LETTERS

Has the first-line management of paediatric OCD improved following the introduction of NICE guidelines?

INTRODUCTION

Obsessive–compulsive disorder (OCD) is a distressing and impairing condition that affects between 0.25% and 4% of children and adolescents.[1] In 2005, the National Institute of Health and Care Excellence (NICE) introduced guidelines for the management of paediatric OCD in the UK.[2] Based on robust evidence, NICE recommended cognitive behavioural therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs) as first-line psychological and pharmacological treatments. However, the extent to which patients are able to access these evidence-based interventions in routine clinical practice remains unclear. To assess the impact of these guidelines, we conducted an audit of the previous treatment received by children with OCD referred to the National and Specialist Paediatric (N&S) OCD clinic at the Maudsley Hospital, London. We hypothesised that publication of NICE guidelines, in 2005, would increase the use of SSRIs and CBT in this group of patients.

METHODS

We compared referrals received from January 2000 to January 2002 (T1 cohort, n=79) with those from January 2009 to January 2011 (T2 cohort, n=143). All data were collected as part of the routine standardised assessment carried out in the N&S OCD clinic. Table 1 shows the baseline demographic/clinical data collected for each cohort. Treatment data were categorised into whether patients had ever previously received CBT for OCD, an SSRI medication or a non-CBT-based psychotherapy (eg, family therapy, counselling, psychodynamic therapy) or whether they had received either NICE-recommended treatment (SSRI or CBT).

RESULTS

Table 1 details our results. Comparing the two groups, the T2 cohort (after NICE guideline publication) were significantly older (mean increase of 8.3 months, $t(220) = -2.16$, $p=0.03$) and reported more severe OCD symptoms (mean Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) score increase of 4.58 points, $t(220) = -6.03$, $p<0.001$). There were no significant differences in gender, age at onset of OCD symptoms, or referral source.

Contrary to our hypothesis, when comparing patients in the T2 cohort with those in the T1 cohort, we found a significant 22.3% decrease in the proportion who had received either NICE-recommended treatments (SSRI or CBT) (χ^2 (1, n=222) $=10.18$, $p=0.001$), with over half having not received either treatment. There was a significant 23.0% decrease in the proportion who had received an SSRI (χ^2 (1, n=222)$=23.87$, $p<0.001$) and no significant increase in patients receiving CBT (χ^2 (1, n=222)$=0.66$, $p=0.418$). We also found a significant 13.1% increase in the proportion of patients receiving non-CBT psychotherapy (χ^2 (1, n=222) $=5.38$, $p=0.019$).

Table 1 Characteristics of each cohort

	T1: 2000–2002 cohort (n=79)	T2: 2009–2011 cohort (n=143)
Clinical characteristics		
Female, %	41.8	46.9
Age at assessment, mean (95% CI)	13 years 10 months (9 years 5 months to 17 years 3 months)	14 years 7 months* (11 years to 17 years 8 months)
Age at onset, mean (95% CI)	10 years 1 months (5 years to 14 years)	10 years 6 months (11 years to 17 years 4 months)
Baseline CY-BOCS, mean (95% CI)	22 (12 to 32)	26 (18 to 35)***
Referral source, %		
Child Psychiatry Services	69.6	73.4
General practitioner	27.8	23.8
Paediatricians	1.3	1.4
Other	1.3	1.4
Previous treatments, %		
CBT or SSRI	67.1	44.8**
CBT	31.6	37.1
SSRI	58.2	25.2***
Non-CBT psychotherapy	11.4	24.5*

Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) reliably measures OCD symptoms severity.
*p<0.05, **p<0.01, ***p<0.001, significant difference between cohorts.
CBT, cognitive behavioural therapy; OCD, obsessive–compulsive disorder; SSRI, selective serotonin reuptake inhibitor.

DISCUSSION

Despite the publication of NICE guidelines in 2005, we found a striking decrease in SSRI use, no increase in the use of CBT, and an increase in non-CBT-based psychotherapies between our two cohorts. Shortage of CBT therapists in child services and concerns around the safety of SSRIs in this population may explain some of our findings.[3 4] Further work is urgently needed to identify the barriers preventing young people with OCD from accessing evidence-based treatments.

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Contributors AN collected data in the T2 cohort, contributed to design of the audit, analysed data and wrote manuscript drafts. YLW collected data in the T1 cohort. FB collated data at the time of assessment and maintained the database. IH designed the data collection and reviewed the manuscript. BC contributed to the design of the audit and reviewed the manuscript. GK contributed to the design of the audit, helped with data analysis and reviewed the manuscript.

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