The prevention of anxiety in children through school-based interventions: study protocol for a 24-month follow-up of the PACES project

Paul Stallard1*, Gordon Taylor1, Rob Anderson2, Harry Daniels3, Neil Simpson4, Rhiannon Phillips5 and Elena Skryabina1

Abstract
Background: Anxiety in children is common and incapacitating and increases the risk of mental health disorders in adulthood. Although effective interventions are available, few children are identified and referred for specialist treatment. Alternative approaches in which prevention programmes are delivered in school appear promising. However, comparatively little is known about the best intervention leader (health care–led vs. school-led), long-term effects or the primary preventive value of such programmes.

Methods/Design: Preventing Anxiety in Children through Education in Schools, or PACES, is a pragmatic cluster randomised controlled trial evaluating the effectiveness of a cognitive-behavioural therapy prevention programme (FRIENDS) on symptoms of anxiety and low mood in 9- to 10-year-old children. Forty-one schools were randomly assigned to one of three conditions: school-led FRIENDS, health care–led FRIENDS or treatment as usual. Assessments were undertaken at baseline, 6 months and 12 months, with the primary outcome measure being the Revised Child Anxiety and Depression Scale score at 12 months. Secondary outcome measures are changes in self-esteem, worries, bullying and life satisfaction.

Discussion: This protocol summarises the procedure for the 24-month follow-up of this cohort. The study will determine the medium-term effectiveness of an anxiety prevention programme delivered in schools.

Trial registration: ISRCTN23563048

Keywords: Prevention, Anxiety, Schools, Children

Background
Anxiety and depressive disorders in children are common. The investigators in the American Great Smoky Mountains Study found that, during a 3-month period, 2.4% of children ages 9 to 16 years fulfilled the diagnostic criteria for an anxiety disorder and 2.2% met the criteria for a depressive disorder [1]. Similar rates were found in the British Mental Health Survey, in which 3.7% of 5- to 15-year-olds had a current anxiety disorder and 1% had a depressive disorder [2]. Comorbidity of anxiety and depression is common [3,4], with cumulative rates suggesting that, by 16 to 17 years of age, 15% to 18% of children will have experienced an impairing emotional disorder of anxiety or depression [1,4].

Longitudinal studies highlight that child mental health disorders persist into adulthood. In the Dunedin birth cohort study, approximately 52% to 55% of young adults with depression or anxiety met the diagnostic criteria for a mental health disorder before 15 years of age, with 75% receiving a first diagnosis before the age of 18 [5]. Childhood anxiety increases the risk of anxiety, depression, substance misuse and educational underachievement in early adulthood [6]. Similarly, childhood depression increases the risk of suicide, subsequent depression and substance misuse. The associated health-related burden and economic and societal costs are considerable, and the need to improve the mental health of children is being increasingly recognised as a priority at the global level [7-9].

Whilst effective psychological treatments are available, few children with emotional disorders receive them. Surveys undertaken in the United Kingdom and the United

* Correspondence: p.stallard@bath.ac.uk
1 Department for Health, University of Bath, 22-23 Eastwood, Bath BA2 7AY, UK
Full list of author information is available at the end of the article

© 2014 Stallard et al; licensee BioMed Central Ltd. This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited. The Creative Commons Public Domain Dedication waiver (http://creativecommons.org/publicdomain/zero/1.0/) applies to the data made available in this article, unless otherwise stated.
States have revealed that approximately one-third of children with anxiety disorders and less than one-half with depressive disorders had sought or received help from specialists over a 1- to 3-year period [10,11]. The persistence of emotional disorders, as well as the immediate and future burden, and the limited reach of treatment services have led to interest in alternative approaches to improve the mental health of children.

School-based mental illness prevention programmes offer an attractive alternative to traditional treatment approaches. Systematic reviews have highlighted that anxiety and depression prevention programmes can be effective, although the results have been widely variable [12-15]. Methodologically, many of these studies are poorly designed, sample sizes are small, comparisons with other active interventions are lacking and follow-up is limited. Implementation studies whereby efficacious interventions are evaluated in suitably powered trials under everyday conditions are comparatively few and have delivered disappointing results. Recent evaluations of large, well-designed depression prevention programmes delivered for children in schools, for example, have failed to find intervention effects [16-18]. Although the results of anxiety prevention programmes have tended to be more encouraging, recent implementation trials have failed to find positive effects [19,20]. Two important issues that will influence programme effectiveness in preventing mental health problems in children are the ways in which the programme is provided (universally versus targeted) and who delivers the intervention (health care professionals versus teachers) [12,14,15].

Prevention programmes can be provided universally (that is, to all of an identified population, regardless of risk status) or targeted toward those at risk of developing mental health disorders or showing early signs of a disorder [21]. Universal programmes avoid the need for costly screening, fit better within complex school timetables, are less stigmatising and provide opportunities for primary prevention. This last point is important because many trials of prevention programmes have focused on demonstrating evidence of treatment effects (that is, reducing current symptom levels) rather than on preventive effects, such as a reduction in the emergence of new cases [22]. Universal interventions tend to have a smaller effect than targeted programmes, however, and, in times of economic pressure, may not be considered the best use of limited resources [23,24].

In terms of delivery, health care professionals or graduates tend to be more effective than trained school staff in delivering depression prevention programmes [15]. Reviewers have found no difference in effectiveness between health care professionals and school staff in the delivery of anxiety prevention programmes [12]. Direct comparisons within prevention trials between health care professionals and school staff have seldom been undertaken, however, so the most effective form of prevention programme delivery is not known.

Of the emotional health prevention programmes that have been developed, FRIENDS for Life has been identified as one of the more efficacious programmes [13,25]. FRIENDS is based on cognitive-behavioural therapy and develops children’s skills to enhance emotional regulation, coping mechanisms and thinking styles. A pragmatic randomised controlled trial is currently underway in the United Kingdom to compare the effectiveness of universally delivered health care–led FRIENDS, school-led FRIENDS and usual school provision of personal, social and health education (PSHE) at 12 months after initiation [26]. The purpose of the Preventing Anxiety in Children through Education in Schools (PACES) trial is to assess the medium-term (24 months) effects. First, differences in emotional health between health care– and school-led FRIENDS and usual school provision of PSHE at 24 months will be investigated. Second, the effects of the three conditions at 24 months on children with high and low levels of anxiety at baseline will be explored.

Methods/Design

PACES is a pragmatic, three-arm, parallel cluster randomised controlled trial, with school used as the unit of allocation and individual participants being the unit of analysis [26]. Participating children were recruited during school year 5 (ages 9 to 10 years), and all were eligible unless they were not attending school (for example, due to long-term sickness or excluded from school) or did not participate in PSHE lessons for religious or other reasons. Parent consent and child assent were obtained before completing the assessments.

Power calculation

The study is powered to detect a difference between the FRIENDS programme (health care–led and school-led) and usual school provision of PSHE. On the basis of an intracluster correlation coefficient of 0.02, 28 pupils per class, 90% consent and 80% retention, effect sizes in the range of 0.28 to 0.30 standard deviations are detectable with 80% power and 5% two-sided α and including 45 to 54 schools (that is, 1,134 to 1,360 consenting pupils). On the basis of these assumptions, a cohort of 907 to 1,088 pupils at 12 months was required.

Randomisation

After recruitment, schools in South West England were randomised on a 1:1:1 ratio to health care–led FRIENDS, school-led FRIENDS or usual school provision of PSHE. Trial arms were balanced for school size, number of students and classes, number of mixed classes, level of educational attainment and preferred time-tabling. A statistician
Interventions

Interventions were delivered in the academic year spanning September 2011 to July 2012. The FRIENDS interventions consisted of nine 60-minute weekly sessions delivered to whole classes of children (that is, universal delivery). Children had their own workbooks, and group leaders had a detailed session plan specifying key learning points, objectives and core activities for each session.

For health care–led FRIENDS, each session was led by two trained facilitators working alongside the class teacher. All facilitators had at least an undergraduate university degree in a relevant discipline, an appropriate professional background and/or experience in working with children and young people. Initial two-day training and ongoing fortnightly supervision were provided by accredited FRIENDS trainers.

In school-led FRIENDS, sessions were led by a trained teacher or a member of the school staff and were supported by two facilitators. School staff attended the same two-day training session and were offered ongoing supervision.

For usual school provision of PSHE, children participated in the usual PSHE sessions provided by the school. All schools were following a UK national programme designed to develop self-awareness, management of feelings, motivation, empathy and social skills [27]. The sessions were planned and provided solely by the teacher and did not involve any external input from the research team.

Twenty-four-month assessment

Recruitment strategy

The PACES cohort transitioned to secondary school in September 2013. This cohort will be invited to participate in the 24-month assessment according to our recruitment strategy drawing upon suggestions from systematic reviews [28].

First, opt-in reply slips and a project information sheet with the university and PACES logos will be sent from schools to parents of all children who participate in the PACES study. Second, playground recruitment visits will be undertaken at the end of the day, when parents collect their children. These recruitment steps will allow informal discussions about the project and an opportunity for parents to allow their children to participate in the study. Third, a range of PACES publicity materials, including the project contact details (for example, pencils, refrigerator magnets, stress balls and message bugs), will be handed out to children during these visits. Fourth, a PACES Facebook page will be established as a way of allowing parents to contact the study team and opt to have their children participate in the study. Fifth, a £30 financial incentive will be offered to compensate parents and children for their time in completing the assessments.

Consent and ethical approval

Signed parent consent and child assent are required for participation in the 24-month assessment. The 24-month assessment was approved by the University of Bath Research Ethics Approval Committee for Health.

Outcome measures: child report

Assessments were undertaken in the original PACES project at baseline and at 6 and 12 months by self-completed questionnaires administered by researchers blinded to allocation arm. The 24-month assessment will involve the same measures that have been completed on the three previous occasions.

The primary outcome for our long-term follow-up is the Revised Child Anxiety and Depression 30-item Scale (RCADS-30) score assessed at 24 months [29]. This self-report questionnaire is used to assess anxiety and depression symptoms that correspond to diagnostic criteria published in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (the DSM-IV). The 30-item scale will be used, which comprises 6 subscales to assess social phobia, separation anxiety, obsessive-compulsive disorder, panic disorder, generalised anxiety disorder and major depressive disorder. Items are rated on a four-point Likert scale. The RCADS-30 has good internal consistency, test–retest stability and convergent and divergent validity [30,31].

Child-reported secondary outcomes will be used to assess self-worth and acceptance, worry, bullying, life satisfaction and school concerns at 24 months. The Rosenberg Self-Esteem Scale [32] is a ten-item, self-completed questionnaire related to overall feelings of self-worth or self-acceptance. The items are answered on a four-point scale ranging from strongly agree to strongly disagree. The Rosenberg Self-Esteem Scale has demonstrated good reliability and validity across a large number of different sample groups, including children aged 7 to 12 years, and is one of the most commonly used and best-known measurement tools for self-esteem.

The Penn State Worry Questionnaire for Children is a self-report questionnaire that measures the tendency of children to engage in excessive, generalised and uncontrollable worry [33]. Items are rated on a four-point Likert scale to assess how strongly each item applies to the child. The original scale consists of 14 items. The 11-item version used in this trial has improved psychometric properties when used with children aged 8 to 12 years [34].

The Olweus Bully/Victim Questionnaire is the most widely used questionnaire to assess the nature and extent of bullying amongst schoolchildren. The two global items
assessing the frequency of self-reported bullying and being the victim of bullying will be used.

Subjective well-being and satisfaction with six aspects of life (school, appearance, family, home, friendships and health) and overall life satisfaction are assessed using a seven-point scale. These aspects were selected from among the 12 domains identified as contributing to the subjective well-being of children [35].

The School Concerns Questionnaire is a 20-item scale assessing worries about starting secondary school [36]. Items cover organisational concerns (that is, changing classes, remembering equipment), social concerns (that is, making new friends, being bullied) and academic concerns (for example, homework, being able to do the work). Each item is rated on a ten-point scale assessing the extent of worry.

**Outcome measures: parent report**

Parents will first complete the same measures they completed at baseline and at 6 and 12 months. The Strength and Difficulties Questionnaire is a brief, widely used behaviour screening questionnaire for 3- to 16-year-olds completed by parents and teachers. It asks about 25 attributes, some positive and others negative. These 25 items cover emotional symptoms, conduct problems, hyperactivity and/or inattention, peer relationship problems and prosocial behaviours, which, added together, generate a total difficulties score [37,38].

Second, parents will complete the parent version of the Revised Child Anxiety and Depression 30-item Scale (RCADS-30-P). This scale covers the same 30 items completed by the children. The RCADS-P has high internal consistency, good test–retest reliability and good convergent and divergent validity [39].

**Outcome measures: economic**

All children will complete the self-report Child Health Utility–9D (CHU-9D) at 24 months [40]. The CHU-9D has been developed specifically for children ages 7 to 11 years and is a validated measure covering nine different domains of health-related quality of life.

A subgroup of parents (n = 307) was interviewed at baseline and at 6 months (n = 284) using the Client Receipt of Service Questionnaire to assess health, social care and educational service use [41]. Parents in this subgroup who opt to participate in the 24-month assessment will be asked to complete this questionnaire again, along with the assessment of life events and a screen of parent physical and mental health that they previously completed.

**Statistical analysis**

Data analysis will be undertaken by study members blinded to allocation arm. Analysis and presentation of data will be in accordance with the Consolidated Standards of Reporting Trials (CONSORT) guidelines, in particular with the extension to cluster randomised trials [42]. The primary comparative analyses will be conducted on an intention-to-treat (ITT) basis with due emphasis placed on confidence intervals for the between-arm comparisons.

We will use descriptive statistics to assess balance between trial arms at baseline. The primary outcome will be assessed by ITT without imputation. To take appropriate account of the hierarchical nature of the data, we will use multivariable mixed-effects regression to compare mean RCADS-30 scores at 24 months for health care–led FRIENDS versus school-led FRIENDS versus usual school provision of PSHE, with adjustments made for baseline RCADS-30 scores and randomisation variables. These analyses will be repeated for secondary outcomes. We will undertake a secondary analysis using interaction terms in the regression model to explore differences at 24 months between randomised arms and the baseline variable (RCADS scores of 0 to 38 (low anxiety) and 39 and higher (high anxiety)).

**Discussion**

Adequately powered randomised trials assessing the effectiveness of anxiety prevention programmes, when implemented under everyday conditions, are required before the widespread use of these programmes can be advocated. Our study will compare an efficacious programme (FRIENDS) delivered by health care professionals or school staff against usual school provision of PSHE. The study will assess the effect of intervention leaders and the impact of the programme on both high- and low-symptom children to determine both reduction in symptomatology and whether the intervention has a preventive effect on low-symptom children. The 24-month assessment will allow the medium-term effects to be determined.

**Study status**

Forty-one schools consented to participate in PACES and were randomised, and one withdrew before baseline assessments were undertaken. The remaining 40 schools had 1,448 eligible participants of whom 1,362 (94%) consented to participate in the study. Twelve-month outcome data were obtained from 1,257 consenting children (94%), resulting in a larger cohort than initially predicted.

Recruitment for the 24-month assessment started in June 2013. Assessments started in October 2013 and are scheduled to be completed by May 2014.

**Abbreviations**

CHU-9D: Child Health Utility Index; CONSORT: Consolidated Standards of Reporting Trials; ITT: Intention to treat; PACES: Preventing Anxiety in Children through Education in Schools; RCADS: Revised Child Anxiety and Depression Scale.

**Competing interests**

The authors declare that they have no competing interests.
Authors’ contributions
PS, GT RA, NS, HD and RP conceived the study and led the bid to secure funding for this work. They have contributed to the development of the protocol and are involved in managing and advising on the project. ES is the trial manager and has contributed to the development of the protocol and the drafting of this paper. All authors read and approved the final manuscript.

Acknowledgements
The project is funded by the NIHR Public Health Research Programme (09/30003/03). The views and opinions expressed in this paper are those of the authors and do not necessarily reflect those of the Department of Health. We thank the members of the TSC for their oversight and support Professor Alan Emond (Chair), Dr Cathy Creswell, Dr Richard Meiser-Stedman, Ms Pauline Rodger and Ms Lucie Pring. We would also like to thank the DMEC, Dr Tamsin Ford (Chair), Dr Oboiba Ukoumunne and Dr Emma McIntosh.

Author details
1Department of Health, University of Bath, 22-23 Eastwood, Bath BA2 7AY, UK.2University of Exeter Medical School, The Veysey Building, Salomon Pool Lane, Exeter EX2 4SG, UK.3Department of Education, University of Oxford, 15 Northam Gardens, Oxford OX2 6UY, UK.4Stona Care and Health, Headquarters building, Bath BA2 5RP, UK.5Wales School for Primary Care Research, Cardiff University School of Medicine, Heath Park, Cardiff CF14 4XN, UK.

Received: 6 November 2013 Accepted: 11 February 2014

References
1. Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A: Prevalence and development of psychiatric disorders in childhood and adolescence. Arch Gen Psychiatry 2003, 60:837–844.
2. Ford T, Goodman R, Meltzer H: The British Child and Adolescent Mental Health Survey 1999: the prevalence of DSM-IV disorders. J Am Acad Child Adolesc Psychiatry 2003, 42:203–211.
3. Garber J, Weersing VR: Comorbidity of anxiety and depression in youth: implications for treatment and prevention. Clin Psychol (New York) 2010, 17:293–306.
4. Essau CA, Conradt J, Petermann F: Psychological impairment of anxiety disorders in German adolescents. J Anxiety Disord 2000, 14:263–279.
5. Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R: Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. Arch Gen Psychiatry 2003, 60:703–717.
6. Woodward LJ, Ferguson DM: Life course outcomes of young people with anxiety disorders in adolescence. J Am Acad Child Adolesc Psychiatry 2001, 40:1086–1093.
7. Kieling C, Baker-Henningham H, Belfer M, Conti G, Eteme I, Omigbodun O, Rohde LA, Sirnath S, Ukkusni N, Rahman A: Child and adolescent mental health worldwide: evidence for action. Lancet 2011, 378:1515–1525.
8. Collins P1, Patel V, Joelli S, March D, Insel TR, Daar AS, Bordin IA, Costello EJ, Durkin M, Faibum C, Glass RI, Hall W, Huang Y, Hyman SE, Jamison K, Kaasa S, Kapur S, Kleinman A, Oggunjii A, Otero-Ojeda A, Poo MM, Ravindranath V, Sahakian BJ, Saxena S, Singer PA, Stein DJ, Anderson W, Dhanday MA, Ewart W, Phillips A, et al for the Scientific Advisory Board and the Executive Committee of the Grand Challenges on Global Mental Health: Grand challenges in global mental health. Nature 2011, 475:27–30.
9. Snell T, Krapp M, Healey A, Gugliani S, Evens-Lacko S, Fernandez JL, Meltzer H, Ford T: Economic impact of childhood psychiatric disorders on public sector services in Britain: estimates from national survey data. J Child Psychol Psychiatry 2013, 54:977–985.
10. Ford T, Hamilton H, Meltzer H, Goodman R: Predictors of service use for mental health problems among British schoolchildren. Child Adolesc Ment Health 2008, 13(2):16–20.
11. Merikangas KR, He JP, Brody D, Fisher PW, Bourdon K, Kessler DS: Prevalence and treatment of mental disorders among US children in the. NHANES. Pediatrics 2001–2004, 2010(125):75–81.
12. Neil AL, Christensen H: Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. Clin Psychol Rev 2009, 29:208–215.
13. Fisk BJ Jr, Richert D, Mann A: The prevention of child and adolescent anxiety: a meta-analytic review. Prev Sci 2011, 12:255–268.
14. Merry SN, Hetrick SE, Cox GR, Brudevold-Hvensen T, Bir JJ, McDowell H: Psychological and educational interventions for preventing depression in children and adolescents. Cochrane Database Syst Rev 2011, 12:CD003380.
15. Calear AL, Christensen H: Systematic review of school-based prevention and early intervention programs for depression. J Adolesc Health 2010, 33:29–438.
16. Sawyer MG, Pfeiffer S, Spence SH, Bond L, Graetz B, Kay D, Patton G, Sheffield J: School-based prevention of depression: a randomised controlled study of the beyondblue schools research initiative. J Child Psychol Psychiatry 2011, 51:199–209.
17. Araya R, Fritschi R, Spears M, Rojas G, Martinez V, Barollet S, Vöhringer P, Gunnell D, Stallard P, Guajardo V, Garte J, Noble S, Montgomery AA: School intervention to improve mental health of students in Santiago, Chile: a randomized clinical trial. JAMA Pediatr 2013, 167:1004–1010.
18. Stallard P, Sayal K, Phillips R, Taylor JA, Spears M, Anderson R, Araya A, Lewis G, Millings A, Montgomery AA: Classroom based cognitive behavioural therapy in reducing symptoms of depression in high risk adolescents: pragmatic cluster randomised controlled trial. BMJ 2012, 345:e6058.
19. Miller LD, Laye-Gindhu A, Liu Y, March JS, Thordarson DS, Garland EJ: Evaluation of a preventive intervention for child anxiety in two randomized attention-control school trials. Behav Res Ther 2011, 49:315–323.
20. Miller LD, Laye-Gindhu A, Bennett AL, Liu Y, Gold S, March JS, Olsson BF, Waechtler VE: An effectiveness study of a culturally enriched school-based CBT anxiety prevention program. J Clin Child Adolesc Psychol 2011, 40(6):518–629.
21. Mazek PJ, Haggerty RJ (Eds.): Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington DC: National Academies Press; 1994.
22. Horowitz JL, Garber J: The prevention of depressive symptoms in children and adolescents: a meta-analytic review. J Consult Clin Psychol 2006, 74:401–415.
23. Giesen F, Searle A, Sawyer M: Identifying and implementing prevention programmes for childhood mental health problems. J Paediatr Child Health 2007, 43:785–789.
24. Stallard P: School-based interventions for depression and anxiety in children and adolescents. Evid Based Ment Health 2013, 16:60–61.
25. World Health Organization (WHO): Prevention of Mental Disorders. Geneva: WHO: Effective Interventions and Policy Options; 2004 Available at http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf (accessed 21 February 2014).
26. Stallard P, Taylor G, Anderson R, Daniels H, Simpson N, Phillips R, Skyrabinia E: School-based intervention to reduce anxiety in children: study protocol for a randomized controlled trial (PAGES). Trials 2012, 13:227.
27. Department for Education and Skills: Excellence and Enjoyment: Social and Emotional Aspects of Learning (Publication DfES 1378 2004). London: DFES Publications; 2005. May 2005. Available at http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/SEAL%20Guidance%202005.pdf (accessed 21 February 2014).
28. Edwards P, Roberts J, Clarke M, DiGuiseppi C, Pratap S, Wentz R, Kwan I: Increasing response rates to postal questionnaires: systematic review. BMJ 2002, 324:1183.
29. Chorpita BF, Moffitt CE, Gray J: Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. Behav Res Ther 2005, 43:309–322.
30. Sandin B, Chorot P, Valiente RM, Chorpita BF: Development of a 30-item version of the Revised Child Anxiety and Depression Scale. J Psychopathol Behav 2010, 15:165–178. Available at http://espace.uned.es/feze/feze.php?id=bibliunivPiscopat-2010-15-3-2020&id=Documento.pdf (21 February 2014).
31. Murs P, Meesters C, Schouten E: A brief questionnaire of DSM-IV-defined anxiety and depression symptoms among children. Clin Psychol Psychother 2002, 9:430–442.
32. Rosenberg M: Society and the Adolescent Self-image. Princeton, NJ: Princeton University Press; 1965.
33. Chorpita BF, Tracey SA, Brown TA, Collica TJ, Barlow DH: Assessment of worry in children and adolescents: an adaptation of the Penn State Worry Questionnaire. Behav Res Ther 1997, 35:569–581.
34. Muris P, Meesters C, Gobel M: Reliability, validity, and normative data of the Penn State Worry Questionnaire in 8–12-yr-old children. J Behav Ther Exp Psychiatry 2001, 32:63–72.
35. Rees G, Goswami H, Bradshaw J: Developing an Index of Children’s Subjective Well-being in England. London: The Children’s Society; 2010. Available at https://www.childrenssociety.org.uk/sites/default/files/docs/research_docs/Developing%20an%20Index%20of%20Children’s%20Subjective%20Well-being%20in%20England.pdf (21 February 2014).
36. Rice F, Frederickson N, Seymour J: Assessing pupil concerns about transition to secondary school. Br J Educ Psychol 2010, 81:244–263.
37. Goodman R: The Strengths and Difficulties Questionnaire: a research note. J Child Psychol Psychiatry 1997, 38:581–586.
38. Goodman R, Scott S: Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? J Abnorm Child Psychol 1999, 27:17–24.
39. Ebesutani C, Chorpita BF, Higa-McMillan CK, Nakamura BJ, Regan J, Lynch RE: A psychometric analysis of the Revised Child Anxiety and Depression Scales–Parent Version in a school sample. J Abnorm Child Psychol 2011, 39:173–185.
40. Stevens K: Assessing the performance of a new generic measure of health-related quality of life for children and refining it for use in health state valuation. Appl Health Econ Health Policy 2011, 9:157–169.
41. Beecham J, Knapp M: Costing psychiatric interventions. In In Measuring Mental Health Needs. 2nd edition. London: Gaskell; Thornicroft G; 2001:200–224.
42. Moher D, Hopewell S, Schulz KP, Montori V, Gøtzsche PC, Devereaux PJ, Elbourne D, Egger M, Altman DG: Consolidated Standards of Reporting Trials Group: CONSORT 2010 Explanation and Elaboration: updated guidelines for reporting parallel group randomised trials. J Clin Epidemiol 2010, 63:e1–e37. A published erratum appears in, J Clin Epidemiol 2012, 65:351.

doi:10.1186/1745-6215-15-77

Cite this article as: Stallard et al: The prevention of anxiety in children through school-based interventions: study protocol for a 24-month follow-up of the PACES project. Trials 2014 15:77.

Submit your next manuscript to BioMed Central and take full advantage of:

- Convenient online submission
- Thorough peer review
- No space constraints or color figure charges
- Immediate publication on acceptance
- Inclusion in PubMed, CAS, Scopus and Google Scholar
- Research which is freely available for redistribution

Submit your manuscript at www.biomedcentral.com/submit