Low intensity and school based interventions for children with anxiety: outcomes, challenges and future directions

Book or Report Section

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Low intensity and school based interventions for children with anxiety: Outcomes, challenges and future directions.

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Overview

Anxiety disorders are one of the most common mental health problems experienced by children and adolescents. They have a significant impact upon all aspects of everyday functioning including family relationships, friendships, academic attainment and social life. Often childhood anxiety persists and increases the risk of anxiety, depression, substance misuse and educational underachievement in late adolescence and early adulthood.

Effective psychological interventions are available with those based on Cognitive Behaviour Therapy (CBT) having the largest evidence base. Whilst this is encouraging, traditional interventions are very intensive, requiring 9-16 hours of face to face meetings. The availability of appropriately trained CBT therapists is limited. There are increasing demands for specialist child and adolescent mental health services whilst funding for services has become very challenging. Developing low intensity interventions would provide a way of using limited clinical expertise more efficiently.

In addition to improving accessibility to psychological services there is also a need to enhance emotional wellbeing through preventive interventions. Only one third of children with anxiety disorders are ever referred to specialist child and adolescent mental health services for treatment. This has led to interest in the development of preventative interventions in community settings such as schools where CBT based programmes can be

widely provided. However little is known about whether these interventions are acceptable to schools and if they are sustainable.

Major Findings

Recent studies have explored whether low intensity interventions such as bibliotherapy, with limited therapist time, can be effective. Lewis and Ollendick evaluated a four-week bibliotherapy program designed to treat young children with persistent and interfering nighttime fears. Nine children between 5 and 7 years of age with a specific phobia of dark/dark alone were randomized to one of three multiple baseline control conditions (1, 2, or 3 weeks). Parents read a self-help book to their children over four weeks while engaging in activities prescribed in the book. The book was based on CBT principles. The parents were seen for only one pre-bibliotherapy session at which time the book was given to them and they were instructed on how and when to read the book to their child and how to interact with them about any concerns raised while reading the book. Pre-post group analyses revealed that 8 of the 9 children demonstrated clinically significant change in phobia severity – a rate equalling that observed in clinic-based CBT programmes. In addition, decreases in child-reported nighttime fears were observed, as were parent-reported decreases in separation anxiety and increases in the number of nights children slept in their own bed.

Similar positive findings of bibliotherapy were reported by Creswell who randomised 136 children (aged 5-12) to either guided parent-led CBT or solution focused therapy. Both interventions were low intensity and involved 5 hours of contact (by phone or face to face) with a primary child and adolescent mental health worker. The two treatments did not differ on clinical outcomes (diagnostic status, global improvement and parent/child reported

symptoms) with good outcomes achieved across both arms (e.g. 59-69% very/much improved post-treatment). However, economic analyses revealed significant cost-benefits of guided parent-delivered CBT in comparison to solution-focused therapy due primarily to the reduced travel and administrative burden associated with this approach.

Low intensity interventions can also be provided on-line with structured CBT programmes being well suited for adaptation and delivery via computer. Waite provided sixty adolescents with an anxiety disorder with a computerised CBT intervention BRAVE-Online. All adolescents received BRAVE-Online, either immediately or following a 12-week wait, with or without additional parent sessions. The program was effective in that 40% of adolescents were free of their primary anxiety disorder immediately post-treatment and this rose to 60% at 6-month follow-up. There was not a significant difference in treatment outcome between adolescents whose parents had or had not received sessions. This suggests that clinical services with limited clinical resources should not routinely commit additional resources to the provision of parent sessions.

In terms of prevention, Stallard found promising reductions in anxiety at 12 months from a CBT programme (FRIENDS for Life) universally provided in schools to 9-10 year old children (n=1362). Interviews with 115 children found high levels of satisfaction with the programme and examples of on-going skills usage. Teachers (n=47) had mixed views and were concerned about how the programme fitted with the school curriculum and the additional time required for delivery. Almost half of the teachers were unable to identify any tangible changes in the children's behaviour. Whilst prevention programmes might be effective and acceptable to children they need to fit within busy school timetables and be perceived as helpful by teachers if they are to be sustainable.

Clinical Implications.

These findings suggest that low intensity interventions supported by books or computerised programmes achieve comparable outcomes to longer, more clinician intensive interventions. The need for fewer clinic attendances and face to face meetings with a specialist therapist might be more convenient for patients and be an efficient and cost-effective way of delivering services. However, interventions need to be perceived as helpful and fit within existing structures and pathways if they are to be sustainable.

Clinical services should consider developing a stepped care approach to the prevention and treatment of anxiety disorders. The first step would be preventive interventions, co-produced with school staff, based on empirically supported models but which fit within the practical timetabling constraints schools. The second would be low-intensity interventions for those with emerging or established anxiety disorders. Low cost interventions offer increased choice and can be flexibly tailored to the needs and preferences of children and parents. The third step would be intensive interventions for those with complex, co-morbid and enduring anxiety disorders.

Future Directions.

Further work is required to establish the benefits of low intensity interventions. In particular, studies need to determine their acceptability and to understand who they work for and who they do not. The optimal length of treatment needs to be determined and the longer-term effects and cost-benefits established. The use of technology including mobile phone apps to deliver and support interventions should be explored. Finally, the social acceptability of

prevention and low intensity interventions needs to be established. If interventions are not perceived by schools, clinicians, children or families to be acceptable or do not readily fit within a community context or care pathway, they will not be sustainable.

Further Readings.

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3. Skryabina E, Morris J, Byrne D, Harkin N, Rook S, Stallard P. Child, teacher and parent perceptions of the FRIENDS classroom-based universal anxiety prevention programme: a qualitative study. School Mental Health. In Press