Evaluating Coverage Needs for Anxiety among Youth of Color in the District

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Methodology

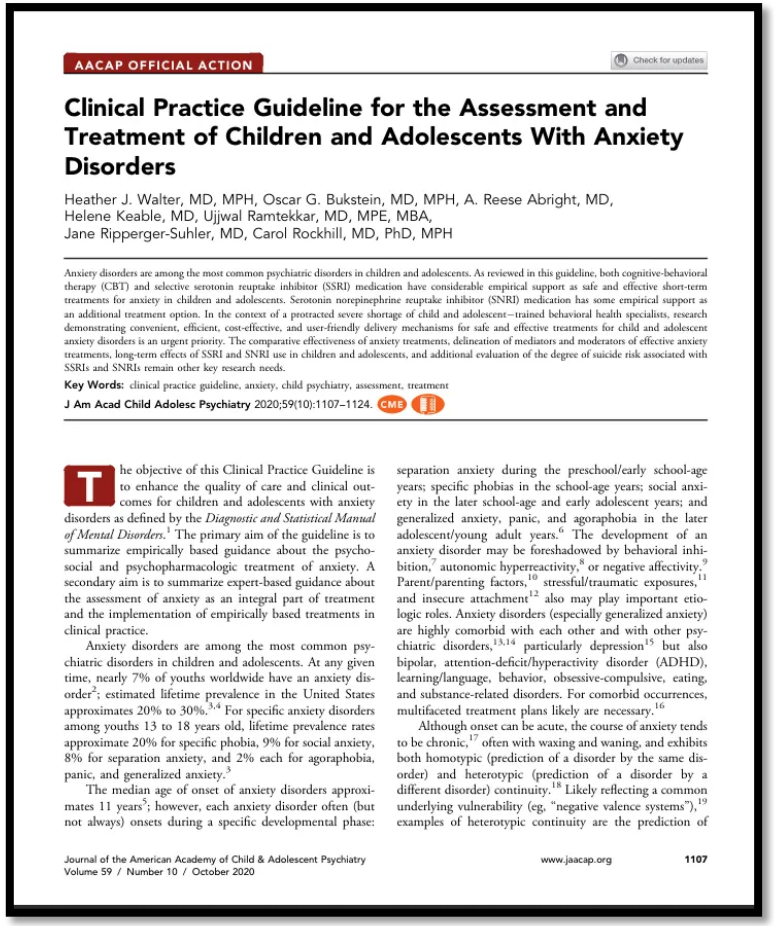
- Analysis of Publicly Available Data
- Review of Clinical Guidelines
- Analysis of Electronic Medical Record (EMR) Data
- Qualitative Interviews with Behavioral and Medical Health Providers

Analysis of Publicly Available Data

- Approximately 1/3 of the U.S. population has met diagnostic criteria for an anxiety disorder in their lifetime
- Initial anxiety symptoms occur early: median age of onset is 11 years
- Around 9 percent of 13- to 18- year-olds nationwide meet the criteria for severe anxiety disorders
- In DC, children in Wards 8, 1, 6, and 7 have the highest levels of serious emotional disturbance
- Though anxiety is common among youth of color, they are less likely than white youth to receive an anxiety diagnosis, which is related to access barriers such as cost
- According to the DC YRBS, mental health concerns are most common among multi-racial, Black, Asian, and Hispanic high school students who identify as LGBTQ+
- 48 percent of LGBTQ+ youth nationwide report not receiving needed mental health care

Review of Clinical Guidelines

- Reviewed publicly available clinical guidelines for treatment of child and adolescent psychiatric disorders
- Most guidelines were found to be not inclusive of racial, ethnic, sexual, or gender minorities
- For example, the AACAP guidelines cite a Mayo Clinic review that provides treatment recommendations based solely on studies predominately conducted among white populations
- **This gap reflects a larger trend within mental and behavioral health research**



AACAP OFFICIAL ACTION

Check for updates

Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders

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Anxiety disorders are among the most common psychiatric disorders in children and adolescents. As reviewed in this guideline, both cognitive-behavioral therapy (CBT) and selective serotonin reuptake inhibitor (SSRI) medication have considerable empirical support as safe and effective short-term treatments for anxiety in children and adolescents. Serotonin norepinephrine reuptake inhibitor (SNRI) medication has some empirical support as an additional treatment option. In the context of a protracted severe shortage of child and adolescent–trained behavioral health specialists, research demonstrating convenient, efficient, cost-effective, and user-friendly delivery mechanisms for safe and effective treatments for child and adolescent anxiety disorders is an urgent priority. The comparative effectiveness of anxiety treatments, delineation of mediators and moderators of effective anxiety treatments, long-term effects of SSRI and SNRI use in children and adolescents, and additional evaluation of the degree of suicide risk associated with SSRIs and SNRIs remain other key research needs.

Key Words: clinical practice guideline, anxiety, child psychiatry, assessment, treatment

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The objective of this Clinical Practice Guideline is to enhance the quality of care and clinical outcomes for children and adolescents with anxiety disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders*.[1] The primary aim of the guideline is to summarize empirically based guidance about the psychosocial and psychopharmacologic treatment of anxiety. A secondary aim is to summarize expert-based guidance about the assessment of anxiety as an integral part of treatment and the implementation of empirically based treatments in clinical practice.

Anxiety disorders are among the most common psychiatric disorders in children and adolescents. At any given time, nearly 7% of youths worldwide have an anxiety disorder[2]; estimated lifetime prevalence in the United States approximates 20% to 30%.[3,4] For specific anxiety disorders among youths 13 to 18 years old, lifetime prevalence rates approximate 20% for specific phobia, 9% for social anxiety, 8% for separation anxiety, and 2% each for agoraphobia, panic, and generalized anxiety.[3]

The median age of onset of anxiety disorders approximates 11 years[5]; however, each anxiety disorder often (but not always) onsets during a specific developmental phase: separation anxiety during the preschool/early school-age years; specific phobias in the school-age years; social anxiety in the later school-age and early adolescent years; and generalized anxiety, panic, and agoraphobia in the later adolescent/young adult years.[6] The development of an anxiety disorder may be foreshadowed by behavioral inhibition,[7] autonomic hyperreactivity,[8] or negative affectivity.[9] Parent/parenting factors,[10] stressful/traumatic exposures,[11] and insecure attachment[12] also may play important etiologic roles. Anxiety disorders (especially generalized anxiety) are highly comorbid with each other and with other psychiatric disorders,[13,14] particularly depression[15] but also bipolar, attention-deficit/hyperactivity disorder (ADHD), learning/language, behavior, obsessive-compulsive, eating, and substance-related disorders. For comorbid occurrences, multifaceted treatment plans likely are necessary.[16]

Although onset can be acute, the course of anxiety tends to be chronic,[17] often with waxing and waning, and exhibits both homotypic (prediction of a disorder by the same disorder) and heterotypic (prediction of a disorder by a different disorder) continuity.[18] Likely reflecting a common underlying vulnerability (eg, "negative valence systems"),[19] examples of heterotypic continuity are the prediction of

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Analysis of Electronic Medical Record (EMR) Data

- Extracted data from the Whitman-Walker Health EMR of patients who have had a visit since 2015 with the relevant anxiety ICD-10 diagnostic codes
- Data included diagnosis codes, age, race, ethnicity, gender, sexual orientation, laboratory tests, and prescribed medications
- These data were used to create treatment scenarios for presentation to medical and behavioral health providers

ICD-10 Code	Code Description
F40.10	Social phobia, unspecified
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42.9	Obsessive-compulsive disorder, unspecified
F43.20	Adjustment disorder, unspecified
F43.21	Adjustment disorder with depressed mood
F43.22	Adjustment disorder with anxiety
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F43.9	Reaction to severe stress, unspecified

EMR Data: Medications

Most common medications at primary care visits:
SSRIs/SNRIs
Anticonvulsants
Other antidepressants
Benzodiazepines
Other anxiolytics, including beta blockers
Most common medications at new mental health visits:
SSRIs/SNRIs
Antihistamines
Anxiolytics
Most common medications at mental health follow-up visits:
SSRIs/SNRIs
Antihistamines
Benzodiazepines
Other anxiolytics

EMR Data: Unique Visit Types

Service Type	Visit Type	Specialty	Description	Modality	Average (median) [range] # of Visits/Year
Primary Care	New	Internal Medicine, Infectious Disease, Family Medicine, Gynecology	New medical visit	In-person	1 (1)
	Follow-Up	Internal Medicine, Infectious Disease, Family Medicine, Gynecology	Medical follow-up	In-person	2 (2)
			Medical phone/audio only visit	Phone/audio	1 (1)
			Medical TeleVisit	Video	2 (2)
		Physical Exam	Medical physical exam	In-person	1 (1)
		Acute Encounter	Medical urgent visit	In-person	1 (1)
Mental Health	New	Behavioral Health/Psychiatry	New patient, screening/assessment	In-person	2 (1)
			New patient, screening/assessment, audio/phone only	Phone/audio	1 (1)
			New patient, screening/assessment, TeleVisit	Video	2 (1)
	Follow-Up	Behavioral Health/Psychiatry	Individual	In-person	5 (3) [1-10]
			Individual phone/audio only	Phone/audio	12 (4) [1-66]
			Individual TeleVisit	Video	10 (4) [1-131]
			Group TeleVisit	Video	4 (3) [1-14]

Qualitative Interviews with Behavioral and Medical Health Providers

- Conducted qualitative interviews with 5 Whitman-Walker Health behavioral and medical health providers to understand their experiences in caring for young patients of color
- Providers often do check if patients are insured but are mostly unaware as to the specific costs of mental health care to their patients
- Where applicable, providers will try to bypass insurance altogether for patients who fit the criteria for a grant from DC's Office of Victim Services and Justice
- Most frequently, providers prescribe a combination of medications (often SSRIs) and therapy for patients with anxiety
    - For medications, cost-sharing is a barrier, particularly for some patients of color who may have adverse side effects to common medicines and may need to try more options
    - For therapy, cost-sharing in the form of co-pays for visits is prohibitive
- Young patients prefer options for therapy modalities, including telehealth/audiohealth and individual and group therapy

Questions?

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Thank you.

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