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Has evidence-based psychosocial treatment for anxiety disorders permeated usual care in community mental health settings?

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A B S T R A C T

Cognitive behavioral therapy (CBT), particularly when it includes an exposure component, is an empirically supported psychosocial treatment for anxiety disorders that has been shown to be highly efficacious, desirable to patients, and cost-effective. However, access to and receipt of exposure-based treatment CBT anxiety remains lacking despite these benefits. The current study reviewed electronic medical records at a large public outpatient psychiatry clinic in order to clarify what usual care for anxiety disorders entails, and to determine the extent to which effective psychosocial treatment is accessible to, and implemented with anxiety disorder patients. Database queries generated from the billing and medical record system at the Los Angeles County Adult Outpatient Psychiatry Clinic identified 582 patients presenting with an anxiety disorder diagnosis in a 6-month time frame. These patients' electronic medical records were reviewed using a standardized data collection form. Findings indicated that the majority of patients received pharmacological treatment for their anxiety. The majority of the psychosocial treatment delivered was supportive therapy. Among the minority of patients who did initiate CBT, an even smaller minority received treatment that included an exposure component, and those who did receive exposure likely received a sub-optimal dose. Understanding usual care delivery patterns is an important preliminary step to identifying and addressing barriers to optimal anxiety disorder treatment in adult community mental health settings.

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The President's New Freedom Commission (2004), the National Institute of Mental Health (Insel, 2009), and leading researchers (see Santucci, McHugh & Barlow, 2012) all highlight the concern that access to and receipt of evidence-based treatment (and in particular, psychosocial treatment) for mental health disorders remains shockingly low. Indeed, the Institute of Medicine (Kohn, Corrigan, & Donaldson, 2001, p.1) has characterized the low uptake of evidence-based practice as “not just a gap, but a chasm.” In particular, national surveys suggest that the dissemination gap for exposure-based treatment for anxiety disorders is particularly large (Hipol & Deacon, 2013; Weissman, Verdeli, Gameroff, Bledsoe, Betts et al., 2006).

Exposure-based treatment, which involves gradual confrontation with feared stimuli, is the treatment of choice for anxiety disorders (see Barlow, 2002). Either delivered as one component of a multi-component cognitive behavioral therapy (CBT) package or as a stand-alone intervention, exposure-based therapy shows large and robust effects in efficacy studies (e.g., Butler, Chapman, Forman, & Beck, 2006; Chambless & Ollendick, 2001; Deacon & Abramowitz, 2004) as well as effectiveness studies in a variety of clinical settings (Roy-Byrne et al., 2010; Stewart & Chambless, 2009; Stuart, Treat, & Wade, 2000). Several studies have demonstrated that CBT for anxiety disorders is at least as effective as medication (primarily referring to SSRIs) in the short-term and shows superior effects in the long-term (Gould, Otto, & Pollack, 1995, 1997; Hofmann, Sawyer, Korte, & Smits, 2009; Roshanaei-Moghaddam et al., 2011). Further, CBT is superior to other forms of psychotherapy for the treatment of anxiety disorders (Tolin, 2010). Thus, many consider exposure-based CBT to represent the first-line treatment for most anxiety disorders (Arch & Craske, 2009; Barlow, 2002).

Exposure-based treatment represents the most scientifically supported psychosocial treatment for anxiety disorders, yet the

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majority of U.S. adults do not know it exists (Arch, Twohig, Deacon, Landy, & Bluett, 2015; Gallo, Comer, & Barlow, 2013). Studies reveal that only 7% (Goisman, Warshaw, & Keller, 1999) to 11% (Young, Klap, Sherbourne, & Wells, 2001) of adults with anxiety disorders receive an appropriate, evidence-based psychosocial treatment for these disorders. Thus, there exist empirically supported psychosocial treatments for anxiety disorders but they remain largely inaccessible to the population that needs them.

Although some successful dissemination and implementation efforts have been made in community mental health settings for children (Chorpita, Taylor, Francis, Moffitt, & Austin, 2004; Cohen & Mannarino, 2008; Weisz et al., 2012), the vast majority of *adults* in community mental health settings do not have access to these evidence-based psychosocial treatments. This lack of access is particularly striking when considering that: (1) effective psychosocial treatments are more cost-effective than pharmacological interventions (Otto, Pollack & Maki, 2000; Roberge, Marchand, Reinharz, Marchand, & Cloutier, 2004); and (2) across every study in which adults are provided education and choice about evidence-based treatments for anxiety, the vast majority prefer exposure-based psychosocial treatment over medication treatment of anxiety (e.g., Arch, 2014; Deacon & Abramowitz, 2005; Feeny, Zoellner, Mavissakalian, & Roy-Byrne, 2009). Lacking knowledge of exposure-based treatment, adults in our communities with anxiety disorders cannot make informed decisions about their mental health care. They then risk investing time and resources on less effective or ineffective treatments (Lilienfeld, Lynn, & Lohr, 2003). In that most adults served in community mental health settings are low-income, they especially cannot afford to invest their limited resources in sub-optimal treatment.

If patients are not receiving exposure-based CBT for their anxiety disorders in community mental health practices, what are they receiving instead? How often are they offered CBT, and how often do they actually undergo a therapeutic dose of CBT with an exposure component in particular? Although large-scale CBT (and particularly exposure) dissemination efforts are lacking in adult community practices (with the exception of the Veterans Administration; Cook et al., 2013; McLean & Foa, 2013), smaller-scale training and dissemination efforts may be taking place in naturalistic ways (i.e., not in the context of a large-scale, funded research project) and permeating typical care in clinical settings. However, we know very little about the actual practices and patterns of treatment delivery in these settings. In order to set priorities for identifying targets to improve practices (e.g., training, addressing systemic or environmental barriers), we must first understand on a more detailed level what patients at community mental health centers are receiving for their anxiety disorder treatment. A better understanding of the patient population and the treatments they are receiving may help to develop a framework for understanding the factors that contribute to this research-to-practice gap by uncovering barriers to successful dissemination and implementation of evidence-based psychosocial treatment for anxiety disorders.

Our overarching goal is to clarify what usual care for anxiety disorders entails at an adult community mental health setting in order to empirically examine the extent to which CBT is accessible to and implemented with low-income adults suffering from anxiety disorders in community mental health settings. We aim to contribute to knowledge that can be used to understand the broader challenges of implementing CBT for anxiety disorders in these settings. The current study thus aims to address several unanswered questions about anxiety disorder treatment delivery and patterns of care within adult community mental health settings. First, we aim to describe the patient characteristics, particularly anxiety disorder diagnoses, at a large, urban, county-funded psychiatry clinic serving thousands of diverse, low-income patients. Second, we aim to elucidate the nature and course of the treatments received by the patients in this clinic. Specifically, we aimed to answer the following questions: (1) What do low-income, predominantly minority adult patients presenting at a large, urban community mental health clinic receive for their anxiety disorder treatment? (2) How often do they initiate CBT and for how long do they continue a course of treatment? (3) How often does CBT include an exposure component? We hypothesized that the majority of patients with anxiety disorders would receive pharmacotherapy and supportive therapy and that only a minority of patients would receive CBT. We also hypothesized that even among the minority of those who received CBT, few to none would receive exposure, arguably the most effective component of CBT treatment.

1. Methods

1.1. Participants

Electronic medical records (EMR) reviewed were those of patients ($N = 582$) at the Los Angeles County Adult Outpatient Psychiatry Clinic (AOPC) who (a) visited the clinic at least once from December 31, 2013–June 30, 2014 and (b) had at least one visit that was billed with any DSM-IV anxiety disorder diagnosis code [i.e., panic disorder with agoraphobia, panic disorder without agoraphobia, agoraphobia without panic attacks, specific phobia, social phobia, post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD), or anxiety disorder not otherwise specified (NOS)]. See below (Patient Characteristics and Visits) for descriptive information about the sample obtained from the chart review.

1.2. Clinic

The Los Angeles County AOPC serves thousands of diverse, low-income psychiatric patients. Clinicians include resident and attending psychiatrists affiliated with the University of Southern California, social workers, and psychologists. Third year psychiatry residents comprise a large percentage of the workforce at the AOPC (approximately 75%), and receive basic CBT training and supervision during their time on the AOPC rotation. The 3rd year residents are also expected to carry a caseload of at least 2–3 CBT cases per year. Doctoral-level (PhD and MD) clinicians with expertise in CBT provide weekly, group supervision to residents on these cases as well as approximately 8 h of didactic training (as part of the residents' didactic lecture series) in CBT over the course of the one-year rotation. Didactic training includes basic skills training in CBT for a variety of psychiatric disorders, as well as a few disorder-specific lectures. Thus, this clinic is representative of other large county clinics but potentially has a larger percentage of clinicians receiving at least basic training and supervision in CBT given its role as a psychiatrist training clinic. Although other county clinics across the country have resident clinicians under similar circumstances, this requirement may not be representative of the average community clinic. The clinic has no formal policy encouraging the use of CBT but informally encourages scientifically supported treatment approaches. In sum, the targeted clinic likely represents a “best case scenario” for CBT delivery among county-based clinics serving similar patient populations.

1.3. Measures/data collection

Collection of all data in the Los Angeles County electronic medical record (EMR) system was approved by the institution's IRB. Data was collected via database queries generated from the billing

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