham reference has not been included as we wished, in this section, to include only

								papers referred to in the treatment recommendations section of the Guideline.
115	SH	Social Anxiety West (SA West)	19	FULL	Table 23	207	MBCT is mentioned but not MBSR.	Thank you for the comment. This has been revised.
116	SH	South London and Maudsley NHS Foundation Trust	13	FULL	7.3		Treatment principles includes "7.3.1.2 Consider psychological interventions that were developed for adults (see section 1.3) for young people (typically aged 15 years and older) who have the cognitive and emotional capacity to undertake a treatment developed for adults)." Not clear why this is not in "7.3.2 Treatment options for children and young people with social anxiety disorder" which includes "7.3.2.1 Offer group-based CBT (see recommendation 7.3.3.1) to children and young people with social anxiety disorder aged 7 years and older."	Thank you for your comment. We have changed the order of the recommendations as you have suggested in both the NICE and full guidelines.
117	ER	Expert reviewer	21	FULL	7.3	209 - 220	A biased picture is obtained in the child and adolescent literature when results are examined purely in terms of post-treatment assessment with no consideration of 6 – 12 month follow-up. The absence of a WLC at these follow-ups (for ethical reasons) makes it difficult, but there is at least one study with a long term WLC (Hudson). I also wondered whether in the child literature it might make more sense to compare pre-test to 6 - 12 month follow-up changes, rather than simply against WLC and placebo? This might present a more valid picture of the effects. Effect sizes could be reported for the pre-test to follow-up results.	Thank you for the suggestion, but we do not consider this is not an appropriate way to calculate comparative treatment effects in randomised controlled trials.
118	ER	Expert reviewer	16	FULL	Table 24	212	Table 24: Summary of results at post-treatment I think there should be a minimum sample size required before any comparison is included in this table, particularly in the "other comparison" section and the sections in Table 24 that include individual studies only given that data have been extracted as subsamples from broader RCTs that included a range of disorders. I would suggest deleting those "other" comparisons from the table.The "other" comparisons should only be included if those studies were specifically examining social phobia treatment with an adequate sample size of social phobics to provide sufficient power to detect effects and used a social phobia specific measure, or the results are reporting clinician ratings based on standardized diagnostic interviews.	Thank you. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these very serious limitations in the data. We only used data for children and young people with social anxiety, and we only included measures of social anxiety. We have clarified this in the protocol.

							This table should also include an indication of the sample size for the social phobics each of the studies for each condition. As the table currently stands it provides a very misleading impression about the state of evidence in the area, and creates serious risk that invalid conclusions can be drawn and disseminated. The key point is the studies are needed with sufficient sample size, power and methodological designs to answer questions about group versus individual, parent versus non-parent, and other comparisons. The only really valid comparison for effect sizes of social phobics extracted from generic programs is the one that includes the merged sample of social phobic participants receiving CBT (in clinic) versus WLC. Even then I wonder why the many studies by leading groups into effectiveness of generic anxiety treatments have not been included eg. Kendall et al, Barrett et al., Cobham et al. The Kendall team in particular is a major omission, as is Walkup et al with the multisite trial. I was also concerned that much of the Beidel et al work is missing from the social phobia specific CBT outcome research. If sample sizes and numbers of studies are sufficient across the merged studies, it might be possible to compare group versus individual CBT And social phobics in a generic CBT program versus social phobics in a social phobia specific program However, other comparisons should be deleted as they are not valid and are misleading. Unless the study is included in Figure 11, they should not be included in the table. Even there, the inclusion of only the Spence et al study in the individual treatment for generic anxiety (with such a small sample size) seems most odd when there are several other major published studies. Also, it is not clear why the studies by Beidel et al., and Albano et al have not been include where CBT approaches were used.	We requested data from the Kendall team and others, but they were not able to provide outcomes for children with social anxiety. We have clarified that we requested data in the protocol.
119	ER	Expert reviewer	22	FULL	Table 24	213	As noted above, several of the comparisons reported in this table are really not valid – sample sizes are too small, and the assessment measures were not specific to social phobia	Thank you. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear

								in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these very serious limitations in the data. We only used measures of social anxiety and have clarified in the protocol.
120	SH	TOP UK Triumph Over Phobia	2	FULL	7.2	222	TOP UK welcomes the recommendation that drugs should not be routinely offered for the treatment of social anxiety disorder n children and young people	Thank you for your comment.
121	SH	TOP UK Triumph Over Phobia	3	FULL	7.2	222	TOP UK welcome the recommendation that CBT interventions used to treat children and young people with social anxiety should be specifically developed for that disorder	Thank you for your comment.
122	SH	TOP UK Triumph Over Phobia	4	FULL	7.2	222	TOP UK welcomes the recommendation that older adolescents should be offered psychological intervention as offered to adults	Thank you for your comment.
123	ER	Expert reviewer	25	FULL	7.3.3	224	7.3.3 Delivering psychological interventions for children and young people This section appears to favour group-based intervention rather than individual therapy but it is not clear why this conclusion would be drawn. It is often difficult to establish groups in clinical contexts given referral rates and feasibility of getting everyone in at the same time. In the real world, individual therapy may be more appropriate and/or realistic. Also, this section does not appear to support parent intervention for the adolescent group. Again there is no evidence to support this view, and it should be a topic perhaps for future research. It is perhaps more pragmatic to suggest that parent involvement is more sensible with the younger age group, rather than older adolescents. Even here, some degree of family participation may be of value to support the young person in therapy (although again evidence here is lacking).	Thank you for your comment. The GDG agreed with your point and the recommendations have been revised to reflect this.
124	ER	Expert reviewer	20	FULL	7.4	214 - 220	There are several instances where the report states “No follow-up data were reported”. Investigation of these papers indicates the in several instances follow-up data were indeed reported.	Thank you. Following the protocol, we analysed controlled effects. Uncontrolled effects at follow-up were not analysed.

125	SH	South London and Maudsley NHS Foundation Trust	15	FULL	7.5		7.5.2 Not sure why “Cognitive behavioural therapy delivered via Parents” – is included as a treatment option since the review of evidence seems to show mainly negative or at best mixed results.	Thank you. We have revised the recommendations.
126	ER	Expert reviewer	18	FULL	7.5.1	214	Page 214. The report states In six studies (all but LAU2010), there was a large effect on self-rated symptoms of social anxiety at post-treatment (SMD = -1.20, 95% CI = -1.97 to -0.43) Comment. This statement needs clarifying given that self-rated measures of social anxiety were not conducted thus cannot be said to have an effect of symptoms of social anxiety. As noted above, a generic measure of anxiety as not necessarily a measure of social anxiety – unless the specific subscale for social phobia/social anxiety has been used.	We only used data for children and young people with social anxiety, and we only included measures of social anxiety. We have clarified this in the protocol.
127	ER	Expert reviewer	23	FULL	7.5.1	216	The report states: In two studies (LYNEHAM2012, SPENCE2011), the small effect was not statistically significant for parent-rated symptoms at post-treatment (SMD = -0.29, 95% CI = -0.96 to 0.38) with no heterogeneity. Parent-rated symptoms were not reported at follow-up. The numbers of social phobics in these studies are too small to specifically mention this effect size. Furthermore parent rated symptoms were reported at follow-up.	Thank you. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these very serious limitations in the data. We only used data for children and young people with social anxiety, and we only included measures of social anxiety. We have clarified this in the protocol. We requested data from the relevant authors, but they were not able to provide outcomes for children with social anxiety. We have clarified that we requested data in the protocol. We have revised the text to indicate that the study does not include an effect versus waitlist at follow-up.

128	ER	Expert reviewer	17	FULL	Figure 11	216	Figure 11: Recovery for CBT compared with waitlist. Why is Spence 2000 in twice in the first section of the table? This study was a social phobia specific study and the waitlist control group size should be larger than that specified, unless there is some reason to separate out parent involved and not involved conditions. It would make more sense to combine these and use the larger wait list control.	Thank you. To include a 3 group study in a pairwise meta-analysis, it was necessary to combine the intervention groups or to split the control group; otherwise, the control group would be counted twice. Both methods result in the same overall effect. We have split the control group so the two intervention effects are clearly reported.
129	ER	Expert reviewer	19	FULL	Figure 12	217	Figure 12. The inclusion of the Hudson study here for the general treatment is suspect given the small sample size. This would not happen in the adult analyses and I suggest that similar standards should apply to the analysis of the child literature. If the required data to answer the question is not available in a reliable, valid and sound set of research studies then this should be stated and set as an area for future research rather than including very dubious data and drawing conclusions from it. When reference is made in the text to studies where the results are not shown in Figure 12 (ie where child and parent report is being referred to) then the sample sizes of social phobics should be noted in the text to present perpective. As noted above, the sample sizes are so small in many of the analyses and the measures not specific to social phobia that the conclusions drawn are extremely dubious.	Thank you. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these serious limitations in the data. We have added the number of participants in each analysis to Table 24. We only used data for children and young people with social anxiety, and we only included measures of social anxiety. We have clarified this in the protocol. We did not remove studies because of size. We identified several interventions for adults that have only been evaluated in small studies and these were included and assessed in the same manner as the studies in children and young people. We have revised the recommendations following this and other comments.
130	SH	CCBT Ltd	3	FULL	7.5.2	220	The guidance states that the internet program referred in “Individual CBT compared with supported internet self-help” was over 10 weeks. This is not true as the program had 12 sessions to be done on a weekly basis.	We apologise if we are confused about the number of sessions in Spence2011, but we have been unable to reconcile the published report with this comment. The published report states that “The online questionnaires

								and telephone diagnostic interviews were re-administered approximately 12 weeks after baseline by which time it was predicted that participants should have completed the 10 weekly therapy sessions." It also says "The program is delivered through 10 weekly sessions for adolescents and five sessions for parents, each of approximately 60 min in duration."
131	E R	Expert reviewer	24	FU LL	7.5.3	220	7.5.3 Self-help versus waitlist It would be preferable to title this section "therapist assisted internet-based treatment" (not self-help). This title also needs changing in Table 24. However, as noted above, unless the total numbers are substantial to provide sufficient power to draw valid conclusions (which they are not) then this sub section should not be included. Furthermore, the Spence et al., 2011 for the internet delivery should not be included in the analyses as the 12 week assessment was not conducted as a post-treatment evaluation. Many of the families had not yet finished treatment in the internet condition. Although the March et al 2009 study did label the assessment as post-treatment,that paper clearly states that many families had not yet finished treatment at that point. Thus I suggest deletion of the internet delivery data from Spence et al. and March et al 2009 studies from this section and from Table 24, as the 12 week assessment point is not a proper post-treatment result. Also, the report states that "Two studies compared self-help interventions for children and young people with any anxiety disorder to waitlist (MARCH2009, SPENCE2011). Interventions were delivered to young people with and without parent involvement." This is not correct. Both studies included parent participation. Parents completed online interventions sessions in both studies. This section also states that treatment Treatment lasted 9 to 10 weeks. This isn't correct for the March 2009 and Spence 2011 studies. They involved 12 internet sessions that were completed over around 12 – 20 weeks. The report states that Parents received approximately 2 hours of contact in one study (MARCH2009) and the amount of contact was	We have revised the title of this section. The GDG decided not to remove Spence 2011, which reports 12-week outcome data, because the time-point was defined by the authors. Importantly, it is comparable to post-treatment assessments for other studies in the guideline. The comment about contact in March2009 indicates the amount of therapist input rather than time spent by participants. We have revised to make this clear. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered the sample sizes.

							unclear in the others (SPENCE2011, TILFORRS2011). This is not correct as parents completed 6 sessions, plus 2 boosters in the March et al study, which would have taken at least an hour each and the Spence 2011 sessions included 5 parent online therapy sessions and 2 parent booster sessions. The report states In two studies (MARCH2009, SPENCE2011) the small effect was not statistically significant for parent-rated symptoms at post-treatment (SMD = -0.33, 95% CI = -0.94 to 0.27) with no heterogeneity (I2 = 0%, chi2 = 0.00, p = 0.97). Reporting of effect sizes here does not make sense with such small sample sizes in a study in which the social phobic children are subsamples and the measures used did not specifically assess social phobia. Also, as mentioned above many of the family in the internet delivered treatment in March et al, 2009 and Spence et al 2011 had not completed treatment at the 12 week point. The 6 month data point would be more appropriate to take as an indicator of outcome.	
132	SH	South London and Maudsley NHS Foundation Trust	16	FULL	8	226	The section on computerised CBT for specific phobias is interesting but the relevance to the main remit is unclear. It should be removed to a separate report.	Thank you for your comment. This guideline was required by the remit to include computerised CBT for specific phobias within its scope.
133	SH	CCBT Ltd	1	FULL	8	226	There seems to be little rationale to include computerised therapy for specific phobias in the social anxiety disorders guidelines. It seems this would be better placed in other guidelines.	Thank you for your comment. This guideline was required by the remit to include computerised CBT for specific phobias within its scope.
134	ER	Expert reviewer	27	FULL	8	226	8 COMPUTERISED COGNITIVE BEHAVIOURAL THERAPY (CCBT) FOR SPECIFIC PHOBIAS IN ADULTS It is a mystery why this section is included in a review of social phobia treatments. There is already a section in the adult treatment area that focuses only on studies that use internet and computer-based approaches that are designed to treat social phobia specifically. Berger et al., 2011; Hedman et al; Titov et al etc. I suggest that chapter 8 should be deleted.	Thank you for your comment. This guideline was required by the remit to include computerised CBT for specific phobias within its scope.

135	PR	Expert reviewer	35	FULL	8	All	Why is a guideline about computerised treatments for specific phobia included in this document? It seems out of place in a guideline about SAD. It also seems to me that the offering of a guideline is premature for the reasons stated immediately above. However, since it is a negative recommendation, I see less danger here.	Thank you for your comment. This guideline was required by the remit to include computerised CBT for specific phobias within its scope.
136	SH	CCBT Ltd	2	FULL	8.3.1	230	The guidelines state "Two trials (Marks et al., 2004, Schneider et al., 2005) included in TA97 (NICE, 2006) could not be included in this review because they did not report results for people with specific phobias and the authors were unable to provide disaggregated data. After speaking to the authors, they confirm no attempt has been made to seek the disaggregated data. The 2005 study in question does actually report that social phobics where highly satisfied and had one of the lowest dropout rates of the phobic groups included in the study. The 2004 study also had a subsample of 39 specifc phobics with no difference in dropout rates between other phobic groups.	Thank you. The GDG wrote to Professor Isaac Marks who replied that he did not have disaggregated outcome data for patients with social anxiety disorder or a specific phobia. Professor Marks copied Mark Kenwright on his reply, and we subsequently contacted Mark Kenwright directly, who was unable to provide disaggregated data and wrote "group sizes had insufficient power to detect a significant improvement for the different phobia types." If CCBT have disaggregated data, we would be delighted to receive these and, as you will be aware, we have written to you requesting this.
137	ER	Expert reviewer	28		Appendix	Appendix 17	In keeping with my comments above, I think it is inappropriate and statistically invalid to list effect sizes for studies for which relatively small samples of social anxiety cases have been extracted from a generic sample. The conclusions that could be drawn are dubious and potentially misleading. I suggest that Appendix 17 and the accompanying text in the main document be limited to analysis of a) those studies that focus specifically on social phobia treatment b) the CSR based on a standardized clinical interview or social-phobia specific questionnaire data (not generic anxiety measures) c) If it is considered appropriate to select socially anxious youth from studies of generic populations then the table be limited to reporting the CSR only, and attempts to make comparisons and reports of effect sizes be limited to studies with total samples that provide sufficient power. I'm not sure what this is but my rough calculation suggests at least 15 per treatment vs 15 per WLC for a study to be included… not those with eg. 6 or 7 eg. Lynham or 12 and 10 Spence et al 2011. This means that	We thank you for your thoughtful feedback. Several recommendations have been revised to reflect the limitations of existing evidence. Following our protocol, we have reported the existing trials. There were few participants in many studies, and this is clear in the text. All effects are listed with confidence intervals, and the quality of all evidence has been assessed using GRADE. When making recommendations, the GDG considered these very serious limitations in the data.

							many of the sub-group effect sizes should not be reported/included eg. CBT (individual); general, CBT (Group), general; The confidence intervals will inevitably be so large as to be meaningless. The authors should just state that there is insufficient evidence to date to enable valid analysis and reporting of these various sub-analyses. This should also be state in the text of the main report.	
138	SH	Nottinghamshire NHS Trust	1	Full/NICE	General		Very prescriptive approach to assessment of social anxiety, which would be difficult to achieve while developing a relationship with a client, particularly one presenting with multiple mental health difficulties	Thank you we have agree that the assessment should take place in the context of a positive relationship. A number of recommendations in section 1.1 of the NICE guideline set out to address this issue.
139	SH	Royal College of Paediatrics and Child Health (RCPCH)	1	NICE	General	General	There are likely to be implications for educating and training of all paediatricians, including both hospital and community based, in being aware of the condition, and the recommendations for offering special circumstances for clinic appointments to lesson anxiety for affected individuals.	Thank you this is an issue which may be taken up by the NICE implementation team.
140	SH	Royal College of Paediatrics and Child Health (RCPCH)	2	NICE	General	General	We agree that access to diagnosis is substantial problem, especially for neurodisabled children and young people. The issue seems to arise in part from diagnostic overshadowing. The document is not clear about how that is going to be addressed.	Thank you. The focus of this guideline is on social anxiety disorder. We do address comorbidities e.g. with other common mental disorders. As far as neurodevelopmemtal disorders are concerned these are address in relevant topic specific guidance e.g. the NICE guidelines on autism.
141	SH	Royal College of Paediatrics and Child Health (RCPCH)	3	NICE	General	General	The whole document seems very CAHMS related yet it acknowledges the enormous difficulties in school and other social settings. Why is there no mention of how they can be resolved and how other professionals including (specially trained?) SLTs/teachers or others would need to be involved? The document should be clearer on this point as the “solutions” do not lie only in 1-1 therapy.	Thank you for your comment. As this is a clinical guideline it is outside the scope to make recommendations for teachers or schools. However recommendation 1.1.7 and 1.4.3 (revised recommendation numbers 1.1.6 and 1.5.2) do recommend that healthcare professionals work with teachers and other relevant parties to ensure the emotional, educational and social needs of children and young people with social anxiety disorder are met.
142	SH	Royal College of	4	NICE	General	Gener	The needs of the whole family are not sufficiently acknowledged and how these might be addressed, given the enormous stresses	Thank you for this comment. The scope of the guideline was focused on the needs of children

		Paediatrics and Child Health (RCPCH)				al	and pressures this disorder can cause.	(and adults) with social anxiety disorder. Our reviews and recommendations were therefore limited to areas such as the impact of family factors on the development and maintenance of the disorder and the role of parents in facilitating interventions for children.
143	SH	Royal College of Nursing	1	NICE	General	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is comprehensive	Thank you for your comments.
144	SH	Social Anxiety West (SA West)	1	NICE / Full	General	General	Social Anxiety West welcomes guidelines and recommendations for the recognition, assessment and treatment of social anxiety disorder, and feels this will make a positive difference to our members.	Thank you for your comments.
145	SH	Social Anxiety West (SA West)	18	NICE/FULL	General 6.7.2 6.7.8 6.10.2 Table 20 Table 22	119 121 143 145 161 172 181 183	Throughout the draft guidelines there seems little differentiation between MBCT and MBSR. They are grouped together as mindfulness, but these are different types of therapies and contain different elements (sources: http://www.bangor.ac.uk/mindfulness and www.mbct.co.uk). We feel that in order to avoid confusion it is important not to generalise the different types of mindfulness treatments available and for the guidelines to be specific as to the type of mindfulness (MBSR or MBCT) that is being referred to in the recommendations and trial results. Mindfulness-based CBT seems to be more commonly referred to as MBCT and we feel it is important to ensure this is made clear in the guidelines to avoid confusion.	Thank you for your comment. Mindfulness Based Cognitive Therapy and Mindfulness Based Stress Reduction were both included and the text has been revised to reflect this.
146	SH	British Association for Behavioural & Cognitive Psychotherapies	9	Full	4.7.1.3 (NICE 1.1.3)	76	It is very helpful to arrange services or appointments flexibly to promote access and avoid exacerbating social anxiety symptoms at the start of contact, but it is important to make clinicians and service users aware that this is a temporary compromise measure as the continued implementation of this may be responsible for contributing to problem maintenance	Thank you we have revised the relevant recommendations in light of your and other comments
147	SH	British Medical Association	2	Full	4.7.1.3-4 (NICE 1.1.3-4)	76-77	We are concerned that the suggestions made in 4.7.1.3 and 4.7.1.4 are unduly onerous on general practice and will disrupt the running of practices for the sake of a minority of patients.	Thank you. These comments are primarily concerned with those services who are providing specialist interventions for social anxiety disorder. While we would not expect such changes to the environment for routine care in general practice we would consider that

								such changes should be considered in any primary setting where specialist services are provided.
148	SH	British Medical Association	3	Full	4.7.1.3 (NICE 1.1.3)	76-77	We are also concerned that the suggestions made in 4.7.1.3 and 4.7.1.4 risked damaging patients as they would allow those with social phobias to develop and practice the type of avoidance behaviours which harm the individual and from which phobias develop into diseases. Instead patients should generally be encouraged not to feel that a more normal waiting room situation is impossible for them, and to 'feel the fear and do it anyway'.	This guideline makes recommendations about the treatment of social anxiety disorder, a recognised diagnosis in the DSM and ICD that is associated with significant disability and impairment in many areas of life. To increase access to treatment, it is important that people with social anxiety and other mental health problems feel comfortable entering and using services, and this guideline makes recommendations to ensure this is the case. Whilst behavioural experiments and exposure may be effective in the context of treatment, situations that provoke feelings of anxiety are likely to increase avoidance if people encounter them (i) prior to receiving a clinical rationale, (ii) without their consent, and (iii) outside the scope of a therapeutic relationship.
149	SH	Royal College of Nursing	2	NICE	1.1.3		Line 8: Consideration should be given to clients' waiting times for appointments. This should be kept to a minimum as it will fuel the anxiety	Thank you we agree with this comment but would expect that this should be the norm in healthcare and that no person should be kept waiting when attending for an appointment .
150	SH	South London and Maudsley NHS Foundation Trust	7	FULL	4.7.1.3 (NICE 1.1.3)	76	Should add choice of gender of therapist where possible	Thank you for your comment we have added 'choice of professional' to the recommendation.
151	SH	Social Anxiety West (SA West)	2	NICE	1.1.3	14	Our members support the offer of flexible and accessible services based on individual needs. We feel this needs to be emphasised as much as possible in the guideline principles. Patients are unlikely to request additional support themselves, and we would like to see the principles emphasise the active promotion and offer of these flexible services. Offering appointments after normal hours is particularly important for patients who work full time and cannot (or do not wish to) take time off during normal working hours. Some of	Thank you for your comment. The guideline makes positive recommendations about the availability of flexible appointments. It would be out of line with other recommendations for this to lead to extended waits.

							our group members have experienced longer waiting periods for flexible services (e.g. in excess of 6 months for out-of-hours CBT). Ideally we would like the guideline principles to state flexibility should not result in delayed treatment, as well as encouraging informed patient choices regarding the practicalities that could affect their access to treatment.	
152	SH	British Association for Behavioural & Cognitive Psychotherapies	10	Full	4.7.1.4 (NICE 1.1.4)	77	Please refer to Comment Order Number 9: *It is very helpful to arrange services or appointments flexibly to promote access and avoid exacerbating social anxiety symptoms at the start of contact, but it is important to make clinicians and service users aware that this is a temporary compromise measure as the continued implementation of this may be responsible for contributing to problem maintenance*	Thank you we have revised the relevant recommendations in light of your and other comments
153	PR	Expert reviewer	11	FULL	4.7.1.4 (NICE 1.1.4)	77	It seems a bit unrealistic for a service setting to offer waiting accomodations outside its own premises, areas which by definition they do not control.	Thank you for this comment. It is expected that such premises will necessarily be in the control of the treatment provider but a setting which is more acceptable to the client.
154	SH	Royal College of Nursing	5	NICE	1.1.4	14 of 47	Line 15 Section 1.1.4 should also include: Contact details of the named professional whom they will be working with.	Thank you, but we consider this to be routine good practice in the NHS and therefore do not think it needs specifying in a recommendation.
155	ER	Expert reviewer	3	FULL	4.7.1.2 (NICE 1.1.7)	76	Note need to ensure multiple informants in assessment process, covering multiple contexts (home, school, social etc) and include clinician diagnostic interviews if possible. Avoid reliance solely on child self-report instruments because of potential social desirability effects, eg. Include parent questionnaires, and clinician diagnostic interviews with parent and youth if possible.	Thank you we agree with this and draw attention to this in a number of recommendations (see revised recommendation numbers 1.1.6, 1.1.10 and 1.1.11).
156	ER	Expert reviewer	9	FULL	7.4.2.1 (NICE 1.1.7)	77	This is a nice ideal, but is it practical? Not sure this is necessary.	Thank you but these options are possible and may be provided in the UK NHS.
157	ER	Expert reviewer	10	FULL	7.4.2.2 (NIC	77	As above - very important, but is it practical? Perhaps also recommend that if providing childcare is not possible, the importance for the parents to arrange childcare and ways to do this	Thank you but these options are possible and may be provided in the UK NHS.

					E 1.1.8)		should be discussed.	
158	S H	Royal College of Nursing	6	NIC E	1.1.1 0	15 of 47	Line 22 Section 1.1.10 should also include: Cultural and ethnic needs should be considered.	Thank you for your comment, however the issues that you are raised are covered by other NICE guidance including 'Service user experience in adult mental health'
159	E R	Expert reviewer	1 1	FU LL	7.4.2 .4 (NIC E 1.1.1 0)	77/ 8	*Second bullet:* Although they can often speak "through" a parent.	Thank you for your comment this recommendation has been amended to reflect this.
160	E R	Expert reviewer	1 2	FU LL	7.4.2 .4 (NIC E 1.1.1 0)	77/ 8	Might want to add: If only one parent/carer attends treatment when two are involved in childrearing, stress the importance of passing on all information to the partner.	Thank you for your comment, revised recommendation 1.1.15 recommends this.
161	E R	Expert reviewer	1 3	FU LL	7.4.2 .5 (NIC E 1.1.1 1)	78	Dealing with anger in some cases when parents are acrimoniously separated.	Thank you but we would consider this issue dealt with under the heading of relationship difficulties in revised recommendation number 1.1.11.
162	E R	Expert reviewer	1 4	FU LL	7.4.2 .6 (NIC E 1.1.1 2)	78	'Gillick competence' Is this a British term? I am not familiar with it, so some professionals reading these guidelines may also not be - might be worth spelling it out or providing a link.	Thank you for your comment. 'Gillick competence' is explained in the Department of Health's advice on consent, to which there is a link in the 'Person-centered care' section of the NICE guideline.
163	E R	Expert reviewer	1 5	FU LL	7.4.2 .8 (NIC E 1.1.1 4)	78	and their developmental stage	Thank you for this comment, we agree it is an important issue but believe this is already covered in recommendation 7.4.2.4
164	E R	Expert reviewer	1 6	FU LL	4.7.3 .1 (NIC	79	This sentence is not clear to me. Do you mean the parents' involvement in therapy? The sentence currently sounds like the young person should have a say in the extent to which their parent	Thank you for your comment, this recommendation has been revised to read *"If parents or carers are involved in the*

					E 1.1.15)		is involved in their general care and raising. In our programs we ask teenagers (from about 13 years) to discuss the extent (and nature) to which they would like their parent(s) to be involved in therapy. Before age 13, we don't ask. I am not sure that children have the insight to be able to say how much help they want from their parent, especially at the outset of therapy. Given the benefits that parents can add to therapy for younger children, I'm not sure they should be given a choice until teenage.	*assessment or treatment..."* (revised recommendation 1.1.16).
165	SH	Royal College of Nursing	7	NICE	1.1.17		Line 25 Section 1.1.17 should also include: Contact with school nurse if Child / Young person agrees	Thank you for your comment. this recommendation is about links with adult mental health services and therefore the GDG did not think this change appropriate here.
166	SH	Anxiety UK	1	NICE	1.2.1		We feel that is important that while during the initial assessment and identification stage that 'generalised' and 'specific' forms of social anxiety are differentiated as specific social phobia (e.g.) performance anxiety related social phobia would clearly require a different treatment protocol. i.e. treatment via beta-blockers. Consideration should also be given to the sufferers' family history of social anxiety. Given that social anxiety frequently leads to isolation the role of patient orgs and peer support cannot be underestimated and we would wish therefore to see referrers giving information about orgs like Anxiety UK and others routinely to sufferers.	Thank you for your comment. When the guideline is published NICE will provide information for the public on its website, which will explain the advice given to NHS professionals in the guideline. This information contains a section on sources of advice and support and Anxiety UK will be listed alongside other relevant national organisations.
167	SH	Social Anxiety West (SA West)	3	NICE	1.2.1	18	We support guidelines to help practitioners with being alert to possible anxiety disorders, as people may not be aware of social anxiety or avoid discussing it. As depression and social anxiety have such high co-morbidity and people may seek help for depression instead of social anxiety, we suggest adding a history of or current depression as a reason to be alert to possible anxiety disorders.	Thank you for your comment, however the GDG felt that this issue is adequately covered by the *Common Mental Health Disorders* guideline (CG 123) and the recommendations regarding assessment in this guideline, particularly recommendation 1.2.6 (revised recommendation number 1.2.5) which prompts clinicians to be aware of comorbid disorders.
168	PR	Expert reviewer	14	FULL	5.3.1.2 (NICE 1.2.2)	93	An unpublished paper by Joseph Himle, University of Michigan, USA, suggests that a cut-off score of 5 may be better than a cut-off score of 6 for the Mini-SPIN when used with a low-income, job-seeking sample.	Thank you, for this comment. The focus of this guideline is the general population with social anxiety disorder and not specific populations such as you identify. Therefore we do not think that the work of Dr Himle would be relevant for the use of the mini-SPIN in this guideline.
169	SH	Anxiety UK	2	NICE	1.2.4		We really welcome the holistic approach to the treatment of social anxiety because we know this disorder significantly impairs	Thank you for your comment.

							sufferers functionality across a number of domains	
170	SH	Anxiety UK	3	NICE	1.2.5		We would recommend this is extended to include internet/online/web cam consultation	Thank you, we have added your suggestion to the recommendation.
171	SH	Selective Mutism Information & Research Association (SMIRA)	10	NICE	1.2.5 and 1.2.6	19	Selective mutism in adults SM is a disorder that first occurs in childhood and can continue into adolescence and adulthood (Bernstein et al, 2009, 2012; Remschmidt et al, 2001; Steinhausen et al, 2006). Adult sufferers tend to be very clear on the matter and recognise that they are unable to speak in some situations because they fear being negatively judged by others (i.e. they have social anxiety disorder) or that they have social anxiety because they freeze and cannot speak in certain situations (i.e. they have selective mutism). Some adults and adolescents meet the criteria for both conditions (Bernstein et al, 2009, 2012; Remschmidt et al, 2001; Steinhausen et al, 2006). If SM is to be included in this document, equal emphasis must therefore be given to children and adults. Reference has already been made to including adults in 2.1.4.	Thank you for your comment. Unfortunately, it is not possible to make any treatment recommendations that are not specific to social anxiety disorder as these would be outside the scope of the present Guideline.
172	SH	Selective Mutism Information & Research Association (SMIRA)	10	NICE	1.2.5 and 1.2.6	19	In addition, we recommend that adults with SM are included in 1.2.5 and 1.2.6 as follows, to be consistent with the guideline for children and young people: Assessment of adults with possible social anxiety disorder 1.2.5 Offer adults with possible social anxiety disorder the choice of an initial assessment by phone or in person. Some adults with social anxiety disorder may prefer written forms of communication such as email or electronic tablet 1.2.6 When assessing an adult with possible social anxiety disorder: ▪ conduct an assessment that considers fear, avoidance, distress and functional impairment ▪ be aware of comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders such as selective mutism, psychosis and autism.	Thank you for your comment. The GDG did not feel this was necessary as selective mutism has been referred to in recommendation 1.2.21 (revised recommendation number 1.4.12) and this list is illustrative, not exhaustive.

173	SH	British Association for Behavioural & Cognitive Psychotherapies	11	Full	5.5.1.3 (NICE 1.2.5)	100	Please refer to Comment Order Number 9: It is very helpful to arrange services or appointments flexibly to promote access and avoid exacerbating social anxiety symptoms at the start of contact, but it is important to make clinicians and service users aware that this is a temporary compromise measure as the continued implementation of this may be responsible for contributing to problem maintenance	Thank you for your comment. We have made several changes to recommendations in this section to emphasise this point and in the recommendations for interventions the GDG have stressed that 'graduated exposure to feared social situations' is a key component.
174	PR	Expert reviewer	15	FULL	5.5.1.4 (NICE 1.2.6)	100	What is the justification for suggested heightened awareness of avoidant personality disorder when the evidence favors the interepretation that this diagnosis suggests little more than greater severity of SAD?	Thank you for this comment. We briefly reviewed avoidant personality disorder in the introduction but as we did not conduct a detailed review of the aetiology and diagnosis of avoidant personality disorder, and the fact that it is in current diagnostic manuals, we feel it is appropriate to leave it in the recommendation.
175	ER	Expert reviewer	23	FULL	5.5.1.4 (NICE 1.2.6)	100	*First bullet:* This is vital but I don't recall seeing any measures above re functional impairment. We have used a 6-item measure developed specifically for SAD, called the Life Interference Scale. It seems to work very well. It has not been published separately, but has been used in a few trials and shows good psychometrics. See: Rapee RM, Abbott MJ, Baillie AJ, Gaston JE. Treatment of social phobia through pure self help and therapist-augmented self help. *British Journal of Psychiatry*. 2007;191:246-252. Rapee RM, Gaston JE, Abbott MJ. Testing the efficacy of theoretically-derived improvements in the treatment of social phobia. *Journal of Consulting and Clinical Psychology*. 2009;77(2):317-327.	Thank you for your comment. The GDG considered quality of life and functioning as different outcomes that are correlated with each other and with symptoms of social anxiety.
176	SH	Anxiety UK	4	NICE	1.2.6		We feel that consideration should also be given to the sufferers' family history in the area of social anxiety while in addition consideration should also be given to any dependents and how they are supported. Sufferers are also acutely sensitive to power dynamics and assessors need to be mindful of this.	Thank you for your comment, these issues are addressed in the *Common Mental Health Disorders* guideline, to which revised recommendation number 1.2.7 refers.
177	PR	Expert reviewer	16	FULL	5.5.1.6 (NICE 1.2.8)	100-101	It is difficult to understand why, in section 5.4.2,, it is stated that there were three instruments that were of importance given "their likely value in informing a comprehensive assessment and their feasibility for routine outcome monitoring (LSAS/LSAS-SR, SPAI-SP, SPIN), but in this section it is recommended that the SPIN, LSAS (but not LSAS-SR), or the Social Interaction Anxiety Scale	Thank you for your comment. Thank you for this comment. The GDG considered the SIAS/SPS were designed to be used together but, in combination, these are too lengthy and too difficult to recommend them in routine clinical practice. We have revised accordingly.

							and Social Phobia Scale be used. These latter scales are fine scales; I call only for consistency here.	
178	SH	Anxiety UK	5	NICE	1.2.10		Consideration should also be given to the use of SMS/text messaging as a communication channel where sufferers have anxiety fears with other forms of communication (phone calls and face to face interactions).	Thank you for your comment, the GDG believe this is covered by '*using their preferred method of communication'*.
179	SH	British Association for Behavioural & Cognitive Psychotherapies	12	Full	5.5.1.10 (NICE 1.2.12)	101	Phrasing the question "If I could wave a magic wand…" may imply that the goal is unrealistic and impossible to attain. I suggest "If you no longer felt anxious in social situations, would you still be depressed?"	Thank you for your comment, this recommendation has been amended in light of your and others' comments.
180	PR	Expert reviewer	17	FULL	5.5.1.10 (NICE 1.2.12)	101	It is stated the one should "[d]iscuss with the person which disorder they prefer to be treated first and ask: "If I could wave a magic wand and you were no longer anxious, would you still be depressed?" This question is a skillfull and useful clinical ploy but it does not equate to asking which disorder should be treated first. Rather, it is an effort to establish a functional relationship between SAD and depression such that SAD is a causal factor in the experience of depression.	Thank you for your comment, this recommendation has been amended in light of your and others' comments.
181	SH	Selective Mutism Information & Research Association (SMIRA)	6	NICE	1.2.14	22	Ensuring appropriate management of selective mutism (2) This section looks at identification of social anxiety disorder with a line of questioning that does not help to distinguish SAD from SM; indeed it appears that the scope of SAD has been broadened to include SM as a young child variant of SAD, despite there being inconclusive evidence to support this view. The reference to avoidance of talking in social situations (line 5) could lead to over-diagnosis of SAD and failure to recognise SM – an unacceptable situation as it deprives children from accessing the appropriate form of treatment. We therefore suggest adding immediately after 1.2.14: Be aware that avoidance of talking in social situations may be attributable to selective mutism. Young children with SM experience anxiety, discomfort and aversion to the *act* of speaking itself, rather than being afraid to speak in case it leads to a negative reaction from others.	Thank you for your comment. Unfortunately, it is not possible to make any treatment recommendations that are not specific to social anxiety disorder as these would be outside the scope of the present Guideline.
182	ER	Expert reviewer	8	FULL	5.3.1.3	93	Include the following Assessment for child social phobia should include at least one	Thank you but we do include such measures for example the Social Phobia and Anxiety

					(NICE 1.2.14)		measure that focuses specifically on social phobia symptoms, not just generic anxiety or broader scales that cover a range of anxiety disorders. At the very least the assessment measure should have a substantial social phobia subscale that can be separately scored.	Inventory for Children (SPAI-C) in recommendation 1.4.9
183	ER	Expert reviewer	18	FULL	5.3.1.3 (NICE 1.2.14)	93	I'm not sure of the extent of any changes now and also not sure about timing issues. However, if NICE is interested, we are currently using very similar questions in a self report format to screen for SAD in young people and are comparing against full diagnostic interview. We should have data on a few cases by Feb and data collection will be ongoing.	Thank you for the feedback and the very kind offer. We would be very happy to include this evidence in the next update, but are unable to add it to this guideline.
184	SH	Anxiety UK	7	NICE	1.2.15		We support the undertaking of the comprehensive assessment by a healthcare professional for young children with social anxiety however would question who in practice would do this, as anxiety disorders frequently fall outside of the remit of CAMHS and social workers.	Thank you for your comment. Whilst this may be the case in some services many CAMHS services do treat children with social anxiety disorder (it is the most common presenting problem in CYP-IAPT after depression) and it is important that assessments are undertaken thoroughly. The extent of local service provision will be for the relevant commissioners to determine.
185	SH	Anxiety UK	8	NICE	1.2.17		Consider changing mental disorders to mental health difficulties to reflect current terminology.	Thank you for your comment, this has been amended to 'mental health problems' to reflect the NICE style.
186	SH	Selective Mutism Information & Research Association (SMIRA)	8.	NICE	1.2.17	23, line 26	Behaviour problem or Anxiety Disorder? (2) We suggest it is more appropriate to include selective mutism in 1.2.17 as follows: 1.2.17 As part of a comprehensive assessment, assess for possible coexisting conditions such as: ▪ other mental disorders (for example, other anxiety disorders such as selective mutism, and depression)	Thank you for your comment. The GDG did not feel this was necessary as selective mutism has been referred to in recommendation 1.2.21 (revised recommendation number1.4.12) and this list is illustrative, not exhaustive.
187	SH	Selective Mutism Information & Research Association (SMIRA)	9	NICE	1.2.18	24	Ensuring appropriate management of selective mutism (3) We suggest adding an assessment for SM such as The Selective Mutism Questionnaire (Bergman, 2008) to the list of assessments for anxiety disorders.	Thank you for your comment. Unfortunately, this is beyond the scope of the current Guideline. As described above, the clinician is advised to carry out a thorough assessment if selective mutism (or other diagnoses) are suspected, but it is beyond the scope of the exercise to recommend specific tools for these additional assessments.

188	ER	Expert reviewer	10	FULL	5.5.2.4 (NICE1.2.18)	103	Should note need to use parent versions of these scales where available given strong tendency of socially anxious children to under-report their symptoms and social desirability effects. Also note need to ensure multiple informants in the assessment process, covering multiple contexts (home, school, social etc) and include clinician diagnostic interviews if possible. Avoid reliance solely on child self-report instruments because of potential social desirability effects, eg. Include parent questionnaires, and clinician diagnostic interviews with parent and youth if possible.	Thank you for this comment. We have amended the recommendation in line with your comment.
189	SH	Selective Mutism Information & Research Association (SMIRA)	7	NICE	1.2.21	25, lines 4-5	Given the strong associations with anxiety that are repeated throughout the literature (Dummit et al. 1997; Ford et al. 1998; Anstendig, 1999; Viana, et al., 2009; Cline & Baldwin, 2004; Vecchio & Kearney, 2005; Cunningham et al., 2006; Cohan et al., 2008), it is more appropriate to refer to SM as an anxiety disorder than a behaviour problem. Furthermore, describing SM as an associated behavioural problem implies that the SM will be ameliorated if the underlying social anxiety disorder is treated. There is no evidence that this is the case and no guarantee that SM will resolve without treatment (Crundwell, 2006; Ford, et al. 1998; Stone, et al., 2002). Based on the theoretical and research literature base, Busse and Downey (2011) conclude that targeted early intervention may result in the prevention and amelioration of many occurrences of selective mutism, while other authors (Bernstein et al, 2009; Johnson and Wintgens, 2001) report that the longer SM is left untreated, the longer it takes to resolve. The above statement therefore puts children with SM at considerable risk as it may delay their access to appropriate targeted treatment for SM.	Thank you for your comment. The GDG were concerned that describing selective mutism as an anxiety disorder may not be widely acceptable. Therefore, this recommendation has now been amended to say "…social anxiety disorder and associated *difficulties*, such as selective mutism"
190	SH	Selective Mutism Information & Research Association (SMIRA)	7	NICE	1.2.21	25, lines 4-5	We therefore suggest *removing* the reference to selective mutism from 1.2.21 as follows: 1.2.21 Develop a profile of the child or young person to identify their needs and any further assessments that may be needed, including the extent and nature of: ▪ the social anxiety disorder and any associated behavioural problems. Examples of associated behavioural problems might include school avoidance, temper tantrums, aggression, etc.	Thank you, this has been amended in light of your earlier comments.
191	S	Royal	5	NIC	1.2.2	25	The section on the profile of the child with suspected social anxiety	Thank you for your comment, this was an

	H	College of Paediatrics and Child Health (RCPCH)		E	1		does not include the presence or absence of neurodevelopmental disorders	oversight and neurodevelopmental disorders have been added to this recommendation (new recommendation number 1.4.12).
192	SH	Selective Mutism Information & Research Association (SMIRA)	7	NICE	1.2.21	25, lines 4-5	Behaviour problem or Anxiety Disorder? (1) Having referred to SM as a variant of social anxiety disorder in the full version (2.1.4), the guideline describes SM as a 'behaviour problem': This is very misleading for the many professionals and members of the public who lack awareness of the proven link between SM and anxiety and regard SM as speech *refusal*. This view was revised in DSM IV but unfortunately lingers on as a popular misconception. Although some authors have suggested that SM is an avoidant behaviour, there is agreement that any avoidance or opposition is secondary to the anxiety experienced when expected to speak in specific situations (Cunningham et al, 2006; Kristensen, 2000, 2001; Dummit et al. 1997; Ford et al. 1998; Anstendig, 1999; Cohen et al. (2008). In this respect SM could be regarded as an *adaptive* behaviour, rather than a behaviour *problem*. However, avoidant behaviour alone does not account for the sense of being physically 'frozen' and unable to speak, nor the intense dread of speaking *per se* as described by SM sufferers (Johnson and Wintgens, 2001; Shipon-Blum, E., 2007; Roe V, 2011).	Thank you for your comments, the full and NICE guideline have been amended to clarify this issue.
193	SH	Social Anxiety West (SA West)	5	NICE	1.3 (General)	25-32 (General)	Social Anxiety West strongly supports the aspect of patient choice in the guidelines. Our members feel they should be able to make their own informed choices regarding their treatment, whether pharmacological or psychological.	Thank you for your comment, we agree it is important for all service users to make informed choices.

	SH	Social Anxiety West (SA West)	6	NICE	1.3.1	25	Social Anxiety West's members have commented on the limitations of using outcome measures (e.g. via formal questionnaire-based inventories and scales), and have requested qualitative outcomes also be recorded to guide further treatment. We would like the guideline principles to emphasise the importance of patient involvement in reviewing treatment efficacy.	Thank you for your comment. The GDG felt it was important to identify instruments that can be used to facilitate on-going monitoring during treatment. We agree that regular discussions about treatment progress are part of good clinical practice.
194	SH	Nottinghamshire NHS Trust	4	NICE	1.3.1	25	Use of routine sessional measures in all treatment approaches – perhaps this would not sit well with some psychological interventions?	Thank you for this comment. The GDG concluded that this is an important part of successful psychological intervention and would be appropriate as part of the recommended treatments.
195	SH	Anxiety UK	9	NICE	1.3.2		We believe given that social anxiety is a routine presentation to IAPT services we feel it would be helpful to indicate in this guidance at which step social anxiety should be treated with consideration given to severity of symptom presentation	Thank you. Individual CBT is a Step 3 intervention as currently set out in the IAPT programme. However, this is an implementation matter and such decisions are for commissioners and local services to determine depending on the model of service provision chosen.
196	SH	Social Anxiety West (SA West)	7	NICE	1.3.2	26	We support the use of CBT as the first-line recommended treatment. We would like to question what treatment or monitoring should be offered while people are on the waiting list for CBT. Members often report feeling 'abandoned' during this time and may undergo changes in circumstances (e.g. moving to a different area) that delay or prevent treatment. We feel supported self-help (including a basic introduction to CBT) would be useful in the interim, and would like the guidelines to encourage practitioners to discuss the waiting period with patients.	Thank you. NICE cannot recommend supported self-help during a wait period as this effectively makes supported self-help a first line treatment and the cost-effectiveness analysis does not support this.
197	SH	Anxiety UK	10	NICE	1.3.4		Our experience is that user led social phobia specific drop in groups are incredibly empowering and should form part of the menu of services available to those living with this condition. Such groups should not just be offered to those who decline CBT but to everybody	Thank you for your comment, however we found no evidence to support a recommendation for the type of groups you refer to.
198	SH	Nottinghamshire NHS Trust	5	NICE	1.3.4 / 1.3.16	26	Supported self-help – some therapists may not be adequately trained to do telephone support and infrequent sessions, not clear that the evidence base considers how effective this treatment would be with 'traditional, face-to-face' therapists.	Thank you for your comment, recommendation 1.3.16 (revised recommendation number 1.3.14) sets out what is required to deliver effective supported self help, however making recommendations regarding training is outside the scope of the guideline.

199	SH	Anxiety UK	11	NICE	1.3.5		We would like to ascertain if there is a reason as to why only adults who decline or only partially respond to CBT should be offered a pharmacological intervention?	Thank you. Individual cognitive therapy and cognitive behavioural therapy are more clinically effective, more cost effective, and less likely to have harmful side effects compared with pharmacotherapy. There is very little evidence about starting psychological therapy and pharmacological therapy at the same time. Therefore, the GDG therefore determined that all people should be offered individual psychological therapy. Some people may decline this offer, and they should be offered a pharmacological intervention.
200	SH	The College of Mental Health Pharmacy	3	NICE	1.3.5 1.3.8	11, line 126, line 18	We are concerned about the recommendation of fluvoxamine as one of two first line SSRIs. Fluvoxamine is rarely used in UK practice, is associated with profound drug interaction (via p450 1A2 inhibition) and often requires twice daily dosing. Given that fluvoxamine is unlicensed in Social Anxiety Disorder we believe fluoxetine would be more appropriate and a safer first line choice.	Thank you. We have revised in light of this and other comments.
201	PR	Expert reviewer	30	FULL	6.13.2.5 (NICE 1.3.6)	197	It is difficult to understand the reasoning behind the recommendations for IPT or short-term dynamic therapy, even is specifically designed for SAD. The data simply are insufficiently supportive. There is really only a signle positive trial for IPT, in which it was quite a bit less efficacious than CT, but better than waitlist. Other trials reviewed in the guideline are not robust. The data for dynamic therapy are just not compelling.	Thank you for your comment. The GDG agreed and decided to revise the recommendation about IPT. One large trial of psychodynamic psychotherapy found a positive effect compared to waitlist. The GDG felt this might be a useful 4th line option for people who have refused other forms of treatment, but have qualified the recommendation in light of concerns about efficacy and cost-effectiveness.
202	SH	Social Anxiety West (SA West)	8	NICE	1.3.7/8	27	We welcome the recommendation for further CBT sessions for those with a partial response, as members often feel one course of CBT is not enough for a full recovery.	Thank you for your comment.

203	SH	The College of Mental Health Pharmacy	4	NICE	1.3.9	P27	Footnote on fluvoxamine is repeated	Thank you for your comment. This will be amended for publication.
204	SH	Anxiety UK	12	NICE	1.3.10		Given the very serious difficulties that can occur if MAOIs are taken with certain food substances we feel the line around monitoring needs to be much more robust to include a time schedule of how often a patient is monitored and patients need to be given clear guidance and information. We would also advise that at the point of dispensing that patients are given clear, verbal and written advice by the pharmacist on the potential side effects of their medication.	Thank you for your comment. Recommendation 1.3.22 (revised recommendation number 1.3.21) recommends that healthcare professionals advise people taking MAOIs of the possible interactions. The GDG felt this sufficiently covered the issues.
205	SH	The College of Mental Health Pharmacy	5	NICE	1.3.10	P28	We would like to see a warning about the potential dietary interactions with tyramine associated with phenelzine included here.	Thank you for your comment. Recommendation 1.3.22 (revised recommendation number 1.3.21) recommends that healthcare professionals advise people taking MAOIs of the possible interactions.
206	SH	The College of Mental Health Pharmacy	6	NICE	1.3.10	P28	We would like to see more clarity on the differences between phenelzine and moclobemide here. For example moclobemide is a reversible MAOI with less risk of dietary interactions.	Thank you for this comment. We have made this clear in the full guideline the difference between these two drugs. In recommendation 1.3.22 we draw attention to the dietary restrictions for both drugs and refer to the SPC.
207	SH	British Association for Behavioural & Cognitive Psychotherapies	17	Full	6.13.4.1 (NICE 1.3.12)	198	Note that in the Clark & Wells' (1995) model, on which the relevant individual treatment and evaluation trials are based, "discrimination training or rescripting to deal with problematic memories of social trauma" was not a component	Thank you for your comment. You are correct in saying that these procedures were not mentioned in the original theoretical article by Clark & Wells. However, they are part of the subsequently developed treatment and have been used in many of the RCTs that are included in the network meta-analysis.
208	PR	Expert reviewer	31	FULL	6.13.4.2 (NICE 1.3.13)	198	Individual CBT Heimberg is described as having an initial 90 minute session followed by 15 60 minute sessions. This is not consistent with the protocol and needs to be corrected to read 16 sessions, all of which are 60 minutes in duration, with the exception of the first in-session exposure session, which should have a duration of 90 minutes. The specific session in which the first in-session exposure occurs varies, but it is generally session 6, 7, or 8.	Thank you, we have revised.
209	S	Social	1	NIC	1.3.1	28-	Social Anxiety West and its members support the number and	Thank you for your comment.

	H	Anxiety West (SA West)	0	E	2/13	29	length of CBT sessions suggested in the guidelines, as this is significantly more than is currently offered as standard (usually 6-8 weeks). Members say this would help with exploring social anxiety in more depth, establishing new patterns of thinking and behaving, and allowing the individual to feel more at ease with their therapist.	
210	S H	Social Anxiety West (SA West)	1 1	NIC E	1.3.1 2/13	28-29	We would like the NICE recommendations to acknowledge that the Clark & Wells model might be more effective than the Heimberg model. Members of Social Anxiety West are also more familiar with the Clark & Wells model from self-help, and therefore may find it more useful for individual CBT to build on this existing knowledge. We would also like differences in the effectiveness of these models to be included in recommendations for further research.	Both interventions are highly effective and their mean effects have largely overlapping confidence intervals. The available data do not support stronger claims about the relative efficacy and cost effectiveness of these interventions.
211	S H	Social Anxiety West (SA West)	9	NIC E	1.3.1 2-15	28-30	We would like the recommendations to emphasise the need for patient choice with regards to their therapist (e.g. gender, location, timing) and type of therapy.	Thank you for your comment. We have added 'choice of therapist' to recommendation 1.1.2.
212	S H	Anxiety UK	1 3	NIC E	1.3.1 3		We feel it would be helpful to indicate where on the stepped care model such treatment would sit - we are presuming step three but this requires clarification.	Thank you for your comment. This guideline does not suggest a stepped-care approach to treating social anxiety disorder.
213	S H	Anxiety UK	1 4	NIC E	1.3.1 6		We would recommend that evidence based self-help books such as "Overcoming Social Anxiety" by Gillian Butler, are routinely promoted to sufferers.	Thank you for your comment. As you suggest, there are several books and computer/internet programmes that may be beneficial. This guideline did not assess the relative merits of specific books, so it cannot endorse a particular product.
214	S H	Social Anxiety West (SA West)	1 2	NIC E	1.3.1 6	30	Our members have found self-help useful, although do not generally feel this is enough to overcome social anxiety completely. Members who have been offered self-help have commented that this can feel like they are not being taken seriously and being dismissed by practitioners. We therefore support this being offered only if individual CBT is refused and with additional assistance, and would like the guidelines to mention that this may have a negative response from patients.	Thank you for your feedback. The guideline recommends exactly this approach – that is, that all people with social anxiety should be offered individual CBT and that the use of self-help is the choice of the user rather than a consequence of resource constraints or part of a stepped-care model.
215	S H	Anxiety UK	1 5	NIC E	1.3.1 8		We suggest this is reworded from "arrange to see" to "arrange to contact" and we feel it would be helpful to clarify/detail the need to liaise with crisis services in the event that contact is not established.	Thank you for your comment but in the context of monitoring people taking antidepressants the GDG felt that seeing the person face to face was preferable.
216	S	Anxiety UK	1	NIC	1.3.1		Please outline in the guidance what would happen if no contact was	Thank you for this. If no contact was made with

	H		6	E	9		able to be established with the sufferer and we feel it would be helpful to clarify/detail the need to liaise with crisis services	the sufferer then standards local procedures would be adopted by the local service. To comment on this is outside the scope of the guideline. Relationships with crisis services would be managed through links with local mental health services this is covered in recommendation 1.1.18
217	SH	The College of Mental Health Pharmacy	7	NICE	1.3.22	P32, line 1	Add such as phenelzine	Thank you for your comment, the GDG did not feel it was necessary to make this distinction. This is a general concern about the class of medications rather than a concern about a specific drug. The GDG considered safety issues were associated with all of these drugs and did not want to imply that concerns are limited to only one of them.
218	SH	Anxiety UK	17	NICE	1.3.25		Consider giving information on psychiatric pharmaceutical helplines to support individuals considering coming off medication eg such as the psychiatric pharmacy helpline provided by Anxiety UK	Thank you for your comment, however this is outside the scope of our guideline – it is not NICE policy to recommend specific contact numbers as these can change over time leading to confusion for future readers.
219	ER	Expert reviewer	28	FULL	7.3.1.1 (NICE 1.4.1)	233	*delivered by competent practitioners:* who have had experience and training in working with young people.	Thank you for your comment, but by competent practitioners the GDG are referring to those who have experience and training and are therefore competent to work with children and young people.
220	SH	Anxiety UK	18	NICE	1.4.3		We feel this is such an important area the current paragraph does not do it justice; this requires a more detailed approach of how to achieve this as it is Anxiety UK's experience that responses by schools to anxiety in children varies enormously in general there being a lack of knowledge, clarity and coordination.	Thank you for your comment, however this is a clinical guideline and we are unable to make recommendations for schools/teachers.
221	SH	South London and Maudsley NHS Foundation Trust	14	FULL	7.3.2.2 (NICE 1.4.5)		7.3.2.2 "Consider parent-delivered CBT (see recommendation 7.3.3.2) for children with social anxiety disorder aged 4-12 years." Would be clearer/consistent if what is now labelled 7.3.1.2 is included as third treatment option in section 7.3.2	We have amended the recommendation in light of your feedback and the comments above.
222	SH	Royal College of Nursing	3	NICE	1.4.5		Knowledge of the stages of child development needed by professional delivering intervention.	Thank you for your feedback, but this is outside of the scope of the current guideline.

223	SH	Royal College of Nursing	4	NICE	1.4.5		Intervention should be delivered in a method appropriate for the clients' level of development.	We have amended the recommendation in light of your feedback and the comments above.
224	ER	Expert reviewer	30	FULL	7.3.3.1 (NICE 1.4.6)	224	I would include some sort of training in re-interpretation of biased beliefs (e.g. cognitive restructuring). It is too easy for exposure to "fail" if the child continues to believe that others are thinking negatively about him/her.	Thank you for the comment. The GDG concluded that evidence supports the use of CBT, and the guideline gives some advice on what this should include. It also made research recommendations and supports the investigation of this and other questions about the most effective components and delivery of interventions for this population.
225	SH	Social Anxiety West (SA West)	13	NICE	1.4.6	34	We would like to question the benefit to children of homogenous (i.e. just children with social anxiety or other anxiety disorders) vs more general mental health groups. If there is evidence for a difference we would like this to be specified in the guideline recommendations and if not it may be a useful area of further research.	We have amended the recommendation in light of your feedback and others' comments.
226	SH	Anxiety UK	19	NICE	1.5.1		We feel the wording is far too strong in this section as in our experience we routinely come across individuals who have benefitted from both mindfulness based CBT and supportive psychotherapy	Thank you for this comment. The GDG considered that some people might benefit from therapies that are not recommended. On balance, there was stronger clinical evidence for other treatments, and they were more cost effective.
227	SH	Social Anxiety West (SA West)	14	NICE FULL	1.5.1 6.7.1 6.13.6.1	35 145 201	Many members of SA West feel they have benefited from mindfulness-based therapies (e.g. mindfulness-based cognitive therapy, mindfulness-based stress reduction and also acceptance and commitment therapy) and would like to see these therapies recommended for further research. Further research should ideally include both comparisons between standard CBT and mindfulness-based cognitive therapy, as well as randomised controlled trials measured against placebo groups.	Thank you for your suggestion. The evidence for mindfulness-based cognitive therapy is very limited, but not so promising that this was considered a research priority.
228	PR	Expert reviewer	32	FULL	6.13.6.1 (NICE 1.5.1)	201	The statement reads "Do not routinely offer mindfulness-based CBT or supportive psychotherapy to people with social anxiety disorder." This is incorrectly stated as I understand it. Mindfulness-based CBT was not evaluated in any study examined in the guideline. Mindfulness training of various sorts, including mindfulness-based stress reduction was. The recommendation as stated is not based on data, but replacement of the word "CBT" with the word "training" would bring it into line.	Thank you. This has been revised in light of this and other comments.
229	S	British	2	FU	6.13.	201	The existing literature that is labelled as "supportive psychotherapy"	We have revised and refer to "supportive

	H	Association for Counselling and Psychotherapy		LL	6.1 (NICE 1.5.1)		here consists of three studies of widely differing treatments, two of them clearly non bona fide (Cottraux 2000; Kniinik 204). This literature is not coherent enough to support a negative ("Do not routinely offer…") recommendation. A more accurate recommendation might be: "Do not offer substandard psychological treatments that are not intended to be fully therapeutic, that is, too short to be effective (eg 3 hrs) or delivered by therapists who are constrained from doing what they normally regard as effective (such as interpreting or addressing client distress). However, the inclusion of a negative recommendation for "supportive psychotherapy" creates the misleading impression that there is a coherent body of practice being referred to, when that is not in fact the case. Thus, it would be better to drop the negative recommendation against "supportive psychotherapy" from the recommendations and to refer Guideline users to the section 4.7.1: Principles for working with all people with social anxiety disorder, principles and to section 6.13.1: Treatment principles.	therapy" following this and previous comments. Interventions provided in these trials were designed to be therapeutic and were evaluated by the authors and by the GDG as such. As noted in our previous response, only COTTRAUX2000 and LIPSITZ2008 were included in the category of "Supportive therapy." We included three examples of psychodynamic psychotherapy as another category (Emmelkamp 2006, Knijnik 2004 and Leichsenring 2012).
230	PR	Expert reviewer	3	FULL	6.13.6.2 (NICE 1.5.2)	201	The recommendation 6.13.6.3, suggesting that benzodiazepine use be limited to short-term for a crisis lacks validity, as no studies of short term use of benzodiazepine for a crisis in SAD patients is provided. There are studies, however, supporting the use of benzodiazepines for acute treatment of SAD, and some evidence for sustained efficacy of clonazepam (as acknowledged on p. 27).	Thank you for your comment, this recommendation has been revised in line with your suggestion.
231	PR	Expert reviewer	4	FULL	6.13.6.2 (NICE 1.5.2)	201	This statement says beta blockers should not be offered routinely to people with social anxiety disorder. I'm not sure what is meant by "routinely," (as I don't think any medicine should be offered routinely) and I agree that there is not strictly speaking an evidence base of studies directly supporting beta blocker use in SAD. Nevertheless, there is evidence for beta blocker efficacy for performance anxiety in anxious performers, that would seem to bear mentioning somewhere in the quidelines, although not meeting the criteria for an evidence based treatment of SAD.	Thank you for your comment, this recommendation has been revised in line with your suggestion.

232	SH	Anxiety UK	20	NICE	1.5.2		Beta blockers are routinely used by those experiencing specific social anxiety to control physical symptoms of anxiety successfully – this should be reflected in the guidance.	Thank you for your comment. We have acknowledged your point in the full guideline (chapter 6) but the evidence does not support a positive recommendation for beta-blockers.
233	SH	Anxiety UK	21	NICE	1.5.6		Over the years that this procedure has been available Anxiety UK has had a variety of feedback from those who have undergone the operation – some have had a successful outcome others have not. Where the operation has had a very negative outcome this had led to issues such as compensatory sweating which is arguably a potentially worse problem than the initial condition	Thank you for your comment, the GDG agreed this operation can have very negative effects and have therefore not recommended it.
234	SH	Anxiety UK	22	NICE	1.5.7		We agree with this, as we believe strongly that young people should explore all non-invasive treatment options first.	Thank you for your comment.
235	SH	Anxiety UK	23	NICE	1.6.1		We are really surprised to see that computerised CBT/e-therapy is not recommended and would like to contest this. Our sister organisation Self Help Services (SHS)(www.selfhelpservices.org.uk) has many years experience of delivering computerised CBT through its NHS contracts and has seen very good outcomes with this therapy for those experiencing social phobia. Additionally e-therapy when provided through an at home service can often act as an entry point for those with social anxiety. SHS has been delivering e-therapy to support those with mild to moderate forms of social anxiety. 1.6.1 refers to “specific phobias”- is this a typo?	Thank you for your comment. Self-help is recommended as a second treatment option for social anxiety, but face-to-face therapy is more clinically efficacious and cost-effective. We did not find sufficient evidence to recommend self-help for specific phobias. The NCCMH were commissioned by NICE to include a review of cCBT for specific phobias within this guideline.
236	SH	Social Anxiety West (SA West)	15	NICE	1.6.1	36	Members would like to be able to discuss treatments lacking evidence with their doctor (e.g. homeopathic/herbal medications, mindfulness) even if they cannot be recommended, and we would like the guidelines to encourage practitioners to engage in open discussions of these with their patients. Members are often using over-the-counter medications already and the guidelines should highlight that this is common place.	Thank you for your comment, however as there is no evidence for the efficacy of such treatments we are unable to recommendation them.
237	SH	Social Anxiety West (SA West)	16	NICE	2	37-41	We very much support recommendations for further research into social anxiety. Social Anxiety West would also like to see further research into support groups (like our own) for social anxiety. Members feel they benefit from the open-ended and long-term availability of our support group, the chance to interact with other people with social anxiety and from a supportive atmosphere for graduated behavioural exposure.	Thank you for your comment. The GDG certainly support further research into this disorder, but did not consider support groups a priority at this time.
238	ER	Expert reviewer	26	FULL	7.3.5 (NIC	225	7.3.5 Research recommendations I suggest that there is one other area of research for the future that	Thank you for your comment. The guideline identified several pressing issues for research.

					E RR)		should be included in this section. Although it seems that generic CBT may be less effective than social-anxiety specific CBT in online therapy, we do not know this. There is a huge need for interventions that are low cost and easily accessed by youth and families. Internet therapy certainly offers an option, if effective. Thus I suggest adding another research recommendation as follows: What is the clinical and cost effectiveness of therapist-assisted internet delivered social-anxiety specific CBT for children and young people with social anxiety disorder?	The GDG concluded that evidence for face-to-face interventions for children is very limited. Research about online interventions may be important in the future, but the GDG did not identify this as one of the most urgent areas for investigation.

These stakeholder were approached but did not comment;

Alder Hey Children's NHS Foundation Trust
Association for Cognitive Analytic
Association for Family Therapy and Systematic Practice in the UK
Association for Psychoanalytic Psychotherapy in the NHS
Association for Rational Emotive Behaviour Therapy
Association for the advancement of meridian energy techniques
Association of Anaesthetists of Great Britain and Ireland
Autism Alliance UK
Autism Treatment Trust
Autonomy Self Help Group
Bolton Council
Bradford District Care Trust
British Association for Psychopharmacology
British Association of Psychodrama and Sociodrama
British Association of Social Workers
British Medical Journal
British National Formulary
British Psychodrama Association
Buckinghamshire Hospitals NHS Trust
Camden Link
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Cerebra
Children's Commissioner for Wales
Citizens Commission on Human Rights
Cochrane Depression Anxiety and Neurosis Group
College of Occupational Therapists

Commission for Social Care Inspection
Contact
Critical Psychiatry Network
Department for Communities and Local Government
Department of Health, Social Services and Public Safety - Northern Ireland
Dorset Primary Care Trust
Equalities National Council
Faculty of Occupational Medicine
Forum for Advancement in Psychological Intervention
George Eliot Hospital NHS Trust
Glencare
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Hammersmith and Fulham Primary Care Trust
Health Protection Agency
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Hindu Council UK
Humber NHS Foundation Trust
Information Centre for Health and Social Care
Institute of Psychiatry
Kent and Medway NHS and Social Care Partnership Trust
Lambeth Community Health
Lancashire Care NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Leicestershire Partnership NHS Trust
Liverpool Community Health
Liverpool Primary Care Trust
Lundbeck UK
Maywood Health Care Centre
Medicines and Healthcare products Regulatory Agency
Mental Heath and Vascular Wellbeing Service
Mind
Mind Wise New Vision
Ministry of Defence
National CAMHS Support Service
National Clinical Guideline Centre
National Collaborating Centre for Cancer

National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Patient Safety Agency
National Public Health Service for Wales
National Specialised Commissioning Group
National Treatment Agency for Substance Misuse
NEt
NHS Bath & North East Somerset
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS Direct
NHS Milton Keynes
NHS Plus
NHS Sheffield
NHS Warwickshire Primary Care Trust
NHS Worcestershire
North Essex Mental Health Partnership Trust
Northumberland, Tyne & Wear NHS Trust
OCD - UK
PERIGON Healthcare Ltd
Pfizer
Pharmametrics GmbH
Public Health Wales NHS Trust
Pulse Doctors
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Pathologists
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Psychiatrists in Scotland
Royal College of Psychiatrists in Wales
Royal College of Radiologists
Royal College of Surgeons of England
Royal National Institute of Blind People

Royal Pharmaceutical Society
Royal Society of Medicine
Scarborough and North Yorkshire Healthcare NHS Trust
Scottish Intercollegiate Guidelines Network
Sensory Integration Network
Sheffield Health and Social Care NHS Foundation Trust
Social Care Institute for Excellence
Social Exclusion Task Force
Solent Healthcare
South Asian Health Foundation
South Essex Partnership NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Step4Ward Adult Mental Health
Surrey and Border Partnership Trust
Sussex Partnership NHS Foundation Trust
Sutton1in4 Network
Tees, Esk and Wear Valleys NHS Trust
The College of Social Work
The National LGB&T Partnership
The Princess Royal Trust for Carers
The Rotherham NHS Foundation Trust
The University of Glamorgan
United Kingdom Council for Psychotherapy
University of Edinburgh
Warrington Primary Care Trust
Welsh Government
Welsh Scientific Advisory Committee
West London Mental Health NHS Trust
Western Cheshire Primary Care Trust
Western Health and Social Care Trust
Whitstone Head Educational
Worcestershire Acute Hospitals Trust
York Hospitals NHS Foundation Trust