



Short communication: A report of the first twelve months of an early intervention service for obsessive-compulsive disorder (OCD)

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ABSTRACT

Objectives: To present a report on the first twelve months of an early intervention service for patients with obsessive-compulsive and related disorders.

Methods: Demographic and clinical data including changes in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) and the Obsessive Compulsive Inventory – Revised (OCI-R) were reported for 48 patients referred to the Western Sydney Obsessive-Compulsive and Related Disorders Service during the first 12 months of its operation.

Results: The service provided education, training and specialised quaternary level assessment and recommendations to patients who have already been assessed by a psychiatrist and/or mental health worker within early intervention teams for psychosis, anxiety clinics and other public psychiatric services. The service failed to reach OCD sufferers early in their course of illness with the mean time from symptom onset being 9.4 years. The use of objective measures such as the Y-BOCS and OCI-R at follow-up was poor and 86.0% ($n = 37$) remained in treatment at 12 months.

Conclusions: An early intervention service for OCD is unlikely to be able to assist sufferers early in their course of illness if it is associated with quaternary clinical services or early intervention programmes for psychosis. Efforts might be better focused on providing education and on early screening of young people in non-clinical settings.

1. Introduction

Obsessive-compulsive disorder (OCD) is a disorder characterised by recurrent, intrusive and distressing thoughts, images or impulses, e.g. concerns about contamination or recurrent sexual images, that are usually accompanied by repetitive behaviours or mental acts, e.g. checking or counting in one's head. OCD has a childhood onset in about half of all OCD sufferers [1], often in adolescence, when children are forming longer term peer relationships, their identity, and working harder at school in order to set the foundations for a future career. OCD is thought to contribute 2.2% of all years life lost (YLL) to disability [2], with long lasting economic costs to society that are estimated to be over \$10 billion dollars per year in the United States alone [3]. With many patients reporting subclinical symptoms prior to the development of their disorder, a five-fold increased risk of developing OCD with an affected first degree relative [4], and an average of seven years delay between symptom development and treatment [5,6], clinicians are

taking note of emerging research indicating that early treatment is associated with improved outcomes [7] and are calling for early intervention programs for OCD [8,9].

Early intervention programs for psychosis have been successfully operating in Australia for over 15 years [10]. It is argued that they have provided cost efficient early recognition and treatment to thousands of young people suffering from psychosis and improved the quality of care delivered to these people and their families [11,12]. This paper aims to describe a new service that aimed to work closely with services providing early intervention for psychosis.

2. Methods

Descriptive statistics were used to evaluate data obtained from electronic medical records pertaining to the first 12 months of operation of the Western Sydney Obsessive-Compulsive and Related Disorders Service. Data included the demographic and clinical characteristics of

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patients referred to and assessed by the service and the standardized measures used by clinicians in the service. These were the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) [13], the Obsessive-Compulsive Inventory- Revised (OCI-R) [14]. An electronic medical records system was used to document the assessment and to record and present results of the standardized assessments. Patient progress was evaluated by graphing scores for these measures and the graphs were shared with patients as an objective indicator of their progress. Ethics approval was granted by the Western Sydney Local Health District Human Research Ethics Committee (2019/ETH12991).

The Western Sydney Local Health District is one of five local health districts in New South Wales (NSW), Australia. These districts are public funded by the NSW government. The district services a population of approximately one million people in the western geographical area of Sydney which tends to be working class and of lower socioeconomic status than the eastern regions of Sydney. There are five hospitals within the health district, one being a stand-alone psychiatric hospital. There are psychiatric units within two of the other hospitals and the area has 14 community mental health services, two of which provide early intervention for psychosis. The Western Sydney Obsessive-Compulsive and Related Disorders Consultation Service was closely affiliated with the two early intervention services for psychosis and the single anxiety clinic that served the area.

3. Results

The Western Sydney Obsessive-Compulsive and Related Disorders Service was developed over a three-year period after a comprehensive literature review on early intervention for OCD and extensive consultation with existing early intervention service providers for psychosis programs in our local area and with local health service administrators. The service eventually developed as a consultative service to provide second opinions and guidance to service providers who were less experienced with treating OCD and related disorders. The core team consisted of a consultant psychiatrist (author VB) and two clinical psychologists (authors VF, JP) from early intervention teams for psychosis. These clinicians contributed to this service in a role above and beyond their set clinical duties, due to their special interest. Other clinicians, psychiatry registrars, psychology students and medical students often participated in the assessment. Referrals are made by emailing a referral form and these referrals are then assessed and prioritized at a weekly intake meeting. The aim of this meeting is to be able to see new referrals within a week. Regular education sessions are held with a variety of staff to increase awareness of OCD and related disorders and the evidence-based treatments that are available. There is a weekly OCD specific peer supervision group where all interested clinicians are invited to discuss cases and discuss related topics of interest. There was also a monthly OCD group for sufferers which aimed to provide support and psychoeducation, it was co-chaired by a member of the core team and a peer worker but the group was poorly attended and only four groups were held prior to the COVID-19 pandemic.

The service assessed 48 individuals in the first 12 months of operation, i.e. from September 2018 to September 2019. The demographic and clinical characteristics are shown in Table 1. Although the majority of referrals had a primary diagnosis of OCD, other primary disorders with comorbid OCD, such as schizophrenia, bipolar disorder and borderline personality disorder were common. Common co-occurring obsessive-compulsive related diagnoses included: dermatillomania (14.5%, $n = 7$); onychophagia (10.4%, $n = 5$); and hoarding disorder (8.3%, $n = 4$). Just over 10% of those referred had been suicidal in last month (12.5%, $n = 6$). A significant proportion of patients (41.7%, $n = 20$) reported an history of OCD in a first degree relative. Most of those referred had reported trials of psychotropic medication in the past, however only around one fifth had reported receiving ERP (20.8%, $n = 10$). Referrals came primarily from early intervention services (50%, $n = 24$), but also from other community teams (37.5%, $n = 18$) and in-

Table 1

Demographic and clinical characteristic of patients referred to the service ($n = 48$).

	Mean (years)	Range
Age	28.2	33–66
	n	%
Proportion male	25	52.1
Marital status		
- Single	40	83.3
- Married	6	12.5
- De facto	1	2.1
- Widowed	1	2.1
Dependents		
- No children	41	85.4
- One or more children	7	14.6
Education		
- Completed secondary school	29	60.4
- Completing secondary school	8	16.7
- Primary level schooling	7	14.6
- Tertiary education	4	8.3
Currently unemployed	42	87.5
First degree relative with OCD	20	41.7
Clinical diagnoses:		
- OCD	20	41.7
- Schizophrenia	16	33.3
- Tic disorder	10	20.8
- PTSD	9	18.8
- Dermatillomania	7	14.5
- Autism spectrum disorder	6	12.5
- Onychophagia	5	10.4
- Bipolar disorder	4	8.3
- Hoarding disorder	4	8.3
- Borderline personality disorder	3	6.3
- Body dysmorphic disorder	2	4.2
- Substance use disorder	2	4.2
- Intellectual disability	1	2.1
Comorbidity		
- >1 comorbid psychiatric disorder	36	75.0
- >2 comorbid psychiatric disorders	22	45.8
Previous treatment with SSRI	39	81.3
Previous treatment with clomipramine	5	10.4
Previous treatment with antipsychotic	38	79.2
Previous ERP	10	20.8
	Mean	n
Initial Y-BOCS score	20.5	43
Initial OCI-R score	27.0	42

OCD = Obsessive-compulsive disorder, PTSD = Posttraumatic stress disorder, SSRI = Selective Serotonin Reuptake Inhibitor, ERP = Exposure and Response Prevention Therapy, Y-BOCS = Yale-Brown Obsessive Compulsive Scale, OCI-R = Obsessive Compulsive Inventory-Revised.

patients of psychiatric wards (12.5%, $n = 6$).

The most frequent recommendations after the initial assessment were to: increase the dose of the SSRI; add ERP; change the SSRI; add an augmenting antipsychotic; change the augmenting antipsychotic; change to clomipramine; and family interventions. Tertiary prevention strategies became a very important focus of the service. Tertiary prevention is not early intervention, but has significant potential when considering that patients experience delays in receiving evidence-based therapies, e.g. exposure and response prevention, and harmful complications such as depression, suicidal ideation, renal impairment, skin conditions and contractures. The average duration of time from initial assessment to the first onset of OCD symptoms was 9.4 years.

Despite training of clinicians, the completion of the Y-BOCS and OCI-R scales were poor at follow-up with only 41.9% ($n = 18$) completing the Y-BOCS and only 23.8% ($n = 10$) completing the OCI-R at follow-up. Although follow-up measures were intended to occur at six months, the time of follow-up assessments varied between four and nine months. In the people that completed the scales at follow-up there did not appear to be a significant difference in severity ratings, even when attempting to evaluate the impact of the age of the person referred. Most patients

(86.0%, $n = 37$) had complex needs and continued to require case management when the file was reviewed at 12 months. According to a self-report survey, 95% ($n = 21$) of clinicians reported that the service was “very useful”. It was also noted that clinicians felt more confident treating obsessive-compulsive and related disorders and formal referrals to the service became less frequent over time.

4. Discussion

To our knowledge, this is the first reported service that has attempted to provide early intervention for OCD. The study has revealed that an early intervention model based on principles of early intervention for psychosis and collaboration with psychosis early intervention teams, neither assessed sufferers early enough (as indicated by average of 9.4 years from OCD onset) or resulted in significant enough reduction of symptoms to enable discharge from case management services (as indicated by 86.0% still requiring case management at 12 months). Despite being perceived by clinical staff as a useful service that aimed to upskill staff in the assessment and treatment of OCD, it does not appear that this service was able to assess people early enough in their course of illness. The implication of this finding is that alternative methods of referral to such a service are necessary. Such methods are likely to require improved mental health literacy among young people and children with direct referrals for assessment and treatment prior to the requirement for treatment at an anxiety clinic, a community mental health centre, a hospital or by an early intervention psychosis team.

Despite the rigorous consultation and literature searches that preceded the commencement of this service, and the attempts to objectively and systematically assess outcomes, evaluation was significantly limited by the low rate of objective assessment at follow-up. The study was also limited by its heterogenous sample which included patients with schizophrenia and co-occurring OCD and complex disorders related to trauma. The severity and complexity of symptoms among those referred is likely to have been greater as the service operated within a public mental health service, rather than in a private clinic or primary care setting.

The study does not indicate that early intervention is ineffective for OCD, but that early intervention should be trialed in a setting where people can have quick and early access to assessment and treatment. In addition to education programmes to improve mental health literacy, there may be benefit in screening school age children or those children who are at higher risk, such as the children of people who suffer from OCD [4], or who have tic disorders [15]. It should be noted that 41.7% of this sample reported OCD in a first degree relative and 20.8% reported comorbid tic disorder. Such screening programmes are likely to be resource intensive and would require rigorous evaluation of outcome measures to adequately assess the effectiveness of early intervention for OCD.

5. Conclusion

Although this study does not support early intervention for OCD, it is limited significantly by the characteristics of those referred to the service that has been described. The characteristics indicate that the sample

assessed by this service was not assessed by this service early enough in the course of their illness. Early intervention services for OCD should consider measures to improve mental health literacy in young people and screening for children who may be at higher risk of developing OCD.

Declaration of Competing Interest

No reported conflicts of interest.

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