

# Mental Health: Universal School-Based Cognitive Behavioral Therapy Programs to Reduce Depression and Anxiety Symptoms

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## Community Preventive Services Task Force Finding and Rationale Statement Ratified February 2019

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## CPSTF Finding and Rationale Statement

### Context

Anxiety and depression are common among children and adolescents. Among children aged 3 to 17 years, 7.1% have been diagnosed with anxiety and 3.2% with depression (Ghandour et al, 2018). These mental health conditions can persist into adulthood and increase risks for suicide, risk-taking behavior (e.g., substance abuse, sexual experimentation), teenage pregnancy, conduct disorder, delinquency, and poor academic outcomes (Anxiety and Depression Association of America, 2018; Weller et al., 2000; Werner-Sielder et al., 2017).

Schools can play an important role in preventing and reducing anxiety and depression as 56.6 million children attend elementary and secondary schools in the United States (National Center for Education Statistics, 2018). Cognitive behavioral therapy (CBT), the most commonly used therapy for anxiety and depression, helps children and adolescents change negative thoughts into more positive, effective behaviors. Implementing CBT programs in schools supports several components of the Whole School, Whole Community, Whole Child (WSCC) Model focused on promoting students' health (CDC, 2018).

### Intervention Definition

Universal school-based cognitive behavioral therapy (CBT) programs to prevent or reduce depression and anxiety symptoms are delivered to all students, regardless of the presence or absence of mental health conditions. These programs help students develop strategies to solve problems, regulate emotions, and establish helpful patterns of thought and behavior.

Trained school staff (e.g., school mental health professionals, trained teachers, nurses) or external mental health professionals (e.g., non-school psychologists, social workers) use therapeutic approaches outlined in an intervention protocol to engage with students in individual or group settings. They deliver the interventions during two or more sessions that are designed to prevent or reduce depression or anxiety symptoms, and promote well-being.

### CPSTF Finding (February 2019)

The Community Preventive Services Task Force (CPSTF) recommends universal school-based cognitive behavioral therapy programs to prevent or reduce depression and anxiety symptoms among all school-aged children and adolescents. The finding is based on strong evidence of effectiveness that children and adolescents participating in universal programs show small decreases in depression and anxiety symptoms.

The CPSTF recommends [Targeted School-Based Cognitive Behavioral Therapy Programs to Reduce Depression and Anxiety Symptoms](http://www.thecommunityguide.org/findings/mental-health-targeted-school-based-cognitive-behavioral-therapy-programs-reduce-depression-anxiety-symptoms) [www.thecommunityguide.org/findings/mental-health-targeted-school-based-cognitive-behavioral-therapy-programs-reduce-depression-anxiety-symptoms] for students who are assessed to be at increased risk for these conditions. The CPSTF also recommends [group](http://www.thecommunityguide.org/findings/violence-psychological-harm-traumatic-events-among-children-and-adolescents-cognitive-behavioral-therapy-group) [www.thecommunityguide.org/findings/violence-psychological-harm-traumatic-events-among-children-and-adolescents-cognitive-behavioral-therapy-group] and [individual](http://www.thecommunityguide.org/findings/violence-psychological-harm-traumatic-events-among-children-and-adolescents-cognitive-behavioral-therapy-individual) [www.thecommunityguide.org/findings/violence-psychological-harm-traumatic-events-among-children-and-adolescents-cognitive-behavioral-therapy-individual] CBT to reduce psychological harm from traumatic events among children and adolescents.

## Rationale

### Basis of Finding

The CPSTF uses recently published systematic reviews to conduct accelerated assessments of interventions that could provide program planners and decision makers with additional, effective options. The following published review was selected and evaluated by a team of specialists in systematic review methods, and in research, practice, and policy related to mental health:

Werner-Seidler A, Perry Y, Calear AI, Newby JM, Christensen H. School-based depression and anxiety prevention programs for young people: a systematic review and meta-analysis. *Clinical Psychology Review* 2017;51:30-47.

The published systematic review included 81 studies (77 studies included in meta-analysis; search period through 2015). The Community Guide systematic review team examined CBT programs for universal school-based programs (38 studies) and targeted school-based programs (29 studies) separately. This document outlines evidence for the universal programs. Ten studies from the published review were excluded because they either did not evaluate CBT programs or they did not provide data for analysis.

The team modified the intervention definition and examined the subset of eight studies from the United States in order to determine applicability. The team collected additional data on study, intervention, and population characteristics; calculated medians and interquartile intervals (IQI) for the summary effect estimates; and performed stratified analyses. Data from the subset were compared with the overall body of evidence. The final CPSTF assessment considered the findings of the published review, additional information from the included studies, and expert input from the team and the CPSTF.

Depression symptoms were most frequently measured with the Children’s Depression Inventory, followed by the Beck Depression Inventory. Anxiety symptoms were most frequently measured with the Spence Children’s Anxiety Scale, followed by the Multidimensional Anxiety Scale for Children. Evidence from included studies showed universal school-based CBT interventions led to small reductions in depression and anxiety symptoms among children and adolescents when compared to control groups. Outcomes were similar in the subset of studies from the United States and the overall body of evidence for depression (see Table 1). There were too few U.S. studies to compare anxiety outcomes.

**Table 1: Depression and Anxiety Symptoms, Overall and U.S. Studies**

Outcome	Overall (38 studies)		U.S. Subset (8 studies)	
	Studies (Comparisons)	Calculated Median Hedges’ g	Studies (Comparisons)	Calculated Median Hedges’ g
Depression Symptoms	27 (37)	0.20 (IQI: 0.11 to 0.39)	8 (11)	0.23 (IQI: 0.20 to 0.44)
Anxiety Symptoms	25 (31)	0.18 (IQI: 0.06 to 0.32)	3 (3)	0.71 (Range: 0.23 to 0.85)

Interquartile Interval (IQI) is calculated for 5 or more comparison groups; range is reported for 4 or less comparison groups.

Estimated interpretations for Hedges’ g effect sizes: 0.2-0.49 = small effect; 0.5-0.79 = moderate effect; ≥0.8 = large effect; 1 = two groups differ by 1 standard deviation.

Comparison numbers are greater than study counts because several studies had multiple study arms.

*Stratified Analyses*

The team performed stratified analyses to examine the potential influence of intervention and participant characteristics on outcomes (see Tables 2 and 3). Reductions in depression and anxiety symptoms were reported for interventions delivered by external mental health professionals or trained school staff. CBT programs delivered to adolescents reported small reductions in depression and anxiety symptoms.

**Table 2: Depression Symptoms Stratified by Intervention and Participant Characteristics, Overall and U.S. Studies**

		Overall (38 studies)		U.S. Subset (8 studies)	
		Studies (Comparisons)	Calculated Median Hedges' g	Studies (Comparisons)	Calculated Median Hedges' g
Personnel delivering program <sup>a</sup>	Trained School Staff	12 (13)	0.20 (IQI: 0.10 to 0.28)	2 (3)	0.20 (Range: 0.06 to 0.21)
	External Mental Health Professional	16 (24)	0.22 (IQI: 0.06 to 0.42)	6 (9)	0.38 (IQI: 0.13 to 0.49)
Student Age	Child (<10 years)	2 (2)	(Range: 0.20 to 0.53)	0	--
	Younger adolescents (10–14 years)	14 (22)	0.20 (IQI: 0.10 to 0.38)	3 (5)	0.21 (IQI: 0.11 to 0.39)
	Older adolescents (> 14 years)	9 (10)	0.30 (IQI: 0.09 to 0.47)	6 (7)	0.23 (IQI: 0.06 to 0.54)
Number of sessions	2-7 sessions	4 (4)	0.15 (Range: 0.06 to 0.36)	1 (1)	0.06
	8-12 sessions	21 (29)	0.20 (IQI: 0.09 to 0.39)	7 (12)	0.22 (IQI: 0.14 to 0.43)
	13-24 sessions	2 (3)	0.29 (IQI: 0.12 to 0.41)	0	--

<sup>a</sup> Personnel delivering program: external mental health professionals—mental health professionals or researchers; trained school staff— classroom teachers, counselors, or nurses

Interquartile Interval (IQI) is calculated for 5 or more comparison groups; range is reported for 4 or less comparison groups.

General interpretations for Hedges' g effect sizes: 0.2-0.49 = small effect; 0.5-0.79 = moderate effect; ≥0.8= large effect; 1 = two groups differ by 1 standard deviation.

**Table 3: Anxiety Symptoms Stratified by Intervention and Participant Characteristics, Overall and U.S. Studies**

		Overall (38 studies)		U.S. Subset (8 studies)	
		Studies (Comparisons)	Calculated Median Hedges' g (IQI: 0.04 to 0.29)	Studies (Comparisons)	Calculated Median Hedges' g (Range: 0.23 to 0.85)
Personnel delivering program <sup>a</sup>	Trained School Staff	12 (13)	0.16 (IQI: 0.04 to 0.29)	0	--
	External Mental Health Professional	13 (18)	0.23 (IQI: 0.08 to 0.33)	3 (3)	0.71 (Range: 0.23 to 0.85)
Student Age	Child (<10 years)	7 (9)	0.06 (IQI: 0.03 to 0.26)	0	--
	Younger adolescents (10–14 years)	11 (15)	0.18 (IQI: 0.10 to 0.32)	1 (1)	0.20
	Older adolescents (> 14 years)	5 (5)	0.34 (IQI: 0.09 to 0.78)	2 (2)	(Range: 0.71 to 0.85)
Number of sessions	2-7 sessions	4 (4)	0.27 (Range: 0.16 to 0.37)	0	--
	8-12 sessions	21 (27)	0.17 (IQI: 0.04 to 0.29)	3 (3)	0.71 (Range: 0.23 to 0.85)
	13-24 sessions	1	0.101	0	--

<sup>a</sup> Personnel delivering program: external mental health professionals—mental health professionals or researchers; trained school staff— classroom teachers, counselors, or nurses

Interquartile Interval (IQI) is calculated for 5 or more comparison groups; range is reported for 4 or less comparison groups.

General interpretations for Hedges' g effect sizes: 0.2-0.49 = small effect; 0.5-0.79 = moderate effect; ≥0.8 or greater = large effect; 1 = two groups differ by 1 standard deviation.

**Applicability and Generalizability Issues**

The systematic review included eight studies from the United States. Information in this section describes this subset of studies.

*Intervention settings*

Of the eight studies that reported school setting, two evaluated interventions in private schools. Studies were conducted in high schools (5 studies) and middle schools (3 studies). No studies were conducted in elementary schools.

*Demographic characteristics*

Most of the studies focused on adolescents (10-17 years of age); none were conducted with children under age 10. Studies included white, black, Hispanic and Asian students; white students made up the majority of participants. Studies included a balance of male and female students across all socioeconomic groups.

### *Intervention characteristics*

#### Number of sessions:

The included CBT programs delivered between 5-12 sessions. None of the programs offered booster sessions.

#### Personnel delivering program:

External mental health professionals included psychologists, researchers, psychology graduate students, mental health nurses, or social workers (6 studies). Trained school staff who delivered interventions were teachers, guidance counselors, or school psychologists (2 studies).

### Data Quality Issues

All studies were randomized control trials.

Werner-Seidler et al. used reporting criteria set by the Preferred Reporting Items Systematic Reviews and Meta-Analyses (PRISMA) Guidelines (Moher et al., 2009) and Cochrane Collaboration 'Risk of Bias' tool (Higgins et al., 2011).

Common limitations in the body of evidence included selection bias, with only 16% of studies reporting the allocation sequence had been adequately generated. The majority of studies did not report enough information to determine if intervention allocations could have been foreseen before or after study enrollment. There was potential contamination between study conditions in 55% of the studies. In addition, participants enrolled in control groups may have had access to material covered in the intervention sessions.

### Other Benefits and Harms

Additional benefits of universal school-based CBT interventions were identified by Werner-Seidler et al. They included removing the need for screening, minimizing stigma associated with singling out some students, and capturing youth who are not currently at risk, but may go on to develop symptoms in the future. The CPSTF postulates the intervention could improve social interactions among students with shared or similar experiences, students' learning abilities (e.g., standardized math and reading test scores), classroom function, and family management of youth with anxiety.

The CPSTF also noted potential harms of the intervention. Students sharing intimate feelings and experiences might be vulnerable to harmful consequences (e.g., bullying, mockery, rumors, privacy concerns). Discussions could also trigger student emotions that require professional attention exceeding the capacities of those delivering the intervention.

### Considerations for Implementation

The following considerations for implementation are drawn from studies included in the existing evidence review, the broader literature, and expert opinion.

- Confidentiality of student information should be a priority, and policies should be clearly communicated to parents and students, especially when there will be group sessions.
- Parents should be notified when students participate in programs or receive mental health services (though this must be balanced with student confidentiality).
- Students should have access to additional mental health services in case issues arise (either on-site or by referral).
- Referral processes should be in place and consistently followed by staff who detect possible child maltreatment or risk of harm to self or others.

- Schools should decide whether trained school personnel or external mental health professionals will deliver program components (balancing potential effects against resource limitations).
  - School staff may be familiar with the student population and school environment, and there may be greater opportunities for program sustainability. They may not, however, have mental health training that would prepare them to handle additional issues.
  - External mental health professionals are professionally trained for mental health issues, but they may not be as familiar with individual students, and additional funding may be required.
- Based on the needs of the student population, school administrators may prefer universal programs. They are easier to schedule and allow for early identification of mental health issues.
- Schools should decide whether universal CBT programs, targeted CBT programs for at-risk individuals, or both, are best suited for their student population. Some schools may prefer a stepped approach to deliver universal CBT programs first, followed by targeted CBT programs for at-risk, symptomatic individuals who did not respond to the universal program. Other schools may prefer to deliver one program only.

### Evidence Gaps

Werner-Seidler et al. suggested a need for additional research and evaluation to answer the following research questions and fill existing gaps in the evidence base.

- How can advances in technology be used to improve intervention reach and availability at a population level?
- What are the infrastructure and personnel needs required to sustain programs?

The CPSTF further identified the following evidence gaps as areas for future research:

- Which strategies best balance the need for parental awareness with child confidentiality?
- What are the long-term effects of early interventions to reduce anxiety and depression symptoms?
- Are programs equally effective in public and private school settings?
- How effective are programs implemented with non-white children or children under 10 years of age?
- What are the follow-up approaches that best support the maintenance of program effects over time?

### References

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## Disclaimer

The findings and conclusions on this page are those of the Community Preventive Services Task Force and do not necessarily represent those of CDC. Task Force evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information and options for decision makers and stakeholders to consider when determining which programs, services, and policies best meet the needs, preferences, available resources, and constraints of their constituents.

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