Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: a randomised controlled trial

The Treatment of Child Anxiety in Primary Care via Guided CBT Self Help: A Randomised Controlled Trial

PROTOCOL VERSION 3

21st May 2012

LREC ethics no:

University of Reading ethics no.:

Trial Registration no.:

The Treatment of Child Anxiety in Primary Care via
Guided CBT Self Help: A Randomised Controlled Trial

RATIONALE: Anxiety disorders are the most common mental health disturbance in childhood and significantly impact on socio-emotional and academic development. Cognitive Behaviour Therapy (CBT) is associated with good outcomes, including when delivered to parents. However CBT is expensive and not widely available. CBT self-help has been shown to be efficacious for other disorders, especially when guidance is provided. We have recently completed an RfPB funded feasibility study of CBT self-help for child anxiety disorders guided by Primary Mental Health Workers (PMHWs), which demonstrated PMHWs deliver the treatment well, parents and PMHWs report high satisfaction, and there are clear improvements in child anxiety. This proposal is to assess the efficacy and cost-efficacy of this intervention.

The study will be conducted within the Oxfordshire Primary Care Child and Adolescent Mental Health Service (PCAMHS). All the PCAMHS workers will be trained in the delivery of the CBT self-help manual. A research assistant (RA) will assess all children and their parents where the referrer identifies anxiety as a primary problem, to confirm primary anxiety status and obtain baseline assessments. Eligible participants will be randomised to either parent-focussed guided self-help or PCAMHS standard treatment, solution focussed brief therapy (SFBT). Outcome and economic assessments will be conducted (blind to treatment condition) 3 months later (i.e. post treatment). Follow-up assessments will be conducted 6 months post-treatment. Treatment sessions will be recorded and assessed for treatment adherence.

SIGNED OFF BY:

ON BEHALF OF THE STEERING COMMITTEE

POSITION: STEERING COMMITTEE CHAIR

Signature: _____ Date: _____

Principal Investigators

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Francia Kilgarriff (PCAMHS, Oxfordshire)

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A. BACKGROUND

Anxiety disorders are the most common form of mental health disturbance in childhood: 5%-10% of children meet diagnostic criteria for an anxiety disorder (1,2,3). These problems have a significant adverse impact on children's emotional and social development and impede scholastic achievement (4). Anxiety disorders tend to be stable over time (3,5) and commonly precede the development of other problems (such as depression and substance abuse; 6,7). The high prevalence and persistence of anxiety disorders in childhood, and the associated risk for the development of further mental health problems, highlight the need for effective and deliverable interventions.

Cognitive Behavioural Treatments (CBT) for children with anxiety disorder have been found to be efficacious (e.g. 8,9,10,11): using conservative intention to treat criteria, the remission rates for primary anxiety disorder are 55% for CBT compared to 13% for controls (11). Clinical gains are well maintained (e.g.12). However, CBT is a specialist form of treatment which is not widely available. Indeed, only a small proportion of children in need of treatment receive appropriate help (13,14). More specifically, a report by the Healthcare Commission (15) identified that less than half of those likely to benefit from 'talking therapies' (including those with anxiety disorders) were able to access them in the preceding 10 months. With regard to CBT specifically, the number of trained therapists in the UK is small - approximately half that of, for example, the Netherlands, Scandinavia or Germany- and the shortfall is especially acute in the child disorder field. It is notable that, of the 59 current national CBT training courses only three focus on training for the treatment of children and adolescents. There is a need for the development of an evidence based efficient system of delivering a CBT treatment for child anxiety disorder.

One promising avenue is a stepped care approach in which a simple first level CBT treatment is offered, with only non-responders being referred for specialist care. Since the delivery of CBT treatments for child anxiety disorder is successful when managed by parents (e.g. 16), the approach we have adopted is to produce a CBT self-help manual (17), written specifically as a guide for parents to help their children overcome problems with anxiety. CBT self-help manuals are highly effective for many adult disorders, such as depression (18),

anxiety disorder (19), and eating disorders (20), in some cases proving as efficacious as standard therapist-led treatment (e.g. 21). There have been few comparisons of guided self-help with pure (unguided) self-help and the findings are inconsistent, but the balance of evidence favours the guided approach (22).

Given the established utility of self-help manuals for mental health difficulties in adult populations, there is a striking lack of research into the use of such an approach with juvenile populations. There is some evidence that manuals for parents can be effective in reducing child symptoms of depression (23), oppositional behaviour (24), chronic headaches (25), enuresis (26), and post-operative pain (27). Promising evidence has also emerged of clinical gains using a self-help manual for child anxiety (28), with particularly positive results with accompanying therapist support among a rural Australian population (29).
The evidence on guided CBT self-help in general, in helping parents manage their children's problems, and the preliminary evidence on child anxiety disorder, all point to guided CBT self-help as a possible efficient and effective means of providing treatment for anxious children. We conducted an RfPB funded feasibility study of guided CBT self-help which demonstrated that this treatment was delivered within primary care to a high standard of treatment adherence, with high levels of parent and therapist satisfaction and clinically meaningful reductions in child anxiety (30). The extant literature and findings from this feasibility study provide a compelling rationale for a systematic evaluation of the efficacy and cost-effectiveness of this treatment approach, and investigation of characteristics of patients for whom this approach works best. There has been a lack of consistency in the published literature with regard to predictors of outcome from CBT for childhood anxiety disorders, however the most consistent predictors include severity of child anxiety and depression pre-treatment (31, 32), child age (32), and parental psychopathology (e.g. 31), in particular anxiety (e.g. 33).

The proposed study is a Randomised Controlled Trial to evaluate the efficacy and cost-effectiveness of guided CBT self-help for child anxiety within Primary Child and Adolescent Mental Health Services (PCAMHS) across Oxfordshire. Participants will be randomly allocated to either the guided CBT self-help condition or PCAMHS standard care (i.e. Solution Focused Brief Therapy, SFBT) in order to establish whether the guided CBT self-help

approach offers benefits in comparison to the intervention families usually receive within PCAMHS. The study will also assess predictors of treatment outcome of guided CBT self-help.

Research Questions

In an RCT for the treatment of child anxiety in primary care, the research questions are as follows:

1. (a) Does guided CBT self-help deliver improved outcomes in comparison to PCAMHS standard care (SFBT)?
   (b) Are group differences maintained 6 months post-treatment?
2. Does guided CBT self-help deliver improved health economic outcomes in comparison to PCAMHS standard care (SFBT)? I.e., will there be a significantly lower cost associated with child anxiety (including all health and social care costs, productivity costs for parents, quality of life units, and missed school time for children) in the guided CBT self-help condition in comparison with the standard care (SFBT) condition.
3. Will more positive treatment outcome be associated with lower levels of baseline parental anxiety, less severe child anxiety and depression, and younger child age?

B. SUMMARY

The aim of the trial is to establish the relative efficacy and cost-effectiveness of (i) guided CBT self-help delivered via parents, and (ii) PCAMHS standard care, solution focused brief therapy (SFBT), for children experiencing anxiety problems.

Patients who consent to join the trial (participants) will be randomised to one of two conditions: (i) Parent focussed guided CBT self help (GSH), or (ii) PCAMHS standard care, solution focussed brief therapy (SFBT)

C. ELIGIBILITY

1. Inclusion Criteria

Child:

In addition to standard PCAMHS criteria:

(i) Aged 5 to 12 years;

(ii) Primary presenting problem is anxiety (**separation anxiety, social phobia, generalized anxiety, specific phobia, panic, agoraphobia**) associated with clinical impairment

2. Exclusion Criteria

Participants will not be eligible if the following criteria are met.

Child:

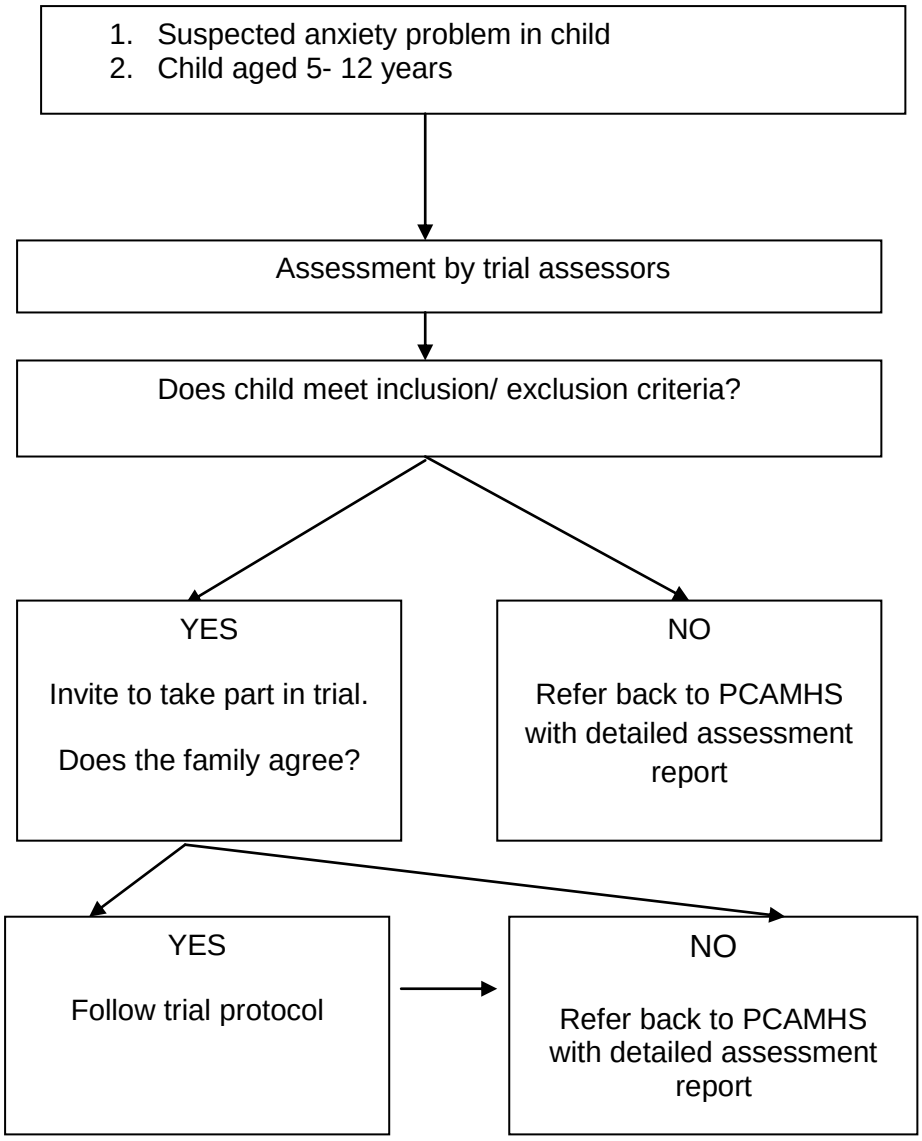
(i) Current prescription of psychotropic medication (or, if psychotropic medication is prescribed, it should have been at a stable dose for at least 8 weeks with agreement to maintain that dose throughout the study).

(ii) The parent or child has a poor understanding of the English language.

(iii) The parent or child has a known physical or intellectual impairment (including autistic spectrum disorder).

D. TRIAL PROCEDURES

1. Recruitment schedule



2. Treatment Interventions

There will be two treatment interventions in the trial:

(1) Guided CBT self-help (GSH)

The GSH programme will be that delivered within our recent feasibility study (using the existing manual, slightly modified to incorporate feedback received from patients and PMHWs who participated in the feasibility study). Guiders will meet with parents face-to-face (F) individually on four occasions (4 x 60 mins) and will have telephone contact (T) on four occasions over an eight-week period (4 x 15 mins) (i.e. F,F,T,F,T,T,F,T); total therapist contact time = 5 hours. PMHWs will, by following their implementation manual, encourage the parent(s) to work systematically through the self-help manual [17], provide opportunities at the face-to-face meetings to role play key skills, and work with parents to overcome problems and challenges that they face in implementing the programme.

(2) Solution Focussed Brief Therapy (SFBT)

The SFBT programme will comprise an initial face-to-face session with the parent and child to initiate the treatment (**60** mins), four face-to-face sessions of solution-focused brief therapy with the child (4 x **45** mins), and a final session with the child and parent to summarise and end treatment (**60** mins); total therapist contact time= 5 hours. Although currently PMHWs may adopt an ecelctic approach to their clinical work, Solution Focused Brief Therapy (SFBT) is the only treatment approach in which all PMHWs have received formal training and is the only treatment approach that is common to all PMHWs across the teams. Furthermore SFBT is a frequently used treatment approach within settings in which a short number of treatment sessions is available (34). For the purpose of this trial, to ensure clear differentiation of the two treatment modalities, PMHWs will be required to follow the manualised approach set out by the European Brief Therapy Association Outcome Study (35).

To ensure adherence to treatment condition, PMHWs will receive two days of training in the particular treatment modality before initiating treatment in each condition. Regular clinical supervision will be provided, with an explicit focus on adherence to and managing difficulties within the subscribed treatment approach. In addition PMHWS will audio-record all treatment sessions, in both conditions, and adherence will be monitored and addressed in ongoing supervision. A sample of these sessions will be rated by independent and reliable

raters (University of Reading Masters students) to quantify adherence to treatment manuals.These ratings will be made directly from the tapes (i.e. no transcribing required). A schedule has already been developed for rating adherence to the guided CBT self-help with a high level of interrater agreement (as part of the feasibility study).

E. RANDOMISATION

Following confirmation of eligibility and informed consent, participants will be randomised to treatment condition. Randomisation will be performed centrally by facsimile contact at the Centre for Statistics in Medicine, Oxford (CSM). The randomisation programme will include a minimisation algorithm to ensure balanced allocation of participants across the two treatment groups for the following potential prognostic factors: child age, child gender, child anxiety severity (ADIS Clinician Severity Rating) and level of parental (the primary parent that will attend treatment) anxiety (DASS-21).

To reduce the possibility of outcome measure events occurring after randomisation and before treatment, intervention will start within 2 weeks of randomisation. Randomised cases will be allocated to therapists in blocks so that individual PMHWs deliver only one form of treatment at a time, with half the PMHWs delivering guided CBT self-help first, and half delivering SFBT first. Randomisation will be administered in liaison with CSM by the team clinical psychologist [*or lead assessor, to be confirmed*] who is not blind to treatment allocation.

F. ROUTINE CARE OUTSIDE OF THE TRIAL

Participants will be asked not to engage in other psychological interventions (in relation to child anxiety or other child difficulties) during the course of the trial (i.e. until after 6 month follow-up assessment). They will also be asked not to initiate psychotropic medication and if psychotropic medication is prescribed, this should have been at a stable dose for at least 8 weeks with agreement to maintain that dose throughout the study. Referrers (e.g.General Practitioners) will be informed of this requirement.

G. SERIOUS AND UNEXPECTED ADVERSE EVENTS

There are no anticipated adverse side-effects of the interventions being delivered. Any adverse or unexpected events resulting in physical or psychological injury that arise from

the administration of research procedures or the provision of treatment within the trial will be recorded for discussion with the Trial Steering Committee. This will include events such as breach of confidentiality, adverse therapeutic interventions, diagnostic error, improper staff behaviour, falls and injuries. Successful treatment of anxiety may involve some distress, however this will be managed and contained by PMHWs, receiving regular expert supervision. Although substantial clinical benefits are anticipated from the interventions, some children can be expected to not respond to the interventions. Where children continue to meet criteria for a current anxiety disorder at the six month post treatment assessment, they will be referred to their local CAMHS team following clinical review and liaison. If other significant difficulties emerge these will be discussed with the referrer and/or local PCAMHS lead.

Any serious and unexpected events that occur will be recorded and monitored by the lead clinician, and the PI will report on these at all TSC meetings.

H. ASSESSMENT OF OUTCOME

1. Primary outcomes

The primary indicator of recovery is that the child's difficulties with anxiety are 'much' or 'very much' improved on the basis of clinical global impression (CGI-I; 36), as assessed post-treatment by an independent assessor, blind to treatment condition and trained to a high level of reliability in the use of the measure. (This measure is the current accepted gold standard outcome criterion for child anxiety trials; 45). The CGI-I will be established on the basis of parent and child report on the Anxiety Disorders Interview Schedule (ADIS-c/p; 37).

2. Secondary outcomes

Secondary outcome measures will be anxiety severity, assessed using the ADIS-c/p and self-report questionnaires of anxiety symptoms (KFQ, 46; SCAS-c/p, 38), and the impact of anxiety on the child's life (CAIS-c/p; 39).

To maintain assessor blindness, the independent assessors will be excluded from discussions about participants during the treatment phase of the study, will be based in a separate location from treatment therapists, and will start each assessment by asking patients to avoid discussing the content of the treatment.

3. Health Economic Assessment

The health economic evaluation will adhere to guidelines for good economic evaluation practice as outlined in the reference case by the National Institute for Health and Clinical Excellence (NICE; 42). The economic analysis will estimate the incremental cost and efficacy of guided CBT self-help in relation to standard care (SFBT). Patient level resource use data, including all health and social care costs (staff costs, GP costs, referrals, and other relevant services identified) as well as leisure and productivity estimates for parents, will be collected within trial forms and valued using appropriate unit costs. Staff training costs and the costs of staff supervision will be identified and allocated pro-rata. The outcome measure for the cost-effectiveness measure will be the improvement status (CGI-I; much/very much improved or not) as well as a measure of 'days off school avoided'. In line with recent recommendations from NICE, the economic evaluation will also include the generic quality of life instrument, the child friendly EuroQol EQ-5D (43,43). These instruments will be administered at baseline, following treatment, and at 6 month follow up.

Consideration of the distribution of the cost and effect data will be given in the economical analysis. In order to explore the variation around the costs and effects generated by the trial data stochastic variance around the cost-effect pairs will be estimated using non-parametric bootstrapping methods. Allowance for differential timing of costs and benefits will be made using recommended discount rates. The incremental cost and the incremental benefits (effectiveness and utility) will be reported within an incremental cost-effectiveness ratio (ICER) format where appropriate. The results for the cost-effectiveness analyses will be expressed in terms of positioning on the cost-effectiveness plane as well as translated into cost-effectiveness acceptability curves, indicating the likelihood that the results fall below any given cost-effectiveness ceiling ratio (Rc).

I. POWER AND SAMPLE SIZE

The primary indicator of recovery will be substantial clinical global improvement (CGI-I; see measures) post-treatment. Effect sizes relating to the CGI-I (or similar outcomes) are not available for SFBT for childhood anxiety, however a difference of two-thirds between the proportion of recovered children in the guided CBT self-help treatment and standard care (SFBT) would be considered to provide good justification for the service changes (primarily

training and supervision) required to adopt the guided self-help approach nationally. In our recent feasibility study, 60% of children recovered, (i.e. were rated as 'much/very much' improved on the CGI-I), based on intention to treat criteria. This would represent a 67% improvement over SFBT if the rate of recoveryin the SFBT condition were 36%. (This is a reasonable estimate, representing a 50% improvement over reported change amongst a wait list control group (23.7%; 11)). A sample size of 136 (n=68 in each group) will provide 80% power to detect such a difference at the 5% significance level. As this sample size calculation is necessarily based on a proxy estimate for the SFBT condition, a secondary power analysis was conducted based on continuous measures of outcome. A recent meta-analysis of outcomes of SFBT (34) reported an effect size of .26 for internalising problems (including anxiety) assessed on the basis of parent and/or child report questionnaires. Equivalent data for guided CBT self-help can be derived from our recent feasibility study, i.e. based on the mean of parent and child reported anxiety symptoms (SCAS-c/p) pre and post-treatment, an effect size of .52 was found. A sample size of 130 (n=65 in each group) will provide 80% power to detect such a difference at the 5% significance level. A sample size of 136 would therefore be sufficiently powered to detect clinically meaningful differences on the primary, categorical, outcome measure (based on a proxy effect size for SFBT) and to detect significant differences between the two conditions on secondary (continuous) measures of outcome. As conservative intention to treat analyses will be conducted patients lost to follow-up need not be replaced.

Our feasibility study involved recruiting children with anxiety disorders aged 5-12 years within two Oxfordshire PCAMHS teams (North and West). During one year, 52 eligible children were recruited to this study. The proposed study will take place within these teams and also in the remaining two Oxfordshire teams (City and South), increasing the potential pool of participants by 150%. Furthermore, given that this is a primary care based intervention, the proposed study will include those with a subthreshold anxiety disorder (18 children (25%) were excluded from the feasibility study on this basis, despite anxiety being the primary presenting problem; see Annex 4). As such, a recruitment period of 11 months will be sufficient to recruit 136 eligible children from all Oxfordshire PCAMHS teams (i.e. ((52 + 18 + (1.5 x (52 + 18)) /12 months) x 11 months= 160; which allows for a somewhat slower initial recruitment phase in the new sites).

J. DATA MANAGEMENT

Data management will be consistent with MRC Guidelines for Good Clinical Practice in Clinical Trials (MRC, 1998) and with the Data Protection Act (1998). Principal investigators will ensure that all personnel are familiar and comply with the MRC guidelines, particularly section 5.9 'Data handling and record keeping' and section 7 'Documentation'.

1. Identifying information

After providing consent, participants will be given a unique, sequential, study identifier. This will be used for randomisation and data entry purposes.

2. Data entry

Data will be entered in to desktop computers , fitted with SPSS for Windows as standard allowing for an immediate interactive message to be displayed if an invalid data entry is made. The PI will arrange appropriate quality assurance checks.

3. Backing up of data

Immediately after every episode of data entry, data will be backed up onto a portable USB drive, which will be securely stored locally. These files will be backed up on a password-protected system on a weekly basis.

K. DATA ANALYSIS

Final statistical analyses will be conducted by a statistical fellow with the University of Reading School of Psychology and Clinical Language Sciences. The main statistical analyses will assess the index treatment versus standard care on the primary outcome by intention to treat. The full analytic strategy for the trial, including definition of intention to treat and variables for adjustment (covariates), and techniques for handling missing observations, will be specified before the data are unblinded. The results from the trial will be presented as comparative summary statistics (i.e. relative risk and risk difference) with 95% confidence intervals. A comparison of the proportion of recovered children, post treatment and at 6 months follow-up, between the two treatment groups will be made using a mixed-effect model. The method has the advantage of taking into account both timepoints

simultaneously, and provides information about the effect of treatment over time. Analysis of treatment effects at each timepoint can be obtained by incorporating a time by treatment interaction in the model. Similar methods will be used for the analysis of secondary outcomes, adjusting for the corresponding baseline measures. Multiple logistic regression analysis will be used to explore predictors of treatment outcome for those receiving the guided CBT self-help. The analysis and reporting of results will follow the general principles of CONSORT (41).

L. MANAGEMENT STRUCTURE

1. Trial Management

The Trial Management Group (TMG) comprises the six grant holders, and the lead clinician (MP). The group will meet periodically throughout the trial as requested by the Principal applicant (CC).

Cathy Creswell will have overall responsibility for the conduct of the study (including budgetting), the analysis of the data, and the reporting of the findings. Francia Kilgarriff, as Service Manager for PCAMHS, will oversee the clinical aspects of the implementation of the project within Oxfordshire (e.g. maintaining a standard procedure for screening referrals, identifying cases for the study, providing risk management advice and supervision), and ensuring that a standard letter is sent to the relevant parents explaining the nature of the study and alerting them to the fact that they will be contacted by the research assistants. She will retain managerial responsibility for the PMHWs and deal with service management and operational issues as they arise. Lucy Willetts will oversee the research assistants and clinical psychologist, in particular ensuring assessments are conducted to a high standard with high levels of reliability. Emma McIntosh will oversee the collection of Health Economic data and will be responsible for its analysis and dissemination. Peter Cooper and Sula Wiltshire will provide support to CC, FK and LW on all aspects of the conduct of the study.

The study investigators will meet on a monthly basis to monitor recruitment and retention using CONSORT methodology, and problem-solve any issues that arise.

2. Trial Steering Committee (TSC)

Overall responsibility for the trial will lie with the Trial Steering Committee comprising: the PI and Prof Peter Cooper (and other applicants as appropriate), an independent Chair, an independent advisor, and a consumer representative. Their function is to maintain the overall integrity of the trial, to receive and consider reports from the Trial Management

Group and take action if appropriate. The Trial Steering Committee will on four occasions throughout the trial.

M. INDEMNITY

University of Reading indemnity will apply:

i. To meet the potential legal liability of the University of Reading for harm to participants arising from the management and design of the research.

ii. To meet the potential legal liability of the investigators/collaborators arising from harm to participants in the conduct of the research.

iii. For payment of compensation in the event of harm to the research participants where no legal liability arises.

N. ETHICS

Approval will be sought from the LREC and University of Reading Research Ethics Committee. All aspects of the study will be conducted in line with MRC Guidelines for Good Clinical Practice in Clinical Trials (MRC, 1998).

O. INFORMED CONSENT

Information about the trial will be provided to both the parents/guardians and child in person from the trial assessor as well as in written information. A copy will be provided for the participants to keep. Written consent will be obtained from parents by the trial assessor. Assent will be obtained from children. Following treatment completion, participants will be asked whether they would be happy for video-taped material to be used for teaching and training purposes. Where participants agree, separate written consent will be obtained.

P. PUBLICATIONS AND ANCILLARY STUDIES

1. Publications

A meeting will be held on completion of the study to allow discussion of the main results among the collaborators. The results will then be presented to a combined meeting of the TSC and IDMEC for comment. Presentations pertaining to the main trial will not be made without the prior agreement of the Trial Management Group.

2. Ancillary studies

An ancillary study will be conducted by Dr Thalia Eley (Institute of Psychiatry, London), in collaboration with CC/PJC. The protocol for this study will be referred to the Trial Steering Committee for final approval. Should there be any further proposals for ancillary studies they will be initially referred to the Trial Management group for consideration. Studies considered appropriate by the TMG will then be submitted to the TSC for final approval.

Q. PROPOSED TIMETABLE

Main tasks	**Proposed timetable**
Finalise protocols	August 2011
Submit Ethics & Trust approval	September 2011
Recruit Trial Assessors	September-October 2011
Ethics Outcomes Register Trial	November 2011
Initiate NIHR award In post: MP (clinical lead) Trial Assessors	1 December 2011
Convene TSC	December 2011
Identify appropriate referrals from PCAMHS (establish wait-list for assessments)	October- December 2011
Training University and PCAMHS staff	December 2011
Initiation of assessments	December 2011
Initiation of treatment	January 2012
Recruitment ends	31 October 2012
Initiation of post-treatment assessments	March 2012
Initiation of follow-up assessments	August 2012
Treatment ends	31 January 2013

Post treatment assessments end	April 2013
Follow up assessments end	September 2013
Analyses and dissemination	October-November 2013

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APPENDIX 1

Abbreviations

ADIS	Anxiety Disorder Interview Schedule
CAIS	Child Anxiety Impact Scale
PCAMHS	Primary Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CGI	Clinical Global Impression
CONSORT	Consolidated Standards of Reporting Trials
CSM	Centre for Statistics in Medicine
DASS	Depression Anxiety Stress Scales
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders –IV
GSH	Guided CBT self-help
KFQ	Koala Fear Questionnaire
MRC	Medical Research Council
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
SCAS	Spence Child Anxiety Scale
SMFQ	Short Mood and Feelings Questionnaire
SPSS	Statistical Package for the Social Sciences
TMG	Trial Management Group
TSC	Trial Steering Commitee

APPENDIX 2

Assessment Schedule

l. Recruitment assessment Conducted within locality	Structured clinical interview: 1. Anxiety Disorders Interview Schedule- Child/Parent version (ADIS-C/P) Questionnaires: 1. Koala Fear Questionnaire (KFQ) 2. Spence Children's Anxiety Scale –parent/child version (SCAS-c/p) 3. Child Anxiety Impact Scale- parent/child version (CAIS-c/p) 4. Short Mood and Feelings Questionnaire (SMFQ-c) 5. Depression Anxiety Stress Scales (DASS-21) Other: 1. Provide health economic diaries
Post-treatment assessment Conducted in locality	Structured clinical interview: 1. Anxiety Disorders Interview Schedule- Child/Parent version (ADIS-C/P)

	Questionnaires: 1. Koala Fear Questionnaire (KFQ) 2. Spence Children's Anxiety Scale –parent/child version (SCAS-c/p) 3. Child Anxiety Impact Scale- parent/child version (CAIS-c/p) 4. Short Mood and Feelings Questionnaire (SMFQ-c) 5. Depression Anxiety Stress Scales (DASS-21) Other: 1. Collect Health economic assessments (EQ-5D, diaries) 2. Provide Health economic diaries 3. DNA samples
6 months post-treatment Conducted in locality	Structured clinical interview: 1. Anxiety Disorders Interview Schedule- Child/Parent version (ADIS-C/P) Questionnaires:

	1. Koala Fear Questionnaire (KFQ) 2. Spence Children's Anxiety Scale –parent/child version (SCAS-c/p) 3. Child Anxiety Impact Scale- parent/child version (CAIS-c/p) 4. Short Mood and Feelings Questionnaire (SMFQ-c) 5. Depression Anxiety Stress Scales (DASS-21) Other: 1. Collect Health economic assessments (EQ-5D, diaries) 2. DNA samples if not provided previously