

Table 1

## Baseline Characteristics of Participants

	OSI + TS (N=222)	C-TAU (N=221)	Overall Mean/ % difference (N=443)
<b>Child Baseline Characteristics</b>			
<b>Age, mean (SD)</b>	9.31 (1.83)	9.08 (1.74)	<u>9.20 (1.79) 0.23</u>
<b>Gender, n (%)</b>			
Male	92 (41)	92 (41)	<u>-0.19184 (41)</u>
Female	127 (57)	128 (58)	<u>-0.71255 (58)</u>
Other	2 (1)	1 (<1)	<u>0.453 (&lt;1)</u>
Prefer not to say	1/222 (<1)	0 (0)	<u>0.451 (&lt;1)</u>
<b>Ethnicity, n (%)</b>			
White <sup>1</sup>	194 (87)	206 (93)	<u>-5.82400 (90)</u>
Mixed <sup>2</sup>	19 (9)	14 (6)	<u>2.2323 (7)</u>
Asian or Asian British <sup>3</sup>	3 (1)	0 (0)	<u>1.353 (1)</u>
Black or Black British <sup>4</sup>	1 (<1)	1 (<1)	<u>0.002 (&lt;1)</u>
Other Ethnic groups <sup>5</sup>	2 (1)	0 (0)	<u>0.902 (&lt;1)</u>
Not stated	3 (1)	0 (0)	<u>1.353 (1)</u>
<b>Previous treatment for anxiety or other psychological difficulties, n (%)</b>	46 (21)	30 (14)	<u>76 (17) 7.15</u>
<b>Prescribed medication for anxiety or other psychological difficulties, n (%)</b>	2 (1)	6 (3)	<u>8/443 (2) 1.81</u>
<b>Education, n (%)</b>			
State school	214 (96)	209 (95)	<u>1.83423 (95)</u>
Independent school	4 (2)	7 (3)	<u>-1.3711 (2)</u>
Special provision school	2 (1)	2 (1)	<u>0.004 (1)</u>
Home educated	2 (1)	3 (1)	<u>-0.465 (1)</u>
<b>Special educational needs, n (%)</b>	33 (15)	32 (14)	<u>0.3865 (15)</u>
<b>Type of special educational needs, n/N (%)<sup>6</sup></b>			
Communicating and interacting	15/33 (45)	11/32 (34)	<u>11.0726/65 (40)</u>
Cognition and learning	16/33 (48)	15/32 (47)	<u>1.6031/65 (48)</u>
Social, emotional, and mental health difficulties	24/33 (73)	20/32 (63)	<u>10.2344/65 (68)</u>
Sensory and/or physical needs	13/33 (39)	12/32 (38)	<u>1.8925/65 (38)</u>
<b>CAIS -P: Total Score, mean (SD)</b>	26.87 (15.26)	25.96 (14.63)	<u>0.9126.42 (14.94)</u>
<b>CAIS-P: Global Items, mean (SD)</b>	6.20 (3.00)	5.86 (2.95)	<u>0.346.03 (2.98)</u>
<b>CAIS-C: Total Score, mean (SD) [n]</b>	26.13 (14.44) [210]	25.75 (15.06) [212]	<u>0.3825.94 (14.74)</u> {422}
<b>CAIS-C: Global Items, mean (SD) [n]</b>	5.30 (2.85) [210]	5.17 (3.18) [212]	<u>0.135.24 (3.02)</u> {422}
<b>RCADS-P: Total Anxiety Score, mean (SD)</b>	46.35 (19.83)	45.91 (19.93)	<u>0.4446.13 (19.86)</u>
<b>RCADS-P: Total Anxiety and Depression Score, mean (SD)</b>	56.18 (23.79)	55.40 (24.17)	<u>0.7755.79 (23.96)</u>
<b>RCADS-C: Total Anxiety Score, mean (SD) [n]</b>	47.14 (19.68) [204]	46.26 (19.96) [209]	<u>0.8746.69 (19.81)</u> {413}



Homemaker	26 (12)	28 (13)	<del>-0.9654 (12)</del>
Retired	0 (0)	0 (0)	<del>0.000 (0)</del>
Other	14 (6)	16 (7)	<del>-0.9330 (7)</del>
<b>Total household income, n/N (%)</b>			
Under £16,000 per year	17/141 (12)	18/136 (13)	<del>-1.1835/277 (12)</del>
£16,001 - £30,000 per year	27/141 (19)	25/136 (18)	<del>0.7752/277 (19)</del>
£30,001 - £40,000 per year	14/141 (10)	18/136 (13)	<del>-3.3132/277 (12)</del>
£40,001 - £50,000 per year	11/141 (8)	12/136 (9)	<del>-1.0223/277 (8)</del>
£50,001 - £60,000 per year	12/141 (9)	17/136 (13)	<del>-3.9929/277 (10)</del>
£60,001 - £70,000 per year	11/141 (8)	7/136 (5)	<del>2.6518/277 (7)</del>
£70,001 - £80,000 per year	8/141 (6)	10/136 (7)	<del>-1.6818/277 (7)</del>
£80,001 - £90,000 per year	6/141 (4)	5/136 (4)	<del>0.5811/277 (4)</del>
£90,001 - £120,000 per year	8/141 (6)	4/136 (3)	<del>2.7312/277 (4)</del>
More than £120,000 per year	3/141 (2)	6/136 (4)	<del>-2.289/277 (3)</del>
Prefer not to say	24/141 (17)	14/136 (10)	<del>6.7338/277 (14)</del>

QSI+TS=Online Support and Intervention for child anxiety plus therapist support; C-TAU=Child Mental Health

Services Treatment As Usual.

NB Percentages have been computed with the number of participants with the response available as the denominator.

<sup>1</sup>Including British, Irish, and any other White background. <sup>2</sup>Including White and Black Caribbean, White and Black British,

White and Asian, and any other mixed background. <sup>3</sup>Including Indian, Pakistani, Bangladeshi, and any other Asian

background. <sup>4</sup>Including African, Caribbean, and any other Black background. <sup>5</sup>Including Chinese, and any other Ethnic group.

<sup>6</sup>Only includes those with special educational needs. <sup>7</sup>Only includes those who are partnered.

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Table 2

Summary statistics, adjusted mean differences, standardised mean differences, and the P-value for non-inferiority for the primary and secondary analyses.

	OSI + TS (N=222)	C-TAU (N=221)	Adjusted Mean Difference [95% CI]* §	Standardised Mean Difference [95% CI]	P-value for non- inferiority†
<b>Primary Analysis</b>					
<b>Child Anxiety Impact Scale – Parent Version (CAIS-P)</b>					
Baseline	26.87 (15.26) [222]	25.96 (14.63) [221]	-	-	-
14 weeks	19.64 (16.00) [163]	18.89 (14.52) [145]	0.00 [-2.34 to 2.34]	0.00 [-0.16 to 0.16]	<0.0001
26 weeks‡	17.99 (15.39) [159]	18.08 (15.08) [130]	0.14 [-2.26 to 2.53]	0.01 [-0.15 to 0.17]	<0.0001
<b>Secondary Analyses</b>					
<b>CAIS-P: Global Items, mean (SD) [n]</b>					
Baseline	6.20 (3.00) [222]	5.86 (2.95) [221]	-	-	-
14 weeks	4.07 (3.12) [163]	3.97 (2.88) [145]	-0.13 [-0.63 to 0.37]	-0.04 [-0.21 to 0.12]	<0.0001
26 weeks	3.60 (3.06) [159]	3.62 (2.84) [130]	0.08 [-0.42 to 0.59]	0.03 [-0.14 to 0.20]	0.0003
<b>Child Anxiety Impact Scale – Child Version (CAIS-C)</b>					
<b>CAIS-C: Total Score, mean (SD) [n]</b>					
Baseline	26.13 (14.44) [210]	25.75 (15.06) [212]	-	-	-
14 weeks	19.27 (15.13) [127]	20.73 (14.50) [114]	-1.61 [-4.55 to 1.33]	-0.11 [-0.31 to 0.09]	<0.0001
26 weeks	17.03 (15.83) [124]	19.89 (16.64) [111]	-2.67 [-5.64 to 0.30]	-0.18 [-0.38 to 0.02]	<0.0001
<b>CAIS-C: Global Items, mean (SD) [n]</b>					
Baseline	5.30 (2.85) [210]	5.17 (3.18) [212]	-	-	-
14 weeks	3.63 (3.05) [127]	4.03 (2.62) [114]	-0.30 [-0.90 to 0.30]	-0.10 [-0.30 to 0.10]	<0.0001
26 weeks	3.61 (3.28) [123]	3.40 (3.18) [111]	0.30 [-0.31 to 0.90]	0.10 [-0.10 to 0.30]	0.012
<b>Revised Child Anxiety and Depression Scale – Parent Version (RCADS-P)</b>					
<b>RCADS-P: Total Anxiety Score, mean (SD) [n]</b>					
Baseline	46.35 (19.83) [222]	45.91 (19.93) [221]	-	-	-
14 weeks	34.09 (23.01) [161]	34.84 (19.92) [143]	-2.22 [-5.49 to 1.04]	-0.11 [-0.28 to 0.05]	<0.0001
26 weeks	30.57 (23.29) [157]	32.03 (20.98) [129]	-0.96 [-4.27 to 2.36]	-0.05 [-0.22 to 0.12]	<0.0001
<b>RCADS-P: Total Anxiety and Depression Score, mean (SD) [n]</b>					
Baseline	56.18 (23.79) [222]	55.40 (24.17) [221]	-	-	-
14 weeks	41.25 (28.26) [161]	41.55 (23.89) [143]	-2.22 [-6.16 to 1.73]	-0.09 [-0.26 to 0.07]	<0.0001
26 weeks	37.45 (28.77) [157]	38.22 (25.39) [129]	-0.54 [-4.54 to 3.46]	-0.02 [-0.19 to 0.14]	<0.0001
<b>Revised Child Anxiety and Depression Scale – Child Version (RCADS-C)</b>					

**RCADS-C: Total Anxiety Score, mean (SD) [n]**

Baseline	47.14 (19.68) [204]	46.26 (19.96) [209]	-	-	-
14 weeks	31.40 (23.18) [127]	32.10 (21.26) [112]	-1.29 [-5.58 to 3.00]	-0.07 [-0.28 to 0.15]	0.0002
26 weeks	29.96 (24.91) [122]	29.53 (22.75) [111]	1.41 [-2.89 to 5.71]	0.07 [-0.15 to 0.29]	0.0098

**RCADS-C: Total Anxiety and Depression Score, mean (SD) [n]**

Baseline	56.98 (23.54) [204]	55.84 (24.14) [209]	-	-	-
14 weeks	37.91 (28.37) [127]	38.11 (25.38) [112]	-0.99 [-6.15 to 4.17]	-0.04 [-0.26 to 0.18]	0.0004
26 weeks	36.30 (30.86) [122]	35.04 (27.27) [111]	2.31 [-2.86 to 7.49]	0.10 [-0.12 to 0.31]	0.018

**Overall Functioning (Outcome Rating Scale (ORS))****ORS: Total Score, mean (SD) [n]**

Baseline	26.25 (8.15) [222]	27.19 (7.78) [221]	-	-	-
14 weeks	29.80 (7.97) [161]	30.94 (7.00) [143]	-0.58 [-1.90 to 0.74]	-0.07 [-0.24 to 0.09]	0.0011
26 weeks	30.68 (8.11) [154]	31.21 (6.77) [127]	-0.21 [-1.58 to 1.15]	-0.03 [-0.20 to 0.14]	0.0003

**Common Comorbid Emotional and Behavioural Problems (Strengths and Difficulties Questionnaire (SDQ-P))****SDQ-P: Emotional Symptoms, mean (SD) [n]**

Baseline	6.41 (2.29) [222]	6.21 (2.40) [221]	-	-	-
14 weeks	4.99 (2.89) [161]	4.62 (2.61) [143]	0.03 [-0.45 to 0.51]	0.01 [-0.19 to 0.22]	0.0011
26 weeks	4.40 (2.76) [154]	4.51 (2.82) [128]	-0.24 [-0.73 to 0.25]	-0.10 [-0.31 to 0.11]	<0.0001

**SDQ-P: Conduct Problems, mean (SD) [n]**

Baseline	2.84 (2.08) [222]	2.72 (2.02) [221]	-	-	-
14 weeks	2.48 (2.12) [161]	2.44 (2.07) [143]	-0.01 [-0.30 to 0.29]	0.00 [-0.15 to 0.14]	<0.0001
26 weeks	2.55 (2.16) [154]	2.39 (2.14) [128]	-0.05 [-0.36 to 0.25]	-0.03 [-0.17 to 0.12]	<0.0001

**SDQ-P: Hyperactivity/Inattention, mean (SD) [n]**

Baseline	5.94 (2.89) [222]	5.66 (2.75) [221]	-	-	-
14 weeks	5.19 (3.01) [161]	4.85 (3.06) [143]	-0.04 [-0.46 to 0.37]	-0.02 [-0.16 to 0.13]	<0.0001
26 weeks	5.44 (3.13) [154]	4.85 (2.74) [128]	0.01 [-0.41 to 0.44]	0.00 [-0.15 to 0.16]	<0.0001

**SDQ-P: Peer Relationship Problems, mean (SD) [n]**

Baseline	2.77 (2.34) [222]	2.67 (2.14) [221]	-	-	-
14 weeks	2.57 (2.33) [161]	2.22 (2.16) [143]	0.19 [-0.12 to 0.49]	0.08 [-0.05 to 0.22]	0.0002
26 weeks	2.55 (2.27) [154]	2.27 (2.03) [128]	0.09 [-0.22 to 0.41]	0.04 [-0.10 to 0.18]	<0.0001

**SDQ-P: Prosocial Behaviour, mean (SD) [n]**

Baseline	7.42 (2.33) [222]	7.48 (2.24) [221]	-	-	-
14 weeks	7.47 (2.31) [161]	7.50 (2.20) [143]	-0.03 [-0.34 to 0.29]	-0.01 [-0.15 to 0.13]	<0.0001
26 weeks	7.27 (2.35) [154]	7.61 (2.34) [128]	-0.15 [-0.48 to 0.17]	-0.07 [-0.21 to 0.08]	0.0002

**SDQ-P: Total Score, mean (SD) [n]**

Baseline	17.95 (7.05) [222]	17.26 (6.53) [221]	-	-	-
14 weeks	15.24 (8.37) [161]	14.13 (7.58) [143]	-0.05 [-1.07 to 0.97]	-0.01 [-0.16 to 0.14]	<0.0001
26 weeks	14.93 (8.35) [154]	14.02 (7.49) [128]	-0.41 [-1.46 to 0.64]	-0.06 [-0.21 to 0.09]	<0.0001

#### Health Economics Outcomes

##### Child parent-report CHU9D utility (UK adult tariff), mean (SD) [n]

Baseline	0.771 (0.771) [222]	0.793 (0.793) [221]	-
14 weeks	0.827 (0.827) [173]	0.841 (0.841) [163]	0.006 [-0.037 to 0.049]
26 weeks	0.833 (0.833) [172]	0.846 (0.846) [162]	0.006 [-0.040 to 0.053]

##### Child parent-report CHU9D utility (Australia adolescent tariff), mean (SD) [n]

Baseline	0.541 (0.541) [222]	0.578 (0.578) [221]	-
14 weeks	0.656 (0.656) [173]	0.671 (0.671) [163]	0.006 [-0.037 to 0.049]
26 weeks			

##### Parent self-report EQ-5D-5L utility (England adult tariff), mean (SD) [n]

Baseline	0.792 (0.792) [222]	0.835 (0.835) [221]	-
14 weeks	0.825 (0.825) [173]	0.860 (0.86) [164]	0.003 [-0.028 to 0.035]

\* OSI + TS versus C-TAU. [OSI+TS=Online Support and Intervention for child anxiety plus therapist support; C-TAU=Child Mental Health Services Treatment As Usual](#). Generalised linear mixed effects model adjusted for randomised arm, assessment time point, baseline score, minimisation variables (child's age, gender, baseline anxiety associated interference, service type), an interaction between randomised arm and assessment timepoint as fixed effects, and a random intercept for each participant. † Wald test. One-sided. Level of statistical significance = 0.025. ‡ Primary Outcome § For health economics outcomes, the mean difference was adjusted for baseline values using an OLS model and was computed on complete observations.¶

Table 3. Parents' (n=11) and therapists' (n=10) experiences around the acceptability of OSI+TS from the qualitative interviews

Parents' experiences of OSI+TS	Illustrative quotes	Implications
<ul style="list-style-type: none"> <li>Parents who initially had reservations about OSI/a parent-led approach could see the benefit once they started the program.</li> </ul>	<p>'I was thinking, em, doing something online... maybe it's better to do this with speaking with somebody, like. But, actually, to be honest, actually it was much better, I found it more helpful in the end.' (14P)</p> <p>'I didn't think it would work. You know, with like with 'me' doing it, I thought you know, she'd be better off with a professional 'cos I don't really know what I'm doing. But I mean it does help.' (19P)</p> <p>'I was hopeful that [my daughter] would have more involvement than she did...but if I'm honest, I got over that quite quickly 'cause the therapist was wonderful and it helped me to understand [my daughter]'s needs better. So, I saw the benefits of it once I started doing it.' (04P)</p>	<ul style="list-style-type: none"> <li>It will be helpful to normalise and address any initial concerns with parents who are being offered OSI+TS.</li> <li>Therapists would benefit from training around how to introduce this approach to parents in a way that allays any initial concerns.</li> <li>This could be more explicitly addressed in further developments to the OSI+TS program.</li> </ul>
<ul style="list-style-type: none"> <li>The program was generally seen as user-friendly, well-designed, and flexible, allowing parents to fit the sessions into daily life. Parents appreciated being able to listen to the audio of the online content, complete sessions on a mobile phone and download the materials.</li> </ul>	<p>'I'm a complete techno idiot. I'm not smart or savvy at all when it comes to tech. And if I can do it, anybody can do it.' (06P)</p> <p>'I just thought it was really easy to navigate. It was very straightforward working through the modules.' (12P)</p> <p>'I was washing the dishes and I was listening to it...the fact that I can come back and read the things again. I can download them. That was very good.' (14P)</p> <p>'I could just log into it anytime that suited me. So even if it was the midnight and I was sat in bed, I could still say right, I want to get this done now.' (04P)</p>	<ul style="list-style-type: none"> <li>Usability is good and for most parents there is good 'fit' - this may provide reassurance to parents, therapists, services, and commissioners in deciding whether to receive, deliver and commission OSI+TS.</li> </ul>
<ul style="list-style-type: none"> <li>Therapists were seen positively, providing support, problem-solving difficulties and</li> </ul>	<p>'I had a little blockage with the step plan. She [child], she wasn't getting as far, you know she just sort of stopped at one level, and I was trying to think why that was and she [therapist] was really helpful for that.' (12P)</p>	<ul style="list-style-type: none"> <li>Therapist support is highly valued and appears to be an essential part of treatment.</li> </ul>

helping parents put strategies into practice.

- Many **parents developed a sense of self-efficacy** that enabled them to feel they had the tools to help their child (and other children) now and in the future.

'The therapist at the time was fantastic. You know she was a massive support to me.' (21P)

'When I doubt myself, she picks me back up again.' (09P)

'The course supported 'me' and empowered 'me'' (04P)

'I feel confident enough that I now have the tools that if that happens with anything in life, not just the person receiving the treatment for myself and for my other child, it's changed my concept on how to deal with life as well.' (09P)

'I think I did learn a lot and will probably continue to evolve and learn that with her.' (16P)

- At the end of treatment, **parents were generally positive about the parent-led approach** and the OSI+TS program (even parents whose children were still experiencing some anxiety problems). For most parents, OSI+TS led to **improvements in their child's anxiety and emotional wellbeing**, leading them to do things previously avoided, as well as **increasing their confidence and resilience**. Some parents described this having a **positive effect on relationships** in the family.

'Where we've come from and where we are now in such a short space of time, in my eyes, is a miracle. I can't...back then I never ever dreamt that we could get to a stage where we are now. (09P)

'I'd do it again in a heartbeat.' (11P)

'It just works, you know, so I'm, I'm really happy with it.' (12P)

'It hasn't particularly worked well for for 'my' daughter, but I think there's a lot more going on there. But I'm so, so glad I've done it.' (06P)

'It's got him going back in his own bed and going to bed at a normal time without me either in there or him up all through the night.' (13P)

'Personally, me and my daughter are now closer. We got to a stage where we were sort of quite estranged...and we can now see a brighter future.' (09P)

- Parents who are being offered the program, therapists, services, and commissioners may find it beneficial to know that the benefits appear to go beyond improvements in the child's anxiety and extend to parents' being equipped with skills to potentially manage future difficulties without the need for further professional input.

- Providing information about the effectiveness of the treatment and parents' experiences of the program may help parents, therapists, services, and commissioners in deciding whether to receive, deliver and commission OSI+TS.



- Two parents felt that they would have **preferred their child to be involved in the sessions and longer face to face appointments** where they could receive more support from the therapist. Doing the program on their own and having to manage other significant stressors in life appeared to make it difficult to engage in the program.
  - 'I do think there's real value of doing it face to face and involving the child.' (17P)
  - 'If he'd had a bad week, I could. I mean, I can talk for England anyway, but I feel like I could have shared a lot more information... I think maybe like maybe, em, an allowance for debriefing for parents in, put into place would be good.' (17P)
  - 'I think it would have been so much massively beneficial if there had been the support of the two parents...probably would have been a bit more beneficial if we were all singing off the same hymn sheet.' (21P)
  - 'I'll most certainly use the techniques and I still do to a degree. But it's just so much other stuff going on to be honest with you.' (21P)
- It will be important to establish factors that are associated with poorer fit/outcomes for OSI+TS and identify whether OSI+TS could be further adapted to improve acceptability and outcomes for these families.

Therapists' experiences	Illustrative quotes	Implications
<ul style="list-style-type: none"> <li>Generally, therapists were enthusiastic about the training and the program in relation to its <b>ease of use and effectiveness</b>. Therapists suggested some minor improvements and requested <b>further training on routine outcome measures (ROMs) and videos</b> illustrating the approach.</li> </ul>	<ul style="list-style-type: none"> <li>'So yeah, I felt like it was sort of good training to begin with.' (02C)</li> <li>'I think it was really it was a great parent-led treatment definitely, and it works. And so you know, I've really enjoyed, really enjoyed, delivering it to be quite honest.' (03C)</li> <li>'I think, generally on the whole, just kind of like, the way it was kind of easy to follow and it was really structured, the modules.' (29C)</li> <li>'I think it's a really great way of working and I think it breaks down lots of barriers for families struggling to access treatments.' (05C)</li> <li>'I thought would have been helpful was if the therapists, like myself, could have access to the parent website, like a test account sort of thing, so that we could actually see what they're seeing.' (10C)</li> </ul>	<ul style="list-style-type: none"> <li>In general, OSI+TS is perceived as having the necessary characteristics to be implemented in services (i.e., good usability and observable improvements in child anxiety).</li> <li>There are some minor improvements that could be made around usability, such as providing the therapist with the parent view of the program. Further training on ROMs and more videos demonstrating the approach would be valued by less experienced therapists.</li> </ul>

	<p>'For those people who are kind of novice practitioners just a little 10-minute video on what each kind of ROM means.' (20C)</p> <p>'While it was well guided, in the instructions and the manuals, seeing in practice before would have been very helpful, I think.' (02C)</p>	
<ul style="list-style-type: none"> <li>Therapists felt that having the questionnaires and content delivered online and being able to monitor engagement within the program <b>reduced burden and time for therapists</b>. Short phone calls with parents appeared to be broadly acceptable to therapists and parents.</li> </ul>	<p>'I can book more cases in and I can be much more flexible with them, so that's been really helpful.' (05C)</p> <p>'I feel like a lot of the responsibility is being lifted from my shoulders because I know the information that the parent has read is good quality, accessible and I can check that they understood it.' (01C)</p> <p>'That's what I love about the Co-CAT - so I can go on, so I might go on the day before to have a quick look.' (08C)</p> <p>'It's easy to like track the progress with the questionnaires that they filled in and see how the scores are changing each week, so that was good. (10C)</p> <p>'You can build that rapport, the same way that we would anyway...and actually having check-ins with parents, 20 minutes is still enough to catch up and check in.' (05C)</p>	<ul style="list-style-type: none"> <li>OSI+TS is perceived to have a relative advantage over other approaches in terms of therapists' time and resources.</li> </ul>
<ul style="list-style-type: none"> <li><b>Some therapists were 'champions'</b> for the approach, voluntarily taking a particular interest in OSI+TS and its adoption in the local service.</li> </ul>	<p>'I really, really really hope that OSI sticks around and that as a Trust we do sign up to it and that we can use it because it is like being given almost the key to the magical Kingdom that you are shown this whole other world...like Willy Wonka's Chocolate Factory and everything is brilliant and marvellous, and then go back to the way it was before...I think I would be a bit gutted to be fair.' (01C)</p> <p>'I'm like guys it's great. You know, it's brilliant, we have to sign up for this. We need it. We need it to do well and to be rolled out across the country.' (05C)</p>	<ul style="list-style-type: none"> <li>The active recruitment of 'champions' could help spread knowledge about OSI+TS, enthusiasm for the approach, and facilitate embedding it into services.</li> </ul>

- Based on small numbers of cases (therapists had only delivered OSI+TS to between 1 and 4 parents), therapists expressed some **ideas around who OSI+TS may or may not work for**. In their experience, it appeared to be acceptable to parents from multi-ethnic communities and those who may experience difficulties in reading or with the English language. They felt OSI+TS may be less successful if children were older, had high levels of anxiety and avoidance, or were unable to articulate their worries. They also felt there were some instances where parents did not have capacity to engage in the program and required more support.
- Although they recognised the positives in using OSI+TS, some therapists described **preferences for, or perceived benefits in, delivering sessions in-person** rather than via OSI+ TS. This appeared to be particularly the
  - ‘Something they brought up consistently is just how easy it was to understand in terms of the language. And it was easy to sort of digest information and also they had the option to have someone to narrate the text, and that was a useful function for them.’ (02C)
  - ‘Yeah, I think for for the younger ones, yes, I think it's definitely got its place for the younger ones.’ (23C)
  - ‘As much as Mum can try and ask those questions she would say like sometimes, he just won't answer the questions, or he'll shut down when she tries to talk to him.’ (10C)
  - ‘My sense is that I'm not sure, it works for children who aren't at school...I'm not sure if it works if the child isn't in situations where they're experiencing all their anxiety.’ (20C)
  - ‘One of her comments was when we had the assessment was that she didn't want to be her child's therapist...then mum was a bit reluctant to start with anyway, then a few weeks in she said, oh it's too parent led. I'm gonna try something else.’ (23C)
  - ‘I think it would really depend on the parent, so I think some parents are more suited to it than others, and some parents need that hour if you know what I mean. It can be like a therapy session for them. And some parents are that busy they just don't need, the time, just don't need you taking up the time, just need the skills...I would definitely just kinda wait and decide after I met the parents.’ (29C)
  - ‘I don't mind doing online interventions, but face to face is still definitely my preference 'cause I think it's just so much easier to build that rapport and engage with someone and see how they're presenting like in front of you.’ (10C)
  - ‘With the treatment as usual [delivering parent-led CBT in a group], it's - I probably get more out of them ones as well, I probably learn more myself, as a, as a practitioner.’ (29C)
- Therapists' initial impressions are that OSI+TS appears to be acceptable to parents from multi-ethnic communities and those who may experience difficulties in reading or with the English language. There are initial impressions that OSI+TS may be less suited to some families.
- However, further evidence is required to determine who may/may not benefit from OSI+TS and therefore who it should be offered to.
- Once evidence becomes available, this should be communicated to therapists in services so that decisions are made based on the evidence.
- Within services, there is likely to be variability in therapists' interest, motivation, values/beliefs, learning opportunities, skills and knowledge, and access to support/supervision to deliver OSI+TS.

case for therapists who had not had professional training or were within the first year of being qualified.

'I'd like to give them all the information and then get them to read the additional materials, for just, to aid more understanding. So, I'd probably talk through the anxious thoughts the physical changes, the anxious behaviors, and then just give that [OSI+TS] as additional knowledge.' (08C)

- If OSI+TS is to be delivered by a range of therapists within services, these factors will need to be assessed and addressed via a range of strategies.

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OSI+TS=Online Support and Intervention for child anxiety plus therapist support; C-TAU=Child Mental Health Services Treatment As Usual

