NICE National Institute for Health and Care Excellence

2019 surveillance of obsessive-compulsive disorder and body dysmorphic disorder: treatment (NICE guideline CG31)

Surveillance report

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Surveillance decision

We will update the guideline on obsessive-compulsive disorder and body dysmorphic disorder.

Reasons for the decision

This section provides a summary of the areas that will be updated and the reasons for the decision to update.

NICE's guideline on obsessive-compulsive disorder and body dysmorphic disorder has not been updated since its publication in 2005. Feedback from topic experts and stakeholders highlighted that clinical practice has progressed in the following areas since publication of the guideline:

- Rapid advances in information technology and telecommunications and the introduction of technology-enhanced cognitive behavioural therapy intervention.
- Advances in transcranial magnetic stimulation and deep brain stimulation technology for treatment of obsessive-compulsive disorder.
- Introduction of new pharmacological interventions and new augmentation therapies amongst treatment-resistant groups.
- Practice variation in stepped care approach particularly access to specialist care services for children.
- Limited access to current NICE recommended treatments.

In addition, service delivery and provision of mental health (including child and adolescent mental health services and improving access to psychological therapies services) has changed since the guideline was developed indicating a need to update it, so that it remains relevant to clinical practice in the UK.

Overview of 2019 surveillance methods

NICE's surveillance team checked whether recommendations in obsessive-compulsive disorder and body dysmorphic disorder (NICE guideline CG31) remain up to date. The 2019 surveillance followed the static list review process, consisting of:

- Feedback from topic experts via a questionnaire.
- A search for new or updated Cochrane reviews and national policy.
- Consideration of evidence from previous surveillance.
- Examining related NICE guidance and quality standards and NIHR signals.
- A search for ongoing research.
- Examining the NICE event tracker for relevant ongoing and published events.
- Consulting on the proposal with stakeholders.
- Considering comments received during consultation and making any necessary changes to the proposal.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Cochrane reviews

We searched for new Cochrane reviews related to the whole guideline. We found no relevant Cochrane reviews published between April 2013 and October 2018.

Previous surveillance

Previous surveillance in 2011 identified 20 studies that were considered to have no impact on recommendations.

The 2013 evidence update included 16 studies in the following areas:

- Initial treatment options – adults (tele-health and technology interventions).
- Acceptance and commitment therapy.
- Initial treatment options for adults – selective serotonin reuptake inhibitors (SSRIs) or group cognitive behavioural therapy (CBT).
- Initial treatment options – children and young people.
- Long-term outcomes after family-based CBT.
- Choice of drug treatment in adults (switching drug treatments).
- Maintenance drug treatment.
- Add-on treatment with antipsychotics.
- Add-on treatment with acetylcysteine.
- Add-on treatment with anticonvulsants.
- Poor response to initial treatment in children and young people (CBT plus SSRIs).
- Areas not currently covered by the NICE guideline – transcranial magnetic stimulation (TMS).

Evidence from the identified studies was considered to be consistent with, or have no impact on the recommendations at the time of the surveillance.

The NICE guideline was placed on the static list in February 2014.

Ongoing research

We checked for relevant ongoing research; of the 4 ongoing studies identified, none were assessed as having the potential to change recommendations.

Intelligence gathered during surveillance

Views of topic experts

We considered the views of topic experts, including those who helped to develop the guideline. For this surveillance review, topic experts completed a questionnaire about developments in evidence, policy and services related to the NICE guideline.

We sent questionnaires to 14 topic experts and received 4 responses.

Advice from topic experts indicated a need to update the guideline in the following areas:

Deep brain stimulation and TMS (areas not currently covered by the NICE guideline)

Two of the 3 systematic reviews highlighted by topic experts (Zhou et al. 2017 and Trevizol et al. 2016) evaluated the efficacy of TMS and repeated TMS. The other systematic review (Alonso et al. 2015) evaluated efficacy and tolerability of deep brain stimulation for the treatment of obsessive-compulsive disorder (OCD).

Evidence from the identified systematic reviews was inconclusive due to mixed findings and low quality studies. Nonetheless, topic experts indicated that there is consistent emerging evidence supporting the use of neurostimulation and rising demand from people for the intervention.

Technology interventions for OCD

Recommendation 1.5.1.1 of NICE's guideline recommends that in the initial treatment of adults with OCD, low-intensity psychological treatments (including exposure and response prevention [ERP]; up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low-intensity approach. Low-intensity treatments include:

- brief individual CBT (including ERP) using structured self-help materials
- brief individual CBT (including ERP) by telephone

- group CBT (including ERP; note, the patient may be receiving more than 10 hours of therapy in this format).

Findings from 1 randomised controlled trial (RCT) highlighted by topic experts (Lenhard et al. 2016) on internet-based CBT for OCD suggest potential benefits. Computerised CBT is not covered in current recommendations.

Pharmacological treatments options for adults

Section 1.5.1 on initial treatment options in NICE's guideline recommends that adults with OCD with moderate and mild functional impairment who are unable to engage in low-intensity CBT (including ERP), or for whom low-intensity treatment has proved to be inadequate, should be offered the choice of either a course of an SSRI or more intensive CBT (more than 10 therapist hours per patient).

Findings from a large NIHR funded network meta-analysis on pharmacological and psychotherapeutic interventions for management of OCD in adults (Skapinakis et al. 2016) generally supports current recommendations on pharmacological treatments. Topic experts highlighted many studies on new add-on pharmacological treatments including: antipsychotics added to SSRIs and add-on treatment with acetylcysteine which are not currently covered in the recommendations. Findings from the highlighted studies (8 small RCTs and 1 systematic review: Paydary et al. 2016; Emamzadehfard et al. 2016; Dold et al. 2015; Pittenger et al. 2015; Afshar et al. 2014; Dold et al. 2013; Rodriguez et al. 2013; Haghighi et al. 2013 and Ghaleiha et al. 2013) suggest that the new combined pharmacological interventions may result in improvement of OCD symptoms.

Initial treatment options for children and young people

Recommendation 1.5.5.2 in NICE's guideline recommends that following multidisciplinary review, for a child (aged 8–11 years) with OCD or body dysmorphic disorder (BDD) with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered.

A topic expert indicated that the current recommendation to reserve SSRIs, as a second-line treatment for young people with OCD, may adversely affect the treatment responses. No evidence was identified through the surveillance review to indicate the optimum treatment strategy for young people with OCD.

Implementation of the guideline

Topic expert and stakeholders indicated that medication management or adequate CBT provision for people with OCD is often not available through improving access to psychological therapies (IAPT) services. This is despite OCD being listed as a condition that is covered by the IAPT programme which aims to improve the delivery of, and access to, evidence-based psychological therapies within the NHS.

Currently recommendation 1.5.6.1 recommends that an SSRI should only be prescribed to children and young people with OCD or BDD following assessment and diagnosis by a child and adolescent psychiatrist who should also be involved in decisions about dose changes and discontinuation. Topic experts and stakeholders expressed that unavailability of UK child and adolescent mental health services (CAMHS) consultants is making this recommendation challenging to implement.

Views of stakeholders

We consulted on the surveillance proposal to update the guideline to get a wider view from stakeholders. Overall, 12 stakeholders commented (including representation from royal colleges [paediatrics and child health, psychiatrists and nursing], professional associations, charities and patient associations). Nine stakeholders provided comments on the surveillance review proposal and the remaining 3 stakeholders stated that they had no substantive comments to make. All stakeholders that provided comments, agreed with the proposal to update the guideline.

Stakeholders highlighted concerns with the existing guideline related to assessment, and interventions for treatment and management. Additionally, stakeholders raised issues around variation in service delivery.

In the consultation, in addition to expressing views on the proposal, we also requested stakeholder feedback on the following areas:

The use of TMS in clinical practice and any relevant evidence on this intervention

Stakeholders commented that TMS is not currently available in the NHS. However, they highlighted additional references (Raymaekers et al. 2017 and Luyten et al. 2016) that support the use of electrical stimulation.

Treatment approaches for young people with OCD and whether SSRIs are increasingly being used as first-line treatment

Stakeholders stated that since the introduction of the NICE guideline there had been a reduction in the use of SSRIs relative to psychological therapies in young people with OCD (Nair et al. 2015). Stakeholders also shared the concerns of topic experts about reserving SSRIs to a second-line treatment in young people with OCD and the limited availability of CAMHS consultants which may adversely affect the treatment responses.

Stakeholders noted that since the guideline was developed in 2005, there is now additional evidence on pharmacological treatments and the new pharmacological third-line treatment options, add-on therapy and combined treatments may need greater consideration in the guideline. They also expressed concern at a lack of provision for those individuals who remain treatment resistant at the end of the existing stepped care pathway as there are currently no recommendations covering this area. Stakeholders highlighted relevant studies which were all identified and assessed through the surveillance which collectively indicate this area should be considered in an update to the guideline.

How often people with OCD are referred to IAPT services and whether there are barriers in access to treatment

Stakeholders commented that most people with OCD are being referred to IAPT services instead of secondary care mental health services, where medication management or adequate CBT provision for OCD is often not available.

They indicated that while IAPT services provide good access for some forms of CBT, there may be the unintended effect of denying those in need of an intensive form of treatment (in terms of labour intensive CBT and/or medication for the OCD). They also commented on significant transformation of the mental health services for children and adolescents and its impact on educational and school interventions including introduction of digitally supported low-intensity psychological treatments. These issues are not currently addressed by the guideline.

Stakeholders identified the following barriers in access to treatment through local IAPT services:

- significant waiting times

- delays in referral
- lack of sensitivity from telephone assessment practitioners
- appointment loss if not confirmed within a few days of being offered
- group therapy offered when preference is for individual therapy
- inaccessibility of IAPT services for some individuals due to the severity of their OCD and a failure of IAPT services to make reasonable adjustments
- lack of specific knowledge and/or experience in treating OCD amongst professionals.

Whether the stepped care pathway currently recommended in the NICE guideline needs reconsideration

Stakeholders commented that the stepped care model needs to be adjusted to take account of the introduction of IAPT services and young people should be treated at the most appropriate step for the severity of their condition.

They indicated that CBT is offered as a first-line treatment in the stepped care model, however recent research (Lovell et al. 2017) found a lack of benefit in low-intensity therapy as a standalone treatment for OCD. Stakeholders expressed concern about the impact of untreated OCD and highlighted relevant studies which were all identified and assessed through the surveillance.

Are ego-dystonic paedophilic or violent thoughts and images a reasonable consideration in risk assessment for individuals with OCD?

Stakeholders commented that while aggressive obsessions should always be fully assessed, it should not be used as evidence that an individual is at increased risk of enacting harm. They emphasised that the effect of inappropriately attributing such risk can be harmful for the patient, as it reinforces their pathological fear that they are a risky person and acts as a barrier to treatment.

Stakeholders also indicated that comorbidities – in particular adequate OCD care during pregnancy and the postnatal period – and home-based care need to be addressed in the update of the guideline as these are not currently covered by existing recommendations.

Stakeholders also highlighted additional references in the following areas: new

pharmacological treatment options (Simpson et al. 2013), harmful effects of SSRIs (Sharma et al. 2016), telephone CBT/active smartphone interventions (Tie et al. 2019; Baland et al. 2018 and Nair et al. 2018), ethnic inequalities in the use of health services in people with OCD (Fernández et al. 2015), CBT for BDD (Krebs et al. 2017 and Mataix-Cols et al. 2015), CBT efficacy for paediatric OCD (Turner et al. 2018; Bennett et al. 2017 and Brown et al. 2015), CBT for comorbid OCD in autism (Russell et al. 2013).

See appendix A for full details of stakeholders' comments and our responses.

See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual for more details on our consultation processes.

Equalities

Stakeholders highlighted that individuals from BAMER (Black, Asian, Minority Ethnic and Refugee) communities are under-represented in OCD specialist services. This will be considered in the update of the guideline.

Editorial amendments

During surveillance of the guideline, we identified the following points in the guideline that should be amended.

NICE's guideline on transition from children's to adults' services for young people using health or social care services published in 2016. A cross referral to this guideline may be useful from section 1.1.2 on continuity of care. This will be considered in the update of the guideline.

Overall decision

After considering all evidence and other intelligence and the impact on current recommendations, we decided that an update is necessary.

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