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AN AUDIT OF OBSESSIVE COMPULSIVE DISORDER IN A BEDFORD (UK) COMMUNITY MENTAL HEALTH TEAM

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SUMMARY

OCD is a condition seen often in Community Mental Health Teams in England. It is treated with medication and psychology. We wanted to assess what co-morbidities were present in our OCD patients, with which medications they were being treated, and whether patients had received psychological treatment. On assessment It is clear that a very large number of the OCD patients in our cohort are complex patients who have not responded to first line treatment, such as SSRIs or basic psychology, and who suffer from co-morbidities. Treatment of these patients, while oriented towards the achievement of recovery, is also relatively complex and long term.

Key words: *Obsessive Compulsive Disorder - psychological treatment – medication - co-morbidities*

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INTRODUCTION

The basic way in which Mental Health Patients are treated in the UK is within Community Mental Health Teams (CMHTs). We wished to assess the treatment of patients with OCD in the community in Bedford East CMHT. The team holds an excel database of all patients under its care. We wished to use the database in order to assess the care provided to our patients with OCD. Our aim was to compare our treatment to the standards set out in the NICE Guidelines.

We were especially interested in whether appropriate psychotherapy had been carried out, in what co-morbidities existed in the sample,and which medications and combinations ofmedications had been used.

METHOD

The Excel Database was examined by hand. The database contains information on ethnicity, gender, age, risk factors, co-morbidities, physical conditions, psychotherapies, the presence of a care co-ordinator, and medication. Treatment standards were as advised by NICE.

RESULTS

The database contained 1334 patients, of which 103, or 7.72% hadOCD .The age range was between 16 and 75 (born 1939).

Psychology

It was found that 29/103 (28.2%) have a care coordinator and 14/103 (13.6%) have been discharged by their care coordinator.

It was found that 19/103 (18.4%) have been referred (inc. re-referred) to psychology. It was also found that 14/103 (13.6%) had completed psychology (One patient had completed psychology but been re-referred). 11/103 (10.7%) have psychology ongoing (including those who have group therapy ongoing and IAPT-a primary care psychology service used by GPs).

On the other hand, 50/103 (48.5%) have no psychology recorded.

Co-Morbidities

33/103 (32.0%) of the OCD patients have bipolar disorder as a co-morbidity. 18/103 (17.5%) of the OCD patients have anxiety disorders as a co-morbidity. 57/103 (55.3%) of the OCD patients have co-morbidities other than bipolar disorder or anxiety disorders. 17/103 (16.5%) of the OCD patients have no co-morbidities. 28/103 (27.2%) have depressive disorder as a co-morbidity. 3/103 (2.91%) have ADHD as a co-morbidity. 10/103 (9.71%) have PTSD as a co-morbidity. 2/103 (1.94%) have bulimia nervosa as a co-morbidity. 2/103 (1.94%) have tic disorder as a co-morbidity. 5/103 (4.85%) have schizophrenic disorder as a co-morbidity. 1/103 (0.971%) have dyslexia as a co-morbidity. 5/103 (4.85%) have a personality disorder as a co-morbidity. 1/103 (0.971%) have a specific phobia as a co-morbidity. 2/103 (1.94%) have dysmorphophobia as a co-morbidity. 1/103 (0.971%) have Asperger's syndrome as a co-morbidity. 1/103 (0.971%) have anorexia nervosa as a co-morbidity. 1/103 (0.971%) have gender dysphoria, 1/103 (0.971%) have transsexualism and 1/103 (0.971%) have fetishism as a co-morbidity (Table 1, Figure 1, Figure 2).

Table 1. Comorbidities in 103 patients with OCD

Co-morbidity	Proportion of the total OCD patients (%)
Bipolar disorder	32.000
Depressive disorder	27.200
Anxiety disorders	17.500
PTSD	9.710
Personality disorder	4.850
Schizophrenic disorder	4.850
ADHD	2.910
Bulimia nervosa	1.940
Tic disorder	1.940
Dysmorphophobia	1.940
Dyslexia	0.971
Specific phobia	0.971
Asperger's syndrome	0.971
Anorexia nervosa	0.971
Gender dysphoria	0.971
Transsexualism	0.971
Fetishism	0.971
No co-morbidity	16.500

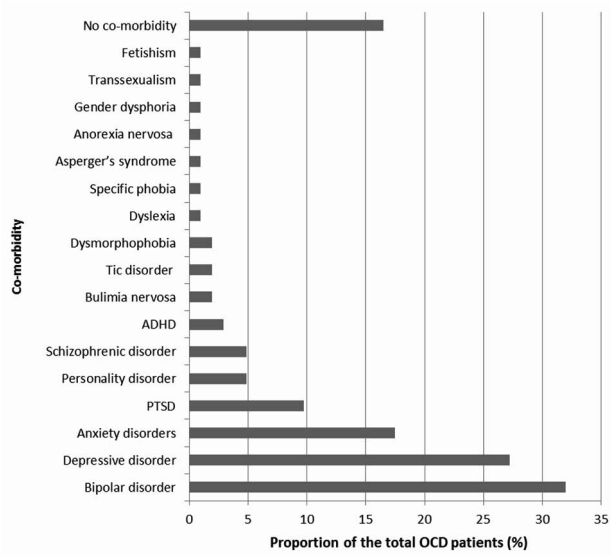

Figure 1. Comorbidities in 103 patients with OCD

Medications used

Antidepressants, antipsychotics and mood stabilisers (anti-manics) are all being used to treat the 103 patients with OCD. The medications in use are as folows, the numbers indicating the number of patients in which the particular medication is used (Table 2, Figure 3).

Doses of antidepressants

Below are indicated the doses of antidepressant recorded in the notes and the number of patients each on these doses. It is appriciated that these figures are correct at the moment the audit was taken and can represent doses at aparticular point of titration of a medication, rather than a fixed dose at an 'end point', hence some doses may appear lower than would be expected in patients with OCD (Table 3, Figure 4, Figure 5, Table 4, Figure 6, Table 5, Figure 7).

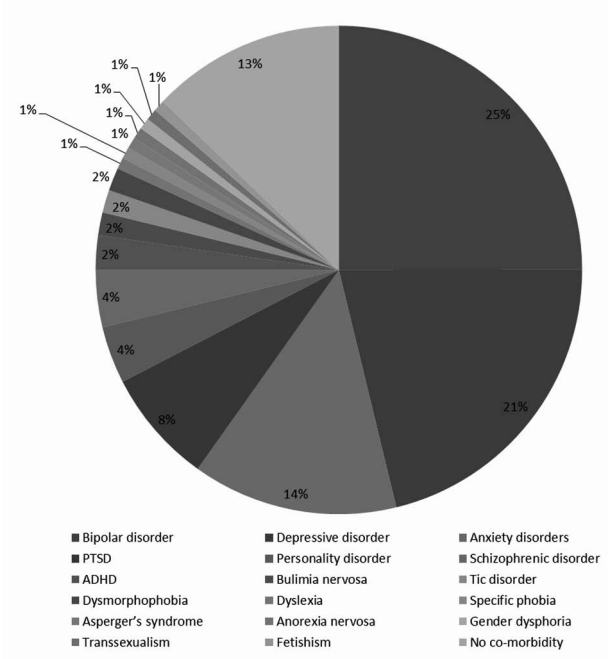

Figure 2. Pie-Chart of co-morbidities of 103 patients with bipolar disorder

Table 2. Antidepressants, antipsychotics and mood stabilisers (anti-manics)

*Antidepressants**	n	*Antipsychotics*	n
SSRIs		Atypicals	
Sertraline	32	Olanzapine	10
Fluoxetine	12	Risperidone	10
Citalopram	11	Quetiapine	22
Paroxetine	6	Aripiprazole	8
Fluvoxamine	3	Amisulpride	2
Escitalopram	2	Typicals	
SNRIs		Trifluoperazine/Stelazine	3
Venlafaxine	11	Chlorpromazine	1
Duloxetine	2		
Tricyclics		*Antimanics*	
Clomipramine	16	Anticonvulsant	
Amitriptyline	4	Depakote (valproic acid)	10
NaSSA^{+}		Semisodium valproate	1
Mirtazapine	7	Lamotrigine	3
		Carbamazepine	2
		Lithium compounds	
		Lithium	1
		Lithium carbonate	3
		Lithium citrate (Priadel)	2

* SSRIs, tricyclics, atypicals and other medications (SNRIs, NaSSA/tetracyclics);

$^{+}$ Noradrenergic and specific serotonergic antidepressant (NaSSA) or tetracyclic antidepressant

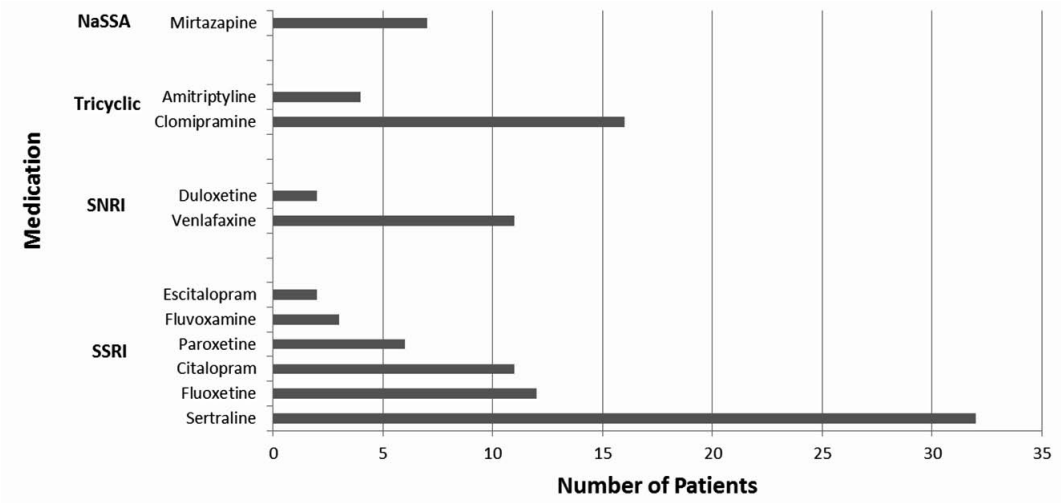

Figure 3. Graph to display the number of patients on each anti-depressant

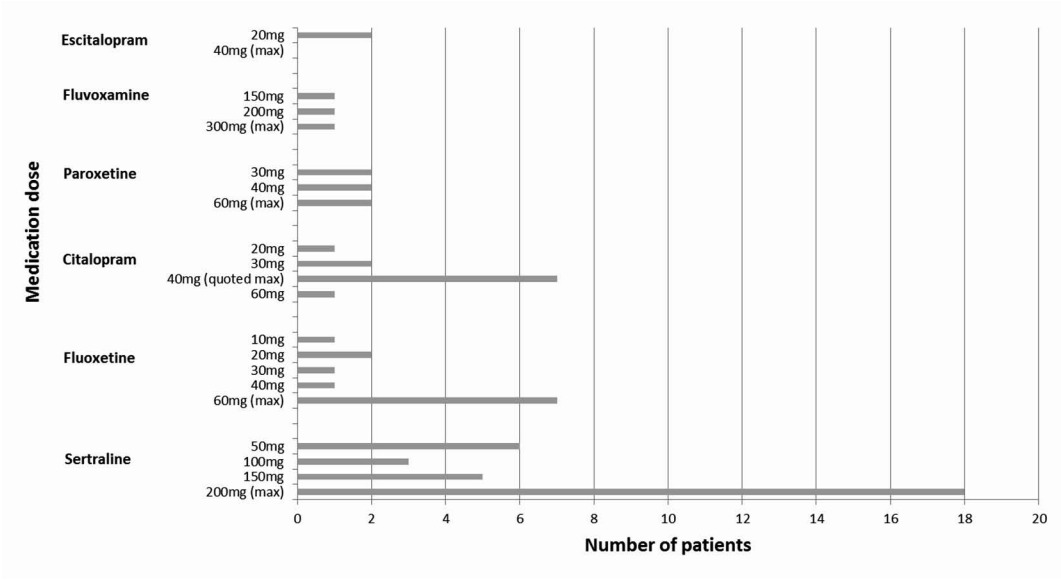

Figure 4. Graph to display number of patients on each dose of SSRI

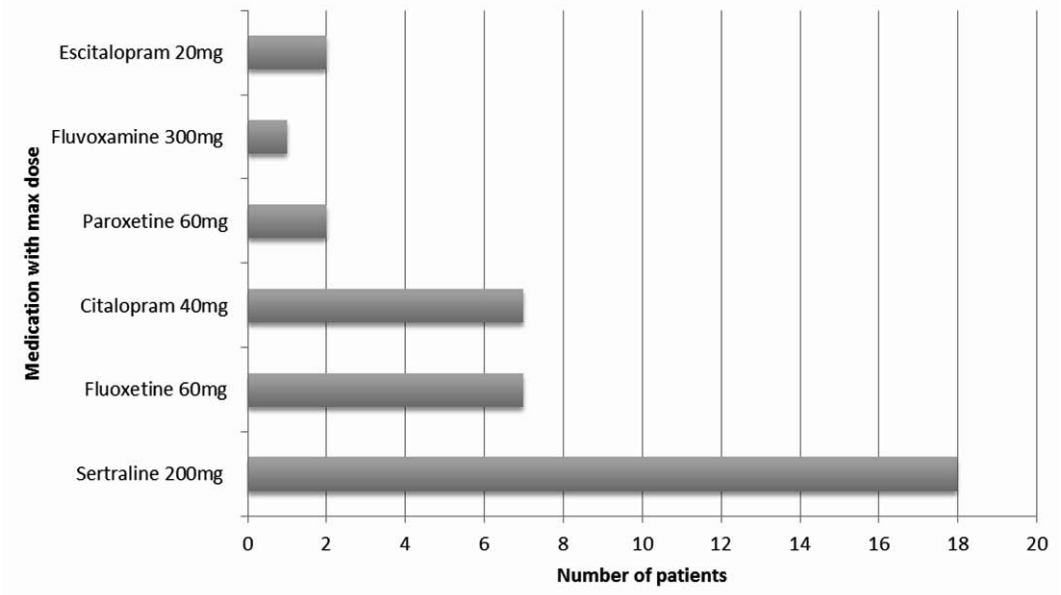

Figure 5. Graph to display number of patients on maximum dose of each SSRI

Table 3. Antidepressant - SSRI

Sertraline	n	Paroxetine	n
200mg (max)	18	60mg (max)	2
150mg	5	40mg	2
100mg	3	30mg	2
50mg	6	Fluvoxamine	
Fluoxetine		300mg (max)	1
60mg (max)	7	200mg	1
40mg	1	150mg	1
30mg	1	Escitalopram	
20mg	2	40mg (max)	0
10mg	1	20mg	2
Citalopram			
60mg	*1*		
40mg (quoted max)	7		
30mg	2		
20mg	1		

Table 4. Tricyclics

Clomipramine	n
250mg (max)	1
225mg	1
200mg	*4*
150mg	4
125mg	1
100mg	1
75mg	*3*
25mg	1
Amitriptyline	
200mg (max)	1
75mg	*2*
20mg	1

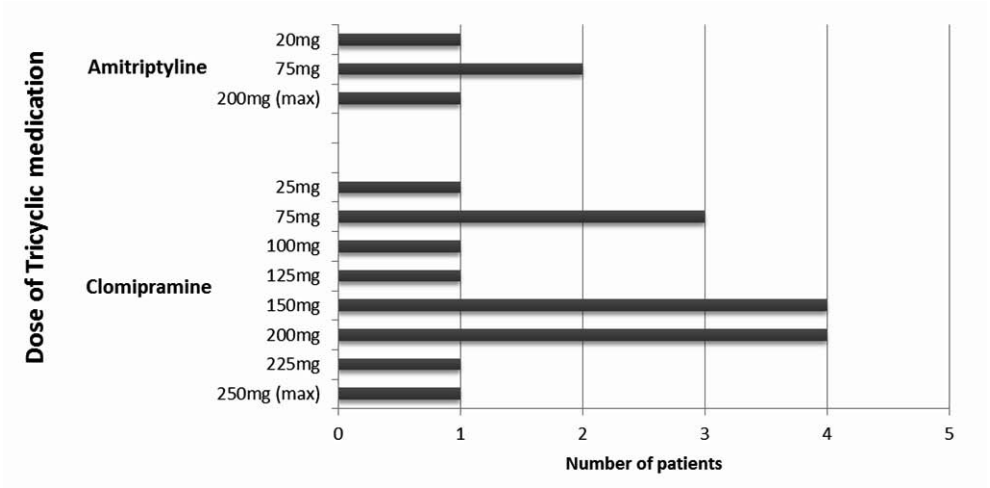

Figure 6. Graph to display number of patients on each dose of tricyclic medication

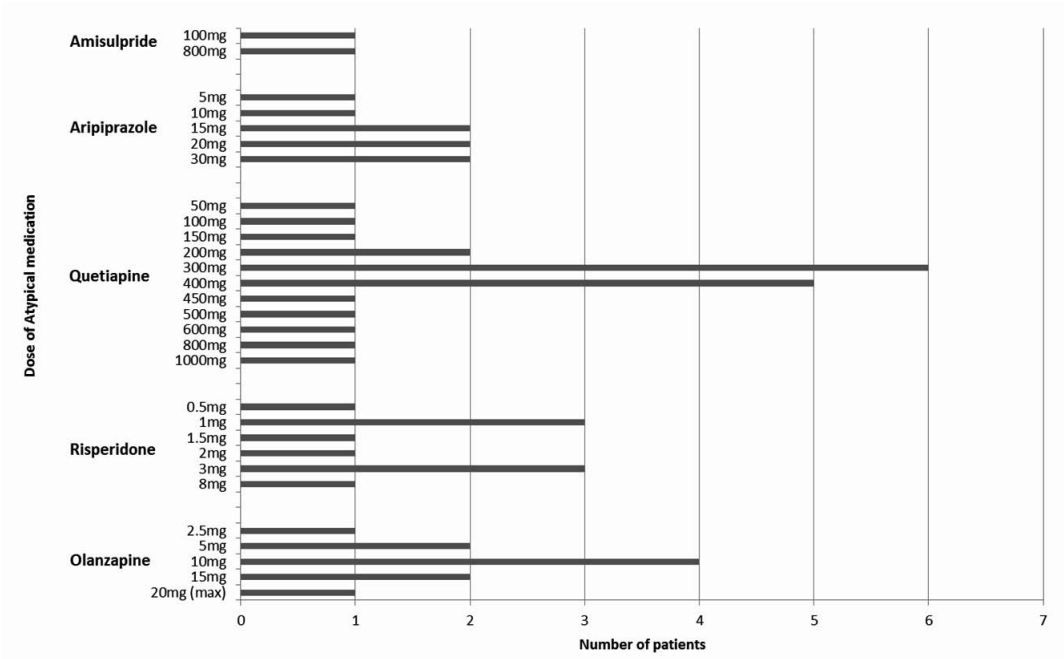

Figure7. Graph to show number of patients on each dose of atypical Antipsychotic Medication

Table 5. Atypical Antipsychotics

Olanzapine	n	Risperidone	n
20mg (max)	1	8mg	1
15mg	2	3mg	3
10mg	4	2mg	1
5mg	*2*	1.5mg	1
2.5mg	1	1mg	3
Quetiapine		0.5mg	1
1000mg	*1*	Aripiprazole	
800mg	1	30mg	2
600mg	1	20mg	2
500mg	1	15mg	2
450mg	1	10mg	1
400mg	*5*	5mg	1
300mg	6	Amisulpride	
200mg	*2*	800mg	1
150mg	1	100mg	1
100mg	1		
50mg	1		

Combinations of SSRIs and Atypical Antipsychotics

62 patients were on SSRIs, 52 on antipsychotics (note 2 patients were on a combination of 2 anti psychotics). 38 (of 103) were on a combination of an antipsychotic and an SSRI. The SSRI's involved were Sertraline, Fluoxetine, Citalopram, escitalopram, paroxetine and Fluvoxamine.

The Typical antipsychotics included: Trifluoperazine (a.k.a stelazine), chlorpromazine, while the Atypical Antipsychotics included: olanzapine, risperidone, quetiapine, aripiprazole, amisulpride (Defined by NICE).

Of the 52 patients on antipsychotics, 48 were on atypicals, 4 were on typicals as defined above. Of those 48 on atypical antipsychotics, 37 were also on an SSRI.

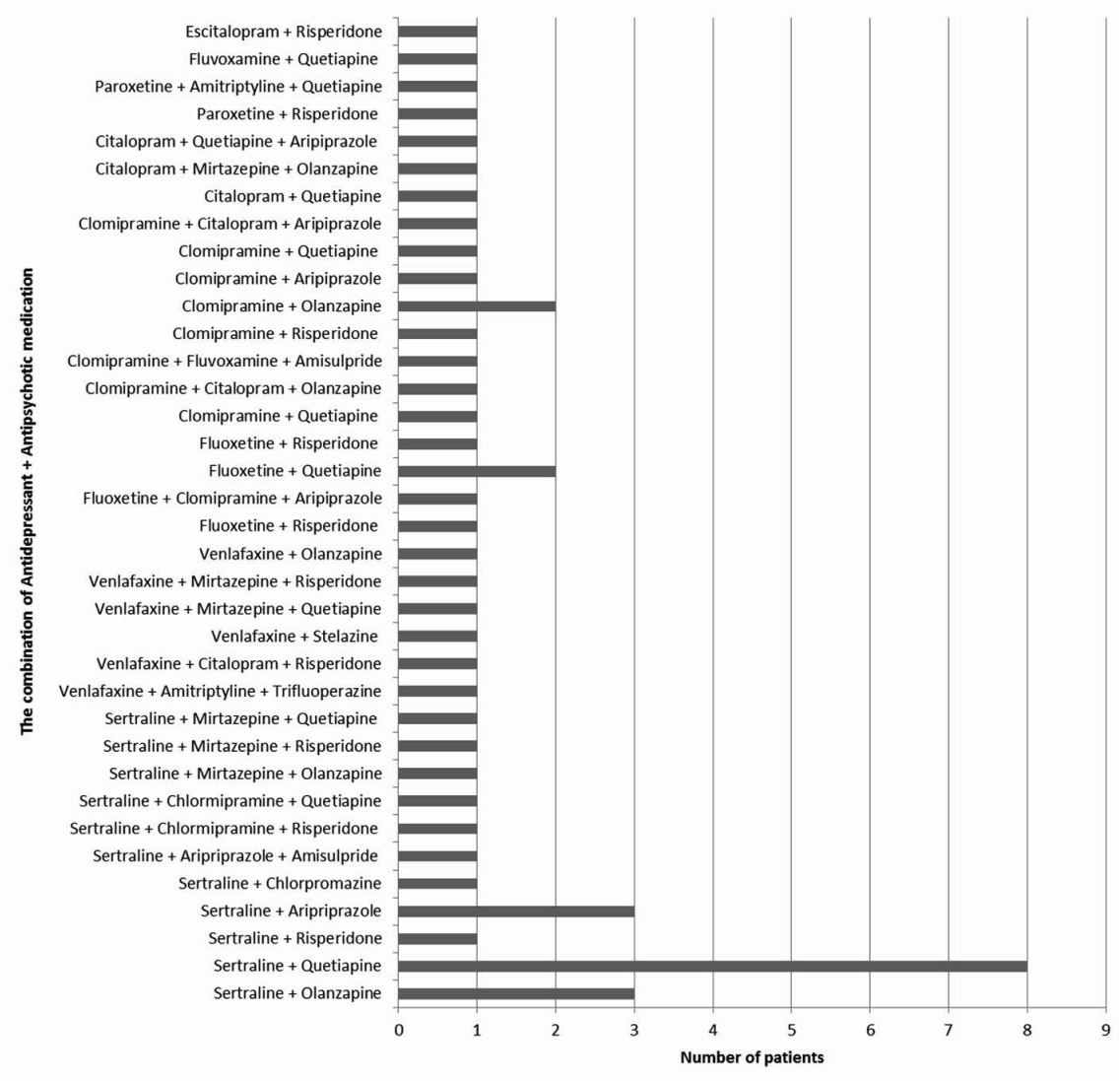

Figure 8. Graph to desplay the number of patients on each Antidepressant and Antipsychotic medication

Correlation of atypical antipsychotic use and use of Psychology

The use of Psychology (Cognitive behaviour therapy) is considered by NICE the first line of treatment for OCD. This is followed by the addition of SSRIs, escalating to the maximum dose. The addition of Atypical Antipsychotics is considered the final phase of the Algorithm before more invasive methods of treatment, and is used in resistant cases.

In assessing this, psychology was considered as having been prescribed if the person is currently undergoing, has completed, has private psychology or if he is being re-referred. Psycholoy was not considered to have been prescribed if the excel cell was blank, or the person has not started yet (e.g. only referred or assessed).

Looking at the 48 patients on atypical antipsychotics, 19 have had or are currently having psychotherapy of a sort, 29 have received no psychotherapy (7 of the 29 have been referred or assessed) but were not included as have not received a session. It is to be supposed that, following NICE, patients should be offered psychotherapy long before being given antipsychotics so that even with the time for a referral to result in a psychotherapy session, one would expect a person to start psychotherapy before being put on antipsychotics (Figure 8, Figure 9).

Use of Mood Stabilisers (Antimanics)

It was investigated whether the patients with Bipolar and OCD were on both SSRIs and mood stabilisers-including Lithium, Depakote (Valproate), Lamotrigine, Carbamazepine, Atypical antipsychotics.

32/104 patients have both OCD and bipolar. Of them, 20 are on SSRI (62.5%).

18/33 patients with both OCD and bipolar are on SSRI plus a mood stabiliser (54.5%) (Figure 10).

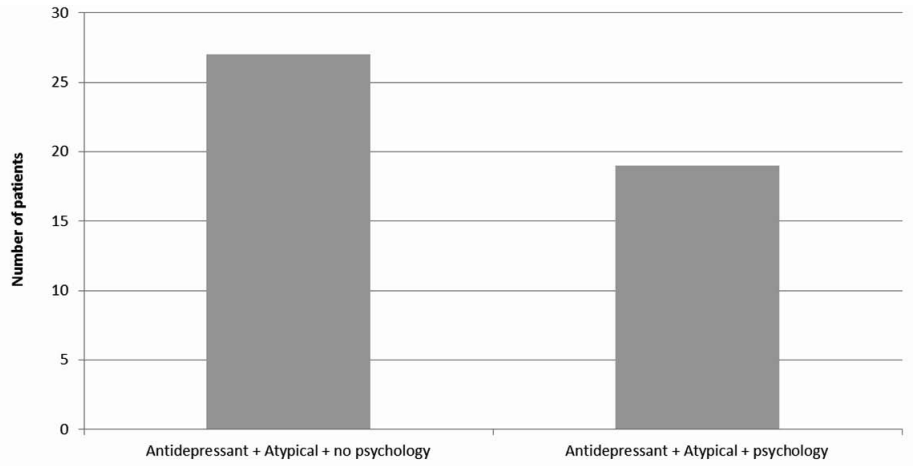

Figure 9. Graph to display the number of patients on antidepressant and atypical medication with and without psychology

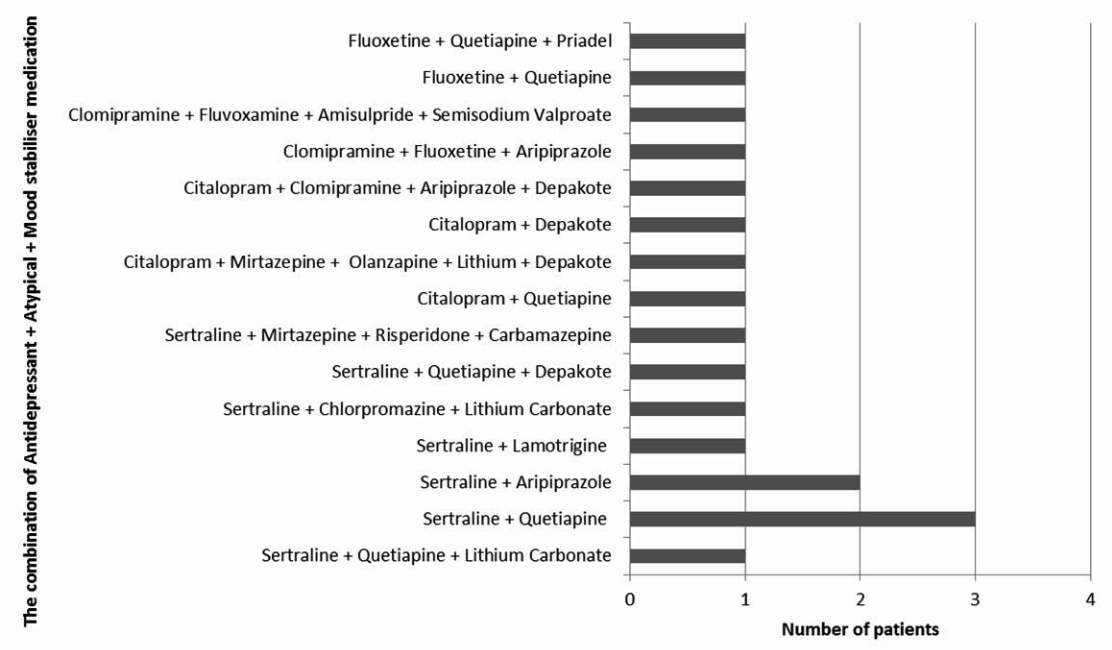

Figure 10. A graph to display the number of patients with Bipolar Disorder and OCD on each combination of medication

DISCUSSION

This study highlights a number of important issues.

The use of psychological interventions is important in the treatment of OCD, indeed NICE recommends Psychological interventions as a first step before considering the use of medication, and later in more complex cases concomitently with the use of Medication (NICE2005). However, it is clear that not all cases of OCD in our sample receive psychological interventions. This is highlighted by the number of patients who have not received psychological interventions and yet are now taking atypical antipsychotics, which means that they are at the 'top' of the algorithm which NICE recommends for treatment of OCD (NICE 2005). This was first noted by us in 2011 (Agius 2011), and the same situation continues today. It may be that some of these patients are not 'psychologically minded', but this only adds to the complexity of these cases. CBT is effective in patients with OCD (O'Kearney 2007, O'Kearney 2006). There is need to make CBT more accessable to patients with OCD, in particular to young persons (O'Kearney 2007, O'Kearney2006), and this can be used in conjunction with SSRIs (Pediatric OCD Treatment Study (POTS) Team 2004). Group therapy on a CBT model (Jónsson 2009) and Internet therapy (Herbst 2014, Lenhard 2014, Andersson 2011) are possibilities being explored with promising results, while studies of self management are being undertaken (Gellatly 2014).

The number of Co-Morbidities identified is striking. In particular the presence of co-morbidity with Bipolar Disorder is particularly impressive , and it appears that numbers with this co-morbidity have risen within our cohort of patients since we first examined this issue in 2011 (Darby 2011), and later in 2012 (Darby 2012). This may be because of the introduction of a much more systematic way of assessing mood disorders, particularly bipolar disorder, in recent years (Agius 2013). The comorbidity of bipolar disorder and OCD clearly increases the complexity of the patients and increases their morbidity, making the prognosis worse (Magalhaes 2010, Timpano 2012, Go 1998, Sasson 2003, Perugi 1997). This co-morbidity has been much discussed in the literature (Joshi 2010, Joshi 2010, Kruger 2000, Chen 1995, Zutshi 2007, Lee 2008, Mahasuar 2011) and Perugi (Perugi1999, Perugi 2002) and Amerio (2014) have made it quite clear that the first priority with these patients will be stabilising their mood. Comorbidity with schizophrenia is also well recorded, and they lead to a reduced quality of life (Uçok 2014). Patients studied with both OCD and Schizophrenia includechronic patients (Faragian 2009), first episode patients (de Haan 2005, de Haan 2013), and patients who are in the earliest 'at ultra high risk state' of Psychosis (Zink 2014).

When one considers the evolving understanding of the neurological correlates of OCD and the interplay between in particular the serotonin and Dopamine systems in bipolar disorder (Matsunaga 2012, Ducasse 2014, Milad 2012, Li 2000, Gu 2008, Aouize rate 2007, Maltby 2005 Kontis 2008, Szechtman 1999, Zohar 2000, van den Heuvel 2005), it cannot be a surprise that comorbidities between OCD and Schizophrenia, bipolar disorder, other anxiety disorders and unipolar depression exist.

In the same way, the combinations of medication used in OCD are reflected in the interplay between the serotonin and dopamine systems (Maltby 2005, Kontis 2008, Szechtman 1999, Zohar 2000) which ultimately affect the glutamate system. Thus, while there is very good evidence for the use of SSRIs in the treatment of OCD in adults, (Gava 2007, Greist 1995, DeVeaugh-Geiss 1994, Soomro 2008), and there is some evidence that Clomipramine may be more efficacious than SSRIs (Piccinelli 1995), there is often need for SSRIs to be augmented by the use of Atypical Antipsychotics (Komossa 2010, Bokor2014). This is reflected in the outcomes of our study.

CONCLUSION

In conclusion, it is clear that a very large number of the OCD patients in our cohort are complex patients who have not responded to first line treatment, such as SSRIs or basic psychology, and who suffer from co-morbidities. Treatment of these patients, while oriented towards the achievement of recovery, is also relatively complex and long term, and it is recommended that it should be constantly measured by the use of such scales as the Ybocs in order to be able to demonstrate progress, which can be expected to occur slowly over time.

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Conflict of interest: None to declare.

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