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Stepped care for anxious youth

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Comparison of stepped care delivery against a single, empirically validated CBT program for
anxious youth: a randomized clinical trial

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Abstract

Objective: Stepped care is embraced as an ideal model of service delivery but is minimally evaluated. The aim of this study was to evaluate the efficacy of CBT for child anxiety delivered via a stepped care framework compared against a single, empirically validated program.

Methods: 281 youth with anxiety disorders (6-17 years) randomly allocated to receive either empirically validated treatment or stepped care involving: 1) low intensity; 2) standard CBT; 3) individually tailored treatment. Therapist qualifications increased at each step.

Results: Interventions did not differ significantly on any outcome measures. Total therapist time per child was significantly shorter to deliver stepped care (774 min) compared with best practice (897 min). Within stepped care, the first two steps returned the strongest treatment gains.

Conclusions: Stepped care and a single empirically validated program for anxious youth produced similar efficacy but stepped care required slightly less therapist time. Restricting stepped care to only steps 1 and 2 would have led to considerable time saving with modest loss in efficacy.

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Psychological treatments for anxiety disorders in youth are now well established and empirically validated ^{1,2}. Standard treatment includes 10-15, 60-minute sessions with a highly trained therapist, delivered in either individual or group format, and including parents to varying degrees ³. Following standard, cognitive behavioural therapy (CBT), around 60% of anxious youth are remitted and this figure increases slightly over the following few months ². However, taking an optimal treatment developed in a university specialist clinic and translating it to application in the real world raises a number of challenges. For example, the treatment packages for child anxiety that are currently evaluated are usually delivered by highly trained specialists. However, the number of specialist hours available in most mental health systems falls far short of the hours required to treat the full population of anxious youth⁴. Delivering highly specialized and maximum intensity interventions for all is also likely to be overly costly for the majority of public health systems. In general, a "one size fits all" model is neither sufficiently flexible nor acceptable for broad utility across entire communities. Not all children want or respond to a single treatment format. While empirically validated treatments for child anxiety that comprise up to 20 hours of specialist time successfully treat around 60% of youth with anxiety disorders, this level of intervention will be unnecessarily extensive for some and not sufficient for others. It is important to begin to empirically evaluate more flexible and comprehensive models of management that will better meet the broad and resource limited needs of public mental health systems.

Stepped care has been promoted as a framework for healthcare delivery that allows a balance between cost savings and maximum intensity treatment ^{5,6}. The primary principle is that the least intensive (and generally least expensive) intervention is delivered to an individual initially and the outcome carefully evaluated before more intensive (and costly) treatments are introduced. This method of titrating treatment according to need is expected to provide greater cost-effectiveness than either restriction to low intensity interventions (which

minimise resources but sacrifice efficacy) or blanket delivery of high intensity interventions (which maximise efficacy but sacrifice resources)⁷. Stepped care to maximise cost-efficacy forms the cornerstone of service delivery recommendations for several major organisations⁸⁻¹⁰. Yet this recommendation precedes the evidence-base that would be required of any other therapeutic recommendation.

There is currently limited evidence for the efficacy and cost-effectiveness of stepped care models with no controlled trials among youth with mental disorders. A recent meta-analysis indicated slightly better cost effectiveness for stepped care than treatment as usual among depressed adults¹¹. This is hardly a strong result, given that treatment as usual commonly equates to “do nothing”¹¹. The most relevant comparison to stepped care needs to be best practice intervention and there are almost no trials where this is done. There are currently no randomized controlled trials of stepped care among anxious youth, although a few uncontrolled evaluations have begun to emerge^{12,13}.

The current trial compared therapeutic outcomes (efficacy) between a single treatment, empirically validated CBT program for childhood disorders and a stepped care intervention consisting of three steps that increased in resource intensity. There is currently no ideal or empirically validated model of stepped care and steps may increase the intensity of a single treatment (e.g., adding more sessions)¹³, deliver treatment in varying formats (e.g., self-help to therapist-delivered)¹⁴, or deliver different treatments (e.g., CBT to medication)¹⁵. In the current trial we focus on varying the format of CBT given its extensive evidence base and the preference of most consumers for psychological interventions over pharmacotherapy¹⁶. We predicted that stepped care would produce better outcomes than single intervention and would do so using fewer therapist resources.

Method

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This parallel design, two-arm randomised (1:1) controlled efficacy trial was conducted within xxxx University. The research was approved by the ethics committees of xxx University and xxx University and all participants gave fully informed consent (parents) or assent (youth). Young people and their parents accessing the clinic for treatment of an anxiety disorder were initially screened via a semi-structured telephone interview to determine approximate suitability and then referred to an appointment with a clinician for semi-structured diagnostic interview. The primary caregiver of all participants signed an informed consent prior to randomisation to either best practice therapist-delivered treatment or stepped care. Young people also provided assent for participation. Once inclusion criteria were ascertained, participants were randomly assigned to one of the two conditions. Randomisation was done by the project manager, based on an internet random number generator (using block size of 50) and sealed envelopes revealing the condition were created. Participants were fully assessed at baseline and 12-month follow-up and completed limited assessments at the completion of each received intervention. Stepped care was conceptualized as an overall package and took a minimum of 9 months. However, due to the practical limits of scheduling, transitions between steps rarely occurred immediately, meaning that the stepped care package could take up to 12 months. Therefore assessment at 12 months was seen as the most appropriate time to compare the two treatments. From the completion of treatment to the 12-month assessment, no further treatment was offered and participants were encouraged to keep using their learned skills, but were not prohibited from seeking outside treatment. They were paid for return of data - \$A50 at the end of each step and \$A200 at 12 month follow-up. Recruitment commenced in August 2012 and ended in May 2014.

Participants

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Participants were seeking treatment for their disorder from a widely known, specialised, university clinic. They were primarily referred by medical practitioners, educational personnel, and self-referral in response to the clinic's reputation. Inclusion criteria were: age between 7 and 17 years, a diagnosed anxiety disorder as their primary (most interfering) disorder, and willingness to be randomised to one of the two conditions. Exclusion criteria were: Autism spectrum disorder or other major developmental disorder diagnosed by a relevant health professional, non-anxiety disorder as their primary presenting problem, recent commencement of pharmacotherapy for anxiety (within past three months), current psychotherapy for anxiety. A sample size of 250 participants was estimated to provide power of 0.8 to detect a significant difference ($p < 0.05$) based on a difference between groups of $d > .3$. Participants were predominantly European-Australian, well educated, and upper middle class.

Interventions

Single program intervention: Participants allocated to the single program received 10, 60-minute, individual sessions (over 12 weeks) with a therapist following a structured program for child anxiety. The program was the Cool Kids anxiety treatment¹⁷ a skills-based intervention that has received repeated empirical validation¹⁸⁻²⁰. Key components include psychoeducation, cognitive restructuring, exposure, and social and problem-solving skills. Parents are included in all sessions for children under 13 and in fewer sessions for adolescents and are taught parenting skills plus some personal anxiety management. The program is supported by a structured manual for the therapist and workbooks for child and parents. In the current trial, the average number of sessions attended was 9.72 (SD = 0.81), with an average total treatment duration of 570.01 (SD = 69.65) minutes.

Stepped care: Given an absence of clear guidelines, we included three steps in this trial based on existing evidence: 1) low intensity intervention; 2) manualised standard CBT; 3) individual formulation-based intervention. In order to mirror real-world practice, the ultimate decision to stop treatment or progress to the subsequent step was made by the family, following feedback from the supervising therapist. At the end of each step, the therapist provided the family with feedback about the child's diagnostic status based on an online diagnostic measure (see below), along with questionnaire scores, and their professional opinion. This information followed typical clinical practice wherein the therapist discussed with the family whether the child still met diagnostic criteria, the extent to which their life remained impaired, and the pros and cons of the next step of intervention. The family weighed up this information and decided whether to move to the next step or not.

A consistent literature has demonstrated the value of low intensity treatments (using printed or online materials) for child anxiety^{18,21,22} and therefore this format was selected as step 1. Low intensity materials followed two forms depending on the child's age. For children aged below 13 years, we followed the parent-as-therapist model as reported in Rapee et al¹⁸. In brief, parents received a detailed book that described the strategies to help their child and the child received a workbook to guide exercises. Adolescents aged 13 and above followed a self-help model as described in Wuthrich et al²³. The adolescents received a CD that included multimedia materials describing therapeutic techniques and exercises and their parents received a handout summarising the techniques and ways in which they could support their child. For children, therapists provided their parents only with up to four, 30-minute sessions over the telephone that focussed on support, motivation, and guidance. Adolescent participants received up to 4, 40-minute calls from a therapist as above, with the time divided between the young person and a parent. Not all families availed themselves of the full number of sessions, similarly to lack of attendance in typical face-to-face therapy. Average

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number of therapist sessions was 3.64 (SD = 0.74) with an average treatment duration of 111.31 (SD = 40.67) minutes.

Step 2 was similar to the single program treatment condition and involved therapist-led sessions following the Cool Kids treatment program. The primary difference was that the number of sessions was flexible according to participant progress, within a maximum of 10. Average number of sessions was 8.10 (SD = 2.34), with an average treatment duration of 465.72 (SD = 155.76) minutes.

Finally, step 3 comprised an individualised intervention following a careful case formulation developed by the therapist (see ²⁴ for a similar approach to treatment resistant children). A structured format was used to determine the helpful components of previous treatment and the barriers to treatment progress. Therapists followed a loose set of treatment guidelines that suggested methods to deal with the most common treatment barriers. Number of sessions was flexible, with a maximum of 12, 60-minute sessions over 14 weeks. Average number of sessions was 10.00 (s.d. = 2.42), with an average treatment duration of 572.30 (s.d. = 145.45) minutes.

Therapists: In order to model real-world application and the increasing resources of stepped care, the qualifications and experience of therapists varied across the conditions. Step 1 therapists were all undergraduate psychology students or psychology trainees and thus represented a low-cost workforce who were required to follow highly structured guidelines. Therapists for both the single program condition and step 2 of stepped care were all fully trained psychologists registered in the state of NSW (ie minimum completed psychology degree plus 2 years applied training). Within the Australian context, these workers represent the modal therapist qualifications that would be received within public mental health services. Finally, step 3 therapists were the most highly qualified and experienced. They all

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had postgraduate clinical psychology degrees (minimum 6 year degree) and had worked specifically with anxious youth for 1-5 years.

Treatment Adherence

All therapy sessions were audiotaped. To assess adherence to the treatment protocols, a graduate student in clinical psychology with experience in treating anxious youth, but who was not affiliated with our treatment clinic, listened to 15% of sessions, selected at random. All sessions were found to focus primarily on manual-consistent material and all therapy components were covered. Material inconsistent with the relevant manual was identified in .06% of the single program sessions; .02% of step 1 sessions; 0% of step 2 sessions; and 0% of step 3 sessions.

Measures

Diagnosis was measured using the Anxiety Disorders Interview Schedule for DSM-IV, Parent and Child versions (ADIS-IV-CP: ²⁵). Interviewing clinicians (graduate students in psychology or completed clinical psychologists) were trained to criteria based on standard procedures in our clinic and provided composite diagnoses based on separate interviews with the child and parent(s). Although they were workers at the clinic, they were blind to treatment condition and all therapists and interviewers were trained not to discuss cases or their assignment. For each disorder for which a child met diagnostic criteria, the clinician also rated the overall severity and life impact of symptoms based on a 0-8 scale (clinician severity rating: CSR). A CSR of 4 or above indicated a clinical level of severity and/or life impact. Where children met criteria for multiple disorders (comorbidity), the disorder with the highest CSR was considered the primary diagnosis. Diagnostic interviews were conducted by clinicians unaware of condition at baseline and again at 12-month follow-up. All interviews

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were recorded and a random sample of 96 (14%) interviews (including both timepoints) was coded by a clinician who was blind to initial diagnoses. Inter-rater agreement was good and ranged from kappa = .77 to .93 to identify specific anxiety disorders anywhere in the child's profile and kappa = .49 to .63 for primary disorders only. A kappa of .80 was obtained to diagnose a child with anxiety primary anxiety disorder (i.e. study eligibility).

Questionnaire measures: Symptoms of anxiety were assessed through self and parent report using the Spence Children's Anxiety Scale, parent and child versions (SCAS-C; SCAS-P: ^{26,27}). The impact and interference of anxiety on the child's life was assessed by the Child Anxiety Life Interference Scale (CALIS ²⁸). This self-report measure has versions for both the child (9 items) and the parent (16 items) to report on the impact of anxiety in the child's life.

Online Diagnostic Assessment: As described above, the family's decision to continue treatment was influenced by diagnostic status of the child following each step in stepped care. To improve efficiency, this assessment was based on an online structured assessment that families completed at home. It comprised a series of questions assessing DSM-IV criteria for the core anxiety disorders summed by the computer, along with open-ended descriptions, which were read by blind assessors. DSM diagnoses were allocated by the assessor (clinical psychologist) by combining the list of DSM criteria with information about the content of fears and avoidance plus the extent of their impact from the open-ended descriptions. The online measure shows acceptable agreement with an overall diagnosis of anxiety based on the ADIS-IV-C/P (kappa > .7; McLellan et al. unpublished data, May, 2017).

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Therapy time: Therapists kept records of all time (in minutes) that they spent engaged in therapy-related activities for each participant. This included preparation time, time spent in each therapy session, time spent on writing notes and associated correspondence or referrals, and all extra-therapy time with the participant such as emails or telephone calls. This total therapist time best reflects the complete therapist resources to treat a patient.

Data analysis

The primary outcome was remission of the primary (most impairing) diagnosis. The primary disorder was considered remitted if DSM-IV criteria were no longer met or if symptomatic criteria were met but the CSR for those symptoms fell below 4 (i.e a sub-clinical severity of symptomatology for the given diagnosis). Secondary outcomes included the continuous measures of symptomatology and impairment, as well as the measure of therapist time.

All analyses were based on intent-to-treat whereby all participants who were randomised were asked to provide data and were included in analyses. Mixed model analyses using maximum likelihood estimation (SPSS version 23), with participants as a random effect were used to compare groups across time (fixed effects) on all continuous measures. Missing data at 12 months (6.8% lost to follow-up) were assumed to be missing at random. Multiple imputation was used to estimate missing data and the pattern of results was compared to mixed model analyses without imputed data²⁹. Given the same pattern of significance between analyses, the non-imputed results are reported here.

Results

Participant characteristics

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A total of 281 youth aged 6 to 16 years ($M = 9.26$, $SD = 2.24$) met inclusion criteria and were allocated to the single treatment program ($n = 142$) or stepped care ($n = 139$) (see Figure 1). The groups did not differ significantly on demographic or diagnostic characteristics (see Table 1), nor did they differ significantly on any outcome measures at baseline (all p 's $> .10$; see Table 2).

Primary outcome

As can be seen in the flow chart (Figure 1), 57 (41.0%) participants in stepped care completed only step 1, a further 54 (38.8%) completed only steps 1 and 2, and 28 (20.1%) utilized all three steps.

At 12-months 178 (68%) of youth were remitted from their primary disorder and remission did not differ significantly between participants in stepped care ($n = 85$; 66.9%) and single treatment ($n = 93$; 69.4%), $\chi^2(1, n = 261) = 0.18, p = .67$.

Mean data are presented in Table 2. There was a significant main effect reduction in total CSR over time, $F(1, 538) = 161.42, p < .001$, but no significant group by time interaction, $F(1, 538) = 0.47, p = .494$.

Secondary outcomes

A more conservative measure of improvement is remission of all diagnoses – ie complete non-clinical status. After 12 months, 132 participants (50.6%) were free of all clinical diagnoses, and the two groups did not differ significantly (stepped care; 61 (48.0%): single program; 71 (53.0%)), $\chi^2(1, n = 261) = 0.64, p = .42$.

On the parent report of child's anxiety symptoms (SCAS-P), mixed model ANOVA indicated a significant reduction in anxiety over time, $F(1, 536) = 217.37, p < .001$; but no significant group by time interaction, $F(1, 536) = 1.29, p = .256$. Similarly, on the child's

report of anxiety symptoms (SCAS-C), there was a significant reduction in anxiety over time, $F(1,535) = 101.96, p < .001$; but no group by time interaction, $F(1,535) = 0.66, p = .417$.

A similar pattern was shown on the measures of life interference caused by anxiety (CALIS). Mixed model analysis of the parent report CALIS indicated a significant reduction over time, $F(1,536) = 146.85, p < .001$; but no significant group by time interaction, $F(1,536) = 0.65, p = .420$. The child's report similarly demonstrated a significant reduction in interference over time, $F(1,535) = 54.58, p < .001$; but no significant group by time interaction, $F(1,535) = 1.16, p = .282$.

The amount of time therapists were engaged in therapy related activities was summed across all sources of time (e.g., direct therapy time, preparation, report-writing) in minutes and compared between groups using a t-test. Therapists spent significantly less total time in the stepped care condition (773.53 min., $SD = 660.87$) compared with single program (897.11 min., $SD = 208.62$), $t(161.96) = 2.09, p = .038$.

Post-hoc analyses

In order to gather a richer understanding of the stepped care condition, we compared the 12-month remission rates between those stepped care participants who stopped treatment at each different step. Within the stepped care group only, of the 50 participants who stopped at the end of step 1 (and returned data), 36 (72.0%) were remitted from their primary disorder at 12 months, and 28 (56.0%) were remitted from all diagnoses at 12 months. Of the 49 participants who stopped at the end of step 2, 36 (73.5%) and 26 (53.1%) were remitted from their primary and all diagnoses respectively. Of the 28 participants who continued to step 3, remission was 13 (46.4%) (primary disorder) and 7 (25.0%) (all disorders). These differences were significant: primary diagnosis, $\chi^2(2, n = 127) = 6.84, p = .033$; all clinical diagnoses, $\chi^2(2, n = 127) = 7.72, p = .021$.

An additional comparison was made between the total therapist time used to provide the stepped care condition for participants who stopped at each step. Participants who stopped at step 1 used an average total of only 182.6 mins (SD = 100.56); those who stopped at step 2 used 887.2 min. (SD = 338.3); while those going on to step 3 used 1740.2 min. (SD = 490.32).

Discussion

The current trial is the first to evaluate the efficacy of a stepped treatment delivery against an empirically evaluated, single treatment for young people with anxiety disorders and in fact is the first to thoroughly evaluate stepped care for any child mental health condition. Many manualised, validated treatments for mental disorders are efficient³⁰. Therefore, it is possible that stepping treatment intensity may not deliver significant benefits in either efficacy or cost-effectiveness over “best practice” treatment. Hence, although stepped care makes considerable logical sense as a method of efficient service delivery, comparison against an empirically validated single treatment program is critical.

The current study demonstrated that this model of stepped care resulted in similar treatment efficacy for anxious youth as current best practice (standard, empirically validated CBT package). Naturally, the key question is whether this similar efficacy can be delivered at a reduced cost. A full economic comparison between the two conditions will be reported in a later paper. However, the current results did indicate that the efficacy of stepped care was achieved with significantly less time investment from therapists. The two modes of delivery differed in requisite therapist time by around 14%, suggesting that a service that utilises the current model of stepped care would be able to treat one additional child for every 7 young people seen. This suggests that stepped care may be a more cost-effective method of delivering treatment for anxious youth.

The final step in the stepped care model that we used failed to deliver very strong incremental benefits. Among those young people who proceeded to step 3, only 25% were remitted from all clinical disorders. Therefore within the current structure, it appears that a two-step model would almost certainly have shown greater cost-efficacy. If we assume that no child who proceeded to step 3 had remitted by step 2, then the total remission of all disorders by the end of step 2 would have been 43%, which compares favourably with total remission in the empirically validated single CBT program (53%). Yet the average therapist time across the sample at the end of step 2 (combination of steps 1 and 2) would have been 617.5 minutes, which is considerably less than the time used in the standard CBT program (897.1 min.). Calculations of this type underscore the value of empirical evaluation of stepped care and the importance of comparing different stepping models for different disorders. It is only through such evaluations that the most efficient models of delivery can be determined.

There is no single model of stepped care^{5,11,13}. The most appropriate mix of treatment types and formats will vary between target disorders, available workforce, and local needs. In the current study, we made a decision to deliver only CBT, given its strong evidence base¹⁻³. In this case, steps differed primarily in format, therapist training, and intensity of delivery. It is very possible that a different combination, especially utilising a different delivery at step 3, may have resulted in stronger efficacy. Introducing medication (e.g. SSRI³¹) or a different form of therapy may have been better than continuing with more intense CBT at the highest step. On the other hand, we currently have little information about efficacious treatment for complex child anxiety cases³² or treatment non-responders²⁴ and the step 3 program was based on largely untested methods. Therefore, further development and evaluation of efficacious CBT programs to treat complex cases of child anxiety, may result in even better outcomes for this stepped care model. Similarly, identifying reliable predictors of youth who

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fail to respond to steps 1 and 2 ³², would allow some young people to be referred directly to step 3, further improving efficiency.

The study has the following limitations. The criteria to determine progress to a subsequent step were necessarily arbitrary. We chose to allow parents to make the ultimate decision based on feedback from a therapist because we felt that this would best represent community practice. However, different results might have emerged using a different set of stepping criteria, such as diagnostic status or questionnaire cut-off scores. Further, the need for experimental rigour meant that this initial study was conducted within a university clinic. As a result, the population were relatively well educated, wealthy, and of limited ethnic diversity. Future research will need to evaluate generalisation of results to community health settings and to different systems of health care across a variety of countries.

With growing recognition of the importance of empirically validating treatments, it is perhaps surprising to note the enthusiasm with which many respected organisations have embraced the promotion of stepped care for mental health in the absence of evidence. Science now needs to catch up. We still need research to develop more efficacious interventions. But empirical evidence is then needed to determine how best to incorporate those interventions into the most efficient service delivery and to evaluate the best combination of interventions for a given disorder in a given setting. The results of this trial show that one particular model of stepped care fails to produce greater efficacy than a single, empirically validated treatment program, but achieves this efficacy with 14% less therapist resource use. Future evaluations

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of other models of stepped care delivery will help to build further cost savings without loss of effects.

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Stepped care for anxious youth

Figure 1: Flow chart showing participant allocation and movement through trial.

Stepped care for anxious youth

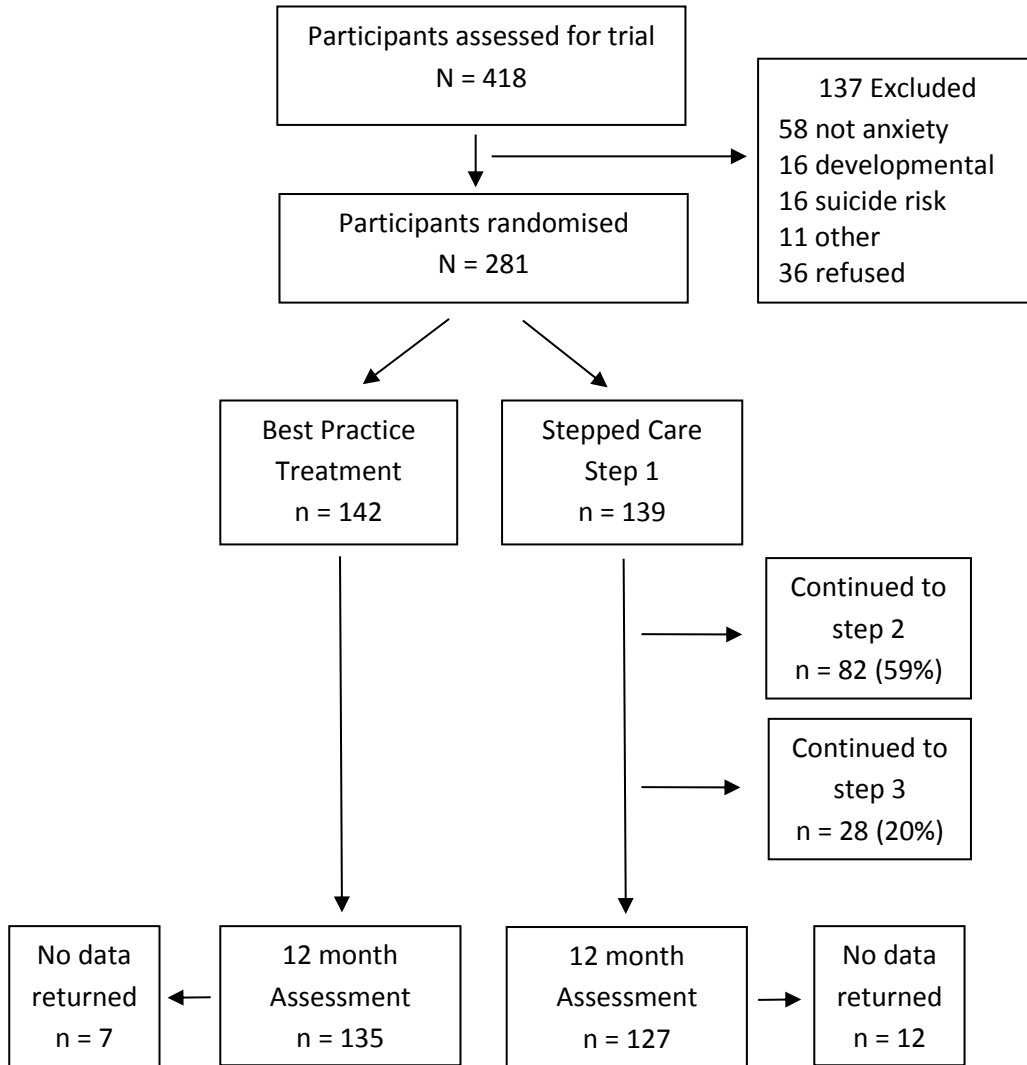


Table 1: Demographic characteristics of the two treatment groups at baseline.

	Single Treatment n = 142	Stepped Care n = 139	χ^2 / t^*
Age (years) (s.d.)	9.10 (2.19)	9.42 (2.28)	1.22; $p=.22$
Number of Females (%)	81 (57.0)	68 (48.9)	1.86; $p=.17$
Number of parents married (%)	124 (87.3)	124 (89.9)	1.83; $p=.77$
Number of two-parent families (%)	125 (88.0)	126 (92.6)	2.99; $p=.39$
Primary caregiver highest education			2.96; $p=.81$
n (%) high school or less	6 (4.2)	6 (4.3)	
n (%) diploma/ apprenticeship	43 (30.3)	37 (26.8)	
n (%) undergraduate degree	37 (26.1)	35 (25.4)	
n (%) postgraduate degree	46 (32.4)	43 (31.2)	
Primary anxiety disorder			8.22; $p=.22$

Stepped care for anxious youth

Separation anxiety disorder (%)	22 (15.5)	16 (11.5)	
Social anxiety disorder (%)	31 (21.8)	40 (28.8)	
Generalised anxiety disorder (%)	63 (44.4)	68 (48.9)	
Specific phobia (%)	14 (9.9)	8 (5.8)	
Other (%) ⁺	12 (8.4)	7 (5.1)	
Comorbid mood disorder	6 (4.2)	10 (7.2)	
Comorbid externalizing disorder	12 (8.5)	21 (15.1)	
Total number of disorders (s.d.)	3.10 (1.48)	2.94 (1.58)	0.93; $p=.35$

* Note - χ^2 is reported when proportions are compared, and t is reported when comparing means.

+ Note –include obsessive compulsive disorder, panic disorder, and anxiety disorder NOS

Table 2: Mean (Standard deviation) scores in the two treatment groups at baseline and 12-months on continuous measures.

	Best Practice			Stepped Care		
	Baseline	12-month	d ¹	Baseline	12-month	d
Total Clinician Rated Severity (CSR)	16.01 (7.79)	7.72 (5.98)	1.19	15.04 (7.91)	7.61 (6.85)	1.00
Child reported anxiety (SCAS-c)	39.87 (18.72)	23.68 (15.16)	0.95	37.78 (17.27)	24.01 (17.38)	0.79
Parent reported child anxiety (SCAS-p)	36.51 (13.33)	18.87 (10.41)	1.47	34.47 (14.38)	19.36 (13.04)	1.10
Child Anxiety Life Interference - child	13.25 (7.49)	7.74 (7.24)	0.75	12.57 (7.30)	8.46 (8.21)	0.53
Child Anxiety Life Interference - parent	26.25 (10.24)	14.38 (10.62)	1.14	24.80 (10.11)	14.40 (11.14)	0.98

Note: 1. Cohen's d denotes effect size of change from baseline to 12 months within each group. CSR – Clinician Severity Rating; SCAS-c – Spence Children's Anxiety Scale, child report; SCAS-p - Spence Children's Anxiety Scale, parent report.