

Clinician Supported Brief Digital Intervention for Child and Adolescent Behaviour and Emotion Difficulties in Ontario Schools: A Brief and Pragmatic Perspective of the Evidence

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What is a Brief Digital Intervention (BDI)?

The Brief Digital Intervention (BDI) is an innovative approach for delivering Cognitive Behaviour Therapy (CBT) skills appropriate for a school setting. The BDI uses online self-directed learning modules to deliver core CBT skills training. The BDI is developed such that each skills module can be delivered in isolation. This allows for more individualized treatment plans. The BDI is also supported by clinicians who meet with the student to help identify goals, review the material from the CBT modules and provide advice about which (if any) subsequent modules are needed. In this way, BDIs are similar to internet delivered CBT programs (iCBT) in their format and content. BDIs are unique in that each skill module is developed as a stand-alone resource, there is clinician support before and after each module, and the intervention is designed to be much briefer than traditional iCBT programs.

Because BDIs are a recent innovative approach to school mental health, there is no literature on BDIs. There are related literatures that are informative. This review briefly examines the literature on dose-response and Short-Term Interventions (STIs) and then focuses on clinician-supported iCBT programs for adolescents.

Dose-Response and Short-Term Intervention (STIs)

Most of the dose-response literature examines outcomes with adult populations. A systematic review found that 20% of adult clients improve after five sessions, and 57.6% of clients are recovered after 12.7 sessions¹. Unsurprisingly, acute mental health difficulties require fewer sessions than chronic difficulties (e.g., 50% improvement after 5 sessions)² and that average levels of pathology also require fewer sessions than more severe pathology³.

With respect to child and adolescent populations, one meta-analysis of school-based mental health services found that there is no dose-response relationship and that the number of sessions did not predict treatment outcome⁴. The studies included in the meta-analysis were delivered in schools or by school personnel and were used a randomized, controlled comparison, or matched-sample quasi experimental design.

Other studies examined mental health outcomes of large geographic areas in the United States using insurance data and treatment outcome measures^{5,6}. These studies also conclude that no dose-response relation exists for children and adolescents. Of note, the above studies all include elementary school aged children in their samples ,

and no systematic reviews or meta-analyses of dose-response relationships in adolescent-only samples could be found.

Conversely, one recent study examined CBT in a school setting with 133 adolescents and found that a reliable change occurred after 2.91 sessions⁷. A meta-analysis of single session interventions for youth found significant improvement in anxiety, conduct, and substance use⁸. Other studies have found that depression in youth can be effectively addressed using single session interventions^{9, 10}.

The research reviewed above is confounded by heterogeneity in service characteristics, clinical complexity and intensity, study design, and methods for evaluating duration. Most “brief” interventions are those considered to be 12 sessions or less. As such, conclusions drawn from this research should be held lightly. Nonetheless, these findings suggest that, in child and adolescent therapy, more does not necessarily mean better. Short Term Interventions appear to be effective for youth and may be especially effective for youth with more acute – rather than chronic – mental health difficulties and for youth with less complex and intense clinical needs.

Clinician Supported-iCBT as a proxy for BDIs: What Problem-areas do iCBT programs help with?

There is a substantial body of literature that has suggests that iCBT is an effective treatment modality for a range of problems, including anxiety, depression, behavioural difficulties and substance use in children and youth¹¹⁻¹⁷. In particular, there is compelling evidence to suggest that clinician-supported iCBT programs are effective in reducing symptoms of anxiety, including social and generalized anxiety (GAD), specific phobia, and obsessive-compulsive disorder (OCD) with effect sizes varying from small to large^{14, 16-22}. Moreover, treatment gains are maintained or even increased after the program ends^{11, 14, 16, 17}. For example, in a randomized control trial including families of children ranging between 8-12, at the end of treatment, 21% of children who received iCBT no longer met the criteria for an anxiety disorder¹⁷. At a 3-month follow-up, this number increased with 50% percent of children no longer meeting the criteria for anxiety diagnosis.

With respect to the treatment of depression, there is some inconsistency in the research findings. One systematic review examining seven meta-analysis of internet-based interventions found that iCBT was not effective in reducing depressive symptoms in children and youth²². However, a more recent study found that transdiagnostic iCBT was effective in reducing depression with moderate-large effect sizes¹¹. Another study found that iCBT lead to significant reductions in depression for boys but not girls¹².

Why and how do ICBT programs help?

Understanding how iCBT programs lead to change is important for inferring whether and how BDIs might lead to change. In the case of CBTs, therapeutic alliance influences treatment compliance and completion, which, in turn, is associated with better outcomes^{11, 23-26}. One study demonstrated that iCBT participants reported an equivalent working alliance to that of face-to-face CBT²³. Additionally, the study

demonstrated both direct and indirect effects of alliance on treatment compliance and outcome. Berg and colleagues found that both clinician support, as well as skills training and learning strategies, contribute to better iCBT outcomes¹¹. This finding is also reflected in a recent meta-analysis which found that both clinician support and skills training contribute to outcome⁸. As such, it appears that a brief amount of clinician support is beneficial for program adherence and efficacy. In addition to therapeutic alliance, aspects of iCBT, including exposure and coping skills such as cognitive restructuring, problem-solving, and intentional distraction, are mechanisms of anxiety reduction^{27, 28}.

Are School-Based iCBT Programs Helpful?

There is encouraging evidence to support the use of internet assisted interventions for use in school-based settings. At the universal level, a self-directed iCBT program entitled MoodGYM has been implemented in schools^{12, 29, 30}. Youth who completed the MoodGYM program demonstrated lower levels of anxiety and depression, albeit effect sizes were small to moderate. MoodGYM was implemented as part of the YouthMood Project with over 1400 youth in a school setting and over 7000 youth in a community setting^{12, 25}. Of note is that no adverse consequences were associated with the universal implementation of the program. Further, there is preliminary evidence to support the use of iCBT as a method of improving social anxiety and comorbid depression related to public speaking in high school students²⁰. A school-based iCBT program called Reframe-IT also demonstrates preliminary evidence for the use of an iCBT program in improving suicidal ideation, frequency of suicide attempts, as well as secondary outcomes such as depression, anxiety and problem solving³¹. However, it is important to note that implementation of Reframe-IT involved a high level of clinician support and the study was underpowered.

When considering the unique context of the school-based setting, challenges with program adherence and completion appear to be a common trend, with several studies reporting that there is a substantial proportion of participants who do not complete the entire iCBT program^{12, 20, 29, 30}. Interestingly, in two studies that reported low program adherence, students who completed some of the modules still experienced benefits^{12, 20}. While there is evidence to suggest that interventions with limited clinician support can be beneficial^{15, 20}, best available evidence suggests that clinician support is an important predictor of adherence to iCBT for children and youth^{11, 32, 25}.

Because iCBT programs are being used as a proxy for BDIs, more detailed information iCBT programs delivered in school settings is provided in Table 1 to facilitate usability of this report.

What are the Unique Barriers in a School Setting?

There are a number of implementation barriers that must be considered when delivering iCBT interventions in a school setting. The Canadian Agency for Drugs and Technologies in Health³³ highlight several barriers associated with iCBT that also pertain to the school setting, such as: access to technology and internet connection, lack of literacy skills and familiarity with technology and lack of access to a private space. Higher severity and complexity of diagnosis may serve as a barrier as youth may

not meet the inclusion criteria for iCBT programs³³. One study reported that parents of youth who were excluded from treatment based on complexity of diagnoses and presentation (e.g., suicidality) expressed concern, stating that access to other treatment was limited and in their view, some treatment was better than nothing³⁴. In the school-setting, this might place clinicians in a difficult position given that clinicians may not have the resources to include these complex youth in their caseload; however, excluding such youth presents an issue of equity.

Exclusion Criteria

Previous literature has outlined some exclusion criteria for iCBT, such as: severe substance abuse, severe conditions of ADHD, acute suicidal ideation, FSIQ below 80, insufficient English language skills to engage with the program material, active psychosis, and ongoing psychological treatment with the potential to interfere with iCBT^{11,35}.

It is important to ensure that students have sufficient language and self-regulation abilities to engage with the material (or have the requisite supports to compensate). Additionally, students with neuroatypicality may also need more acceptance-based interventions than is typically included in CBT programs (e.g., the thought “I will never be good at math” may not be a cognitive distortion for someone with a LD in math, and this person would benefit more from acceptance and problem-solving interventions rather than cognitive restructuring). Youth with visual impairments or who are deaf or hard of hearing might not be able to fully engage with the program and might experience subsequent frustration or invalidation. Additionally, participants with severe mental health difficulties are often excluded from iCBT research³⁶. Further research is needed to assess the effectiveness of iCBT in this population.

There are some instances where internet-based interventions might be contraindicated or harmful for youth. Youth with experiences of chronic misattunement or invalidation, and low trust in treatment systems may experience this as a recapitulation of previous harms and become even less inclined to engage in treatment. While this risk is also present for in-person treatment, in-person treatment provides space for the clinician to attend to ruptures in the moment. Similarly, youth with recent trauma histories may experience harm from iCBT or similar forms of treatment in that trauma-reappraisal shortly after the traumatic event is associated with worse long-term outcomes and that breathwork and independently guided cognitive restructuring related to traumatic events can be associated with short-term deterioration³⁷.

Ethics and Equity Issues to Consider

When evaluating digital interventions such as iCBT for use in a school-based context, it is imperative to consider issues of ethics and equity. Given the digital nature of iCBT programs, ensuring that all students have access to necessary resources (e.g., technology, private space, and internet connection) is important in ensuring equitable access to treatment. Conversely, offering BDIs widely may increase the availability of in-person resources for those who cannot access digital interventions. Because iCBT programs are a pre-packaged prevention program broadly targeted for use with all

youth, iCBT modules are inherently, not culturally responsive. Similarly, given the lack of individualization associated with iCBT modules, they are not responsive to trauma-related processes. Further, the limited ability of iCBT to provide individualized treatment to clients may present challenges for individuals with varying levels of English language competency or those with information processing differences. In turn, this may make the self-directed learning required in iCBT less effective. Nonetheless, the clinician supported sessions may be sufficient to address these difficulties.

Summary

BDIs are a new and innovative approach to addressing mental health difficulties in school settings. It is designed to support youth with acute or lower-severity difficulties or as an adjunct to other plans of care. This research snapshot reviews related bodies of research to inform decision making about the use of BDIs in schools.

The literature reviewed suggests that brief interventions can be helpful especially for more acute mental health difficulties and those with lower severity and complexity. The literature reviewed also suggests that internet-delivered CBT (iCBT) programs delivered in both schools and community settings are effective especially when clinician support is provided as an adjunct to the iCBT material.

That being said, there are important barriers and considerations to be made when deciding to use iCBT programs with specific individuals. Chronic, severe, and complex mental health difficulties likely require a higher dose and more comprehensive intervention than what is provided in a BDI. It is also important to consider an array of barriers that might impeded a student's ability to access and make sense of the information in BDIs which includes external barriers like access to internet and a private space, as well as internal barriers like information processing and self-regulation abilities. It is also important to consider whether the skills taught in the BDI are likely to address the problem area. For example, youth whose difficulties are caused by external situations (e.g., anxiety about housing insecurity when that insecurity is real; anger about racism and experiences of discrimination) or organic factors (e.g., self-criticism about academic difficulties for youth with LDs and ADHD) may not benefit from cognitive restructuring without appropriate guidance by a clinician.

Because iCBT programs are a pre-packaged prevention program broadly targeted for use with all youth, iCBT modules are not responsive to culture, trauma history, or life stressors. Youth in low-income, rural, and marginalized communities may have less access to the resources required to effectively engage with the iCBT materials. Conversely, offering BDIs widely may increase the availability of in-person resources for those who cannot access digital interventions and those who require more intensive plans of care.

Overall, this research snapshots that BDIs are likely to be safe and helpful for most youth when delivered with clinician support.

Disclaimer

The information summarized in this review is a brief and pragmatic perspective on the evidence with the purpose of informing decision makers about the safety and potential

efficacy of using BDIs in Ontario schools. Evidence related to iCBT, Short Term Interventions, and Dose-Response response relations in child and adolescent mental health was reviewed for this purpose. Rather than working from a top-down systematic review approach, this paper uses a bottom-up question-focused perspective to review the data. As such it is possible there is other relevant research which was not identified in our rapid review process. The conclusions drawn reflect our best understanding of the research reviewed. Should new research be brought to our attention these conclusions may need to be updated. Furthermore, use of these conclusions for other purposes should be done with caution.

Citation

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Table 1
Program and demographic information for existing iCBT programs

Authors (year)	Program name/ Information	Number/ length of Sessions	Age Range	Outcomes	Demographic Information	Used in School-Setting	Clinician Support
Calear et al. (2009)	MoodGym	5 sessions (20-40 minutes each)	12-17	Reductions in anxiety (RCMAS) and depressive symptoms (CES-D) for males only with moderate completion rates	Country Australia Residence Rural (16%) School Demographics private, public, coeducational, single-sex, metropolitan, rural	Yes	Teacher-guided
Khanna & Kendall (2010)	Camp-Cope-A-Lot	12 sessions (35 minutes each) 2 parent sessions	7-13	Reductions in anxiety for those in iCBT condition compared to control	Country United States	No	clinician supported with the last 6 sessions individualized for client
March et al. (2011)	BRAVE-Online	10 child sessions (60 minutes each) 5 parent sessions (60 minutes each) Booster session at 1 and 3 months	12-18	iCBT program produced significant reductions in clinic rated anxiety. Reductions were comparable to clinic-based CBT	Country Australia	No	Clinician supported via web/email
Neil et al. (2009)	MoodGym	5 sessions (20-40 minutes each)	13-17 (school sample) 19 and under (community sample)	Adherence and completion were higher in school-based context compared to community context	Country Australia Residence Rural (195)	Yes	Teacher-guided vs. no support
O'Kearney et al. (2009)	MoodGym	5 sessions (20-40 minutes each)	7-13	No initial reduction in depression (CES-D) but reduction in Tx group 20 weeks post intervention	Gender Female (100%) SES Moderate-high income	Yes	Teacher-guided

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