

**Obsessive compulsive disorder: core
interventions in the treatment of obsessive
compulsive disorder and body dysmorphic
disorder**

NICE guideline

First draft for consultation, February 2005

If you wish to comment on the recommendations, please make your
comments on the **full** version of the draft guideline.

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Key priorities for implementation

PCTs, mental healthcare trusts, and children's trusts that provide mental health services should have access to a specialist obsessive compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary healthcare team that can help increase the skills of mental health practitioners in the assessment and evidenced-based treatment of children and adults with OCD or BDD, provide high quality advice, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment across the lifespan.

Specialist mental healthcare professionals who work with children, young people and adults with OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high quality information about OCD and BDD. Such information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD.

People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder, and the shame and distress experienced.

Because OCD and BDD often affect not only the person with OCD or BDD but also their family/carers, healthcare professionals should promote a collaborative approach with the person with OCD or BDD and their family/carers, wherever this is appropriate and possible.

Children, young people, or adults who have been successfully treated, discharged but re-referred after a first episode of OCD or BDD should be seen as soon as possible rather than placed on a routine waiting list.

Children and young people with OCD

For children and young people with OCD with moderate to severe functional impairment, and for those with OCD with mild functional impairment for whom guided self help has been ineffective or refused, cognitive-behavioural therapy (including exposure and response prevention) involving the family and adapted to suit the developmental age of the child, should be offered as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family/carers.

Following multidisciplinary review, if a **child** (6 to 11 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT involving the family, the addition of a selective serotonin reuptake inhibitor (SSRI) to ongoing psychological treatment may be **cautiously** considered.

Following multidisciplinary review, if a **young person** (12 to 18 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT involving the family, an SSRI should be offered in addition to continuing psychological treatment.

Adults with OCD

In the initial treatment of adults with OCD or BDD, low intensity psychological treatments including exposure and response prevention (ERP) (up to 10 therapist hours per patient) may be offered if the degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:

- computer guided ERP with brief scheduled contacts with a trained support worker
- brief individual cognitive behavioural therapy (CBT) that includes ERP using structured self-help materials
- brief individual CBT (including ERP) by telephone

- group CBT (including ERP).

For adults with OCD with mild functional impairment who are unable to engage in low intensity CBT or for whom low intensity treatment has proved to be inadequate, healthcare professionals should offer the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious.

For adults with OCD with moderate functional impairment, healthcare professionals should offer the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP as these treatments appear to be comparably efficacious.

BDD

All children and young people with BDD should be offered CBT (including ERP) involving the family and adapted to the developmental age of the child as first-line treatment.

Adults with BDD with mild to moderate functional impairment should be offered a course of CBT (including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation) in individual or group formats or an SSRI, depending upon the patient's preference.

The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C or good practice point [GPP]) is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see Section 5).

Obsessive compulsive disorder (OCD) is characterised by the presence of either obsessions or compulsions, but commonly both. The symptoms cause significant functional impairment and/or distress. An obsession is defined as an unwanted intrusive thought, image, or urge which repeatedly enters the person's mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. A compulsion can either be overt and observable by others, such as checking that a door is locked, or a covert mental act that cannot be observed, such as repeating a certain phrase in ones mind.

Body dysmorphic disorder (BDD) is characterised by a preoccupation with an imagined defect in one's appearance or, in the case of a slight physical anomaly, the person's concern is markedly excessive. BDD is characterised by time-consuming behaviours such as mirror gazing, comparing particular features to those of others, excessive camouflaging tactics to hide the defect, skin-picking, and reassurance seeking.

1 Guidance

1.1 Good practice points relevant to the care of all people with OCD or BDD and their families

1.1.1 Understanding

1.1.1.1 People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder, and the shame and distress experienced. **[GPP]**

1.1.1.2 When assessing a person with OCD or BDD, healthcare professionals should sensitively explore the hidden distress and disability commonly associated with OCD and BDD, providing explanation and information wherever necessary. In particular, people with OCD who are distressed by their obsessive thoughts should be informed that such thoughts are occasionally experienced by almost everybody, and when frequent and distressing are a typical feature of obsessive-compulsive disorder. **[GPP]**

1.1.2 Continuity of care

1.1.2.1 OCD and BDD are frequently recurring or chronic conditions that often affect some of the most intimate aspects of a person's life. Healthcare professionals should therefore ensure continuity of care and minimise the need for multiple assessments by different healthcare professionals. **[GPP]**

1.1.3 Information and support

1.1.3.1 Treatment and care should take into account the individual needs and preferences of people with OCD or BDD, and they should have the opportunity to make informed decisions about their care and treatment. Where patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – *Reference guide to consent for examination or treatment* (2001) (available from www.dh.gov.uk).

1.1.3.2 Good communication between healthcare professionals and people with OCD or BDD is essential. Provision of information, treatment and care should be tailored to the needs of the individual, culturally appropriate, and provided in a form that is accessible to people who have additional needs, such as learning difficulties, physical or sensory disabilities, or limited competence in speaking or reading English. **[GPP]**

1.1.3.3 Healthcare professionals should inform people with OCD or BDD, family and carers about local self-help and support groups for OCD and/or BDD, and encourage them to participate in such groups where appropriate. This may be particularly helpful as many people with OCD or BDD hide the symptoms of the disorder from others. **[GPP]**

1.1.4 Religion

1.1.4.1 Where obsessive compulsive symptoms involve a person's religion, such as religious obsessions and scrupulosity, healthcare professionals should consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process. **[GPP]**

1.1.5 Families and carers

1.1.5.1 Because OCD and BDD often affect not only the person with OCD or BDD but also their family/carers, healthcare professionals should promote a collaborative approach with the person with OCD or BDD and their family/carers, wherever this is appropriate and possible. **[GPP]**

1.1.5.2 In the treatment and care for people with OCD/ BDD, family members should be provided with good information (both verbal and written) about the disorder, its likely causes, its course and treatment. **[GPP]**

1.1.5.3 Assessment and treatment plans for people with OCD or BDD should, where appropriate, involve relevant family members and carers, assess the impact of their behaviours on others, (including and especially dependent children) and the degree to which carers are involved in supporting or carrying out behaviours related to the disorder. **[GPP]**

1.1.5.4 If dependent children are considered to be at risk of emotional, social or mental health problems as a result of the behaviour of parent

with OCD and/or the child's involvement in such activity, independent assessment of the child should be requested. **[GPP]**

1.1.5.5 In the treatment of people with OCD or BDD, especially when the disorder is moderate to severe or chronic, an assessment of the carers' social, occupational and mental health needs should be offered. **[GPP]**

1.2 Stepped care for children, young people, and adults with OCD or BDD

The stepped-care model of OCD and BDD draws attention to the different needs of people with OCD and BDD – depending on the characteristics of their OCD or BDD, their personal and social circumstances, and the responses that are required from services. It provides a framework in which to organise the provision of services in order to identify and access the most effective interventions (see Figure 1).

Who is responsible for care?	What is the focus?	What do they do?
Step 6: Inpatient care or intensive treatment programmes (CAMHS Tier 4)	OCD or BDD with severe distress or disability, risk to life or severe self-neglect.	Reassess, discuss options, care coordination, SRI, CBT including ERP, or combination of SRI and CBT including ERP, augmentation strategies, consider admission or special living arrangements
Step 5: Multidisciplinary care with expertise in OCD or BDD (CAMHS Tier 3/ 4)	OCD or BDD with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse	Reassess, discuss options: SRI, CBT including ERP, or combination of SRI & CBT including ERP; consider care coordination, augmentation strategies, admission social care. For children and young people: reassess, discuss options: CBT including ERP, / SSRI/clomipramine/ combined treatment For teenagers consider referral to specialist services outside CAMHS if appropriate
Step 4: Multidisciplinary care in primary or secondary care (CAMHS Tier 2/3)	OCD or BDD with co-morbidity or moderately impaired functioning or poor response to initial treatment	Assess & review, discuss options: For adults: ERP, SSRI, alternative SSRI or clomipramine, consider CBT, combined treatments. For children and young people: CBT including ERP, then consider CBT/ SSRI/clomipramine/ combined treatment
Step 3: GP/primary care team, PCMH (primary care mental health worker)/ family support team (CAMHS Tier 1 or 2)	Management and initial treatment of OCD or BDD	Assess & review, discuss options. For adults according to impairment: guided self help, computerised ERP, individual or group ERP, SSRI, or consider combined treatments; consider involvement with the family. For children and young people: guided self help, CBT including ERP, involve family and consider involving school
Step 2: GP, practice nurses, school health advisors, general health settings (including hospitals) (CAMHS Tier 1)	Recognition/ assessment	Detect, educate, discuss treatment options, signpost voluntary support organisations, provide support to individuals, families, work/ schools, or refer to any of the appropriate levels
Step 1: Individuals, public organisations, NHS	Awareness	Provide, seek, share information about OCD or BDD, & its impact on individuals & families

Figure 1. The stepped care model

Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person's needs. It assumes monitoring of the course of a person's difficulties and referral to the appropriate level of care.

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Each step introduces additional interventions; the higher steps normally assume interventions in the previous step have been offered/attempted, but there are situations where an individual may be referred to any appropriate level.

The guidance follows these six steps:

- awareness of OCD or BDD by individuals, public organisations, and the NHS
- recognition of OCD or BDD in primary care, school health, and general hospital settings
- management and initial treatment of recognised OCD or BDD in general practice
- involvement of multidisciplinary care in primary and secondary care for OCD or BDD
- involvement of multidisciplinary teams with specific expertise in the management of OCD or BDD
- involvement of inpatient care or intensive treatment programmes for OCD or BDD where there is risk to life, severe self-neglect, severe distress or disability.

At all stages of assessment and treatment, family and carers should be involved as appropriate. This is particularly important in the treatment of children and young people with OCD where it may also be helpful to involve others in their network, for example teachers, school health advisors, educational psychologists, and educational social workers.

1.3 Step 1: awareness, recognition and training

Although the more common forms of OCD are likely to be recognised when people report symptoms, less common forms of OCD and many cases of BDD may remain unrecognised, sometimes for many years. Relatively few mental health professionals may have expertise in the recognition, assessment, diagnosis and treatment of the less common forms of OCD and BDD.

1.3.1.1 PCTs, mental healthcare trusts, and children's trusts that provide mental health services should have access to a specialist OCD/BDD multidisciplinary healthcare team that can help increase the skills of mental health practitioners in the assessment and evidenced-based treatment of children and adults with OCD or BDD, provide high quality advice, and – when appropriate – conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment across the lifespan. **[GPP]**

1.3.1.2 Specialist mental healthcare professionals who work with children, young people and adults with OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high-quality information about OCD and BDD. Such information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD. **[GPP]**

1.3.1.3 Specialist OCD/BDD teams should work with people with OCD or BDD and carers to provide training in the recognition, basic epidemiology, assessment and treatment of people with OCD and BDD. Such training should be for all mental health workers, and cosmetic surgery and dermatology professionals. **[GPP]**

1.4 Step 2: recognition and assessment

Given that people with OCD may have difficulty in disclosing their symptoms, people with disorders known to be commonly associated with OCD or BDD should be specifically assessed for these conditions and the possibility of

comorbidity, especially those with depression and anxiety. People with comorbid depression should be assessed for the risk of suicide.

1.4.1 OCD

1.4.1.1 For children, young people and adults known to be at higher risk of OCD, such as people with symptoms of depression, anxiety, alcohol or substance misuse, BDD or an eating disorder, or for people attending dermatology clinics, healthcare professionals should routinely consider and explore the possibility of comorbid OCD. **[C]**

1.4.1.2 In the assessment of people at higher risk of OCD, the following six questions should be asked to identify children, young people or adults with OCD.

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you'd like to get rid of but can't?
- Do your daily activities take a long time to finish?
- Are you concerned about orderliness and symmetry?
- Do these symptoms interfere with your life? **[C]**

1.4.1.3 If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts reported by a person with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. **[GPP]**

1.4.1.4 In people who have been diagnosed with OCD, healthcare professionals should assess suicide risk, especially if the person has also been diagnosed with depression. **[GPP]**

1.4.2 BDD

1.4.2.1 For children, young people and adults known to be at higher risk of BDD, such as those with symptoms of depression, social phobia,

alcohol or substance misuse, OCD or an eating disorder, or for people seeking cosmetic surgery or attending dermatology clinics, healthcare professionals should routinely consider and explore the possibility of comorbid BDD. **[GPP]**

1.4.2.2 In the assessment of people at higher risk of BDD, the following five questions should be asked to help identify children, young people or adults with BDD.

- Do you worry a lot about the way you look a lot and wish you could think about it less?
- What specific concerns do you have about your appearance?
- On a typical day, how many hours a day is it on your mind? (More than a hour a day is considered excessive)
- What effect does it have on your life?
- Does it make it hard to do your work or be with friends? **[GPP]**

1.4.2.3 In people who have been diagnosed with BDD, healthcare professionals should assess suicide risk, especially if the person has also been diagnosed with depression. **[GPP]**

1.4.2.4 Mental healthcare specialists in BDD should work in partnership with cosmetic surgeons and dermatologists to ensure that an agreed screening system is in place to accurately identify people with BDD. **[GPP]**

1.4.2.5 People with suspected BDD attending dermatology departments should be referred for a comprehensive mental health assessment. **[GPP]**

1.4.2.6 People with suspected BDD seeking cosmetic surgery should be assessed by mental health specialists in BDD prior to surgery being offered because the outcome of surgery for these people is unpredictable. Symptoms of BDD may persist; the patient may be dissatisfied with the procedure and continue to seek further treatment. **[GPP]**

1.5 Steps 3-5: interventions for people with OCD or BDD

The treatments for OCD and BDD that are effective should be offered at all levels of the health care system. The difference in the treatments at the higher levels will reflect increasing experience and expertise in the implementation of a limited range of therapeutic options. For many people, initial treatment may be best provided in primary care settings. However, people with more impaired functioning, higher levels of comorbidity, or poor response to initial treatment will require care from teams with greater levels of expertise and experience in the management of OCD or BDD.

1.5.1 Initial treatment options

Irrespective of level of care, the following recommendations should be taken into account when selecting initial treatments for people with OCD or BDD. The specific recommendations as to how to provide these treatments follow in the subsequent sections.

Regulatory authorities have identified possible risks associated with the use of SSRIs in depression especially among children, young people and young adults. The risks in other disorders including OCD/BDD are currently uncertain. Consequently, the recommendations about the use of SSRIs for people with OCD or BDD have taken account of the position of regulatory authorities.

Adults

In the current regulatory context, offer adults with milder impairments low intensity cognitive behaviour therapy (CBT) first, reserving higher intensity CBT and specific drug treatments for those with greater impairment. The intensity of psychological treatment has been defined as the hours of therapist input per patient. By this definition most group treatments meet the definition of a low intensity treatment (less than 10 hours therapist input per patient), although each patient may be receiving a much greater number of hours of therapy. Professionals offering psychological treatments should have received appropriate training for the intervention they are offering.

1.5.1.1 In the initial treatment of adults with OCD or BDD, low intensity psychological treatments including exposure and response prevention (ERP) (up to 10 therapist hours per patient) may be offered if the degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:

- computer guided ERP with brief scheduled contacts with a trained support worker
- brief individual CBT (including ERP) using structured self-help materials
- brief individual CBT (including ERP) by telephone
- group CBT (including ERP). **[C]**

1.5.1.2 For adults with OCD with mild functional impairment who are unable to engage in low intensity CBT or for whom low intensity treatment has proved to be inadequate, healthcare professionals should offer the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious. **[C]**

1.5.1.3 For adults with OCD with moderate functional impairment, healthcare professionals should offer the choice of either a course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP because these treatments appear to be comparably efficacious. **[B]**

1.5.1.4 Adults with BDD with mild to moderate functional impairment should be offered a course of CBT (including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation) in individual or group formats or an SSRI, depending upon the patient's preference. **[B]**

- 1.5.1.5 Adults with OCD or BDD with severe functional impairment, or for whom psychological or pharmacological treatments have proved ineffective, should be offered combined treatment with an SSRI and CBT. **[C]**

Children and young people

In the current regulatory context regarding prescribing SSRIs, offer children and young people with OCD or BDD psychological treatments first.

- 1.5.1.6 For children and young people with OCD with mild functional impairment, guided self-help may be considered in conjunction with support and information for the family. **[C]**
- 1.5.1.7 For children and young people with OCD with moderate to severe functional impairment, and for those with OCD with mild functional impairment for whom guided self help has been ineffective or refused, CBT (including ERP) involving the family and adapted to suit the developmental age of the child, should be offered as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family/carers. **[B]**
- 1.5.1.8 If psychological treatment is declined by children or young people with OCD and their families, or they are unable to engage in treatment, an SSRI may be cautiously considered with specific arrangements for careful monitoring of adverse events. **[B]**
- 1.5.1.9 All children and young people with BDD should be offered CBT (including ERP) involving the family and adapted to the developmental age of the child as first-line treatment. **[C]**
- 1.5.1.10 If the child or young person's OCD or BDD is not responding to treatment as a result of other co-existing factors such as the presence of co-morbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of parental mental ill-health, additional or alternative interventions for

these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD. **[C]**

1.5.2 How to use psychological interventions for adults

Cognitive behavioural treatments involving exposure and response prevention are effective treatments for OCD and BDD. The format and delivery of such therapy should take into account specific features of problems experienced by the person with OCD or BDD and the interventions should be adapted accordingly.

- 1.5.2.1 For people with obsessive thoughts who do not have overt compulsions, CBT including exposure to obsessive thoughts and response prevention of mental rituals and neutralising strategies, should be considered. **[B]**
- 1.5.2.2 For people with OCD living with family/carers, involving a family member or carer as a co-therapist in exposure and response prevention should be considered where this is appropriate and acceptable to the person with OCD and the family member or carer. **[B]**
- 1.5.2.3 For people with more severe OCD who are housebound, unable or reluctant to attend a clinic, or have significant problems with hoarding a period of home-based treatment may be offered. **[C]**
- 1.5.2.4 For people with more severe OCD who are housebound and unable to undertake home treatment because of the nature of their symptoms (such as contamination concerns or hoarding that prevents therapists' access to the person's home), a period of CBT by telephone may be considered. **[C]**
- 1.5.2.5 For people with OCD who refuse, or do not engage with, treatments that include ERP, individual cognitive therapy specifically adapted for OCD may be considered. **[C]**

- 1.5.2.6 When family members or carers of people with OCD or BDD have become involved in compulsive behaviours, avoidance or reassurance seeking, treatment plans will need to help them reduce their involvement in these behaviours in a sensitive and supportive manner. **[GPP]**
- 1.5.2.7 People with OCD or BDD with significant functional impairment may need access to appropriate support for travel and transport to allow them to attend for their treatment. **[GPP]**
- 1.5.2.8 For adults with OCD, cognitive therapy adapted for OCD may be considered as an addition to exposure and response prevention to enhance long-term symptom reduction. **[C]**
- 1.5.2.9 For adults with BDD, group or individual CBT should be offered based on treatment protocols that address the specific features of BDD; the decision to use group or individual formats should be jointly decided by the individual with BDD and the healthcare professional. **[GPP]**
- 1.5.2.10 Towards the end of treatment, healthcare professionals should inform people with OCD or BDD about how the principles learned can be applied to the same or other symptoms if they occur in the future. **[GPP]**
- 1.5.2.11 Psychoanalysis, transactional analysis, hypnosis, marital/couple therapy and therapies other than cognitive and/or behavioural therapies should not routinely be offered as specific treatments for people with OCD. **[C]**

1.5.3 How to use psychological interventions for children and young people

Psychological treatments for children and young people should be collaborative and engage the family. Always consider the wider context and the other professionals involved with the child. Rewards to encourage the child can be helpful. When working with young people, the recommendations

on the use of psychological interventions for adults may also be considered when appropriate.

1.5.3.1 In the cognitive-behavioural treatment of children and young people with OCD or BDD, particular attention should be given to:

- developing and maintaining a good therapeutic alliance with the child/young person as well as their family
- maintaining optimism in both child and family
- collaboratively identifying initial and subsequent treatment targets with the child or young person
- actively engaging the family in planning treatment and in the treatment process, especially in ERP where, if appropriate, they may be asked to assist the child or young person
- encouraging the use of ERP if new or different symptoms re-emerge after successful treatment
- liaising with other professionals involved in the child/young person's life, including teachers, social workers and other health professionals, especially when compulsive activity interferes with the ordinary functioning of the child/young person. **[GPP]**

1.5.3.2 In the psychological treatment of children and young people with OCD or BDD, addition and/or inclusion of behavioural or operant rewards in order to enhance the child's motivation and reinforce desired behaviour changes, should be considered. **[C]**

1.5.4 How to use pharmacological interventions for adults

Current published evidence suggests that SSRIs are effective in treating people with OCD and BDD, although evidence for the latter is limited and less certain. However, SSRIs may increase the risk of suicidal ideas and self harm in people with depression and in younger people. It is currently unclear

whether there is an increased risk for people with OCD or BDD. Regulatory authorities recommend caution in their use until evidence for differential safety has been demonstrated. Appropriate monitoring is therefore needed, especially when initiating treatment and around dose changes. Patients should also be warned about, and monitored for, relapse and discontinuation/withdrawal symptoms when stopping or reducing SSRIs.

Starting the treatment

1.5.4.1 Common concerns about taking medication for OCD/BDD should be addressed. Patients should be advised, both verbally and with written material, that:

- craving and tolerance do not occur **[C]**
- there is a risk of discontinuation/withdrawal symptoms on stopping, missing doses, or reducing the dose of the drug **[C]**
- there is a range of potential side effects, including worsening anxiety, suicidal thinking and self-harm, which need to be carefully monitored, especially in the first few weeks of treatment **[C]**
- there is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly **[C]**
- taking medication should not be seen as a weakness. **[GPP]**

Monitoring risk

1.5.4.2 People with OCD or BDD started on SSRIs who are not considered to be at increased risk of suicide or self harm should be monitored closely and seen at an appropriate and regular basis agreed by the patient and the healthcare professional, and this should be recorded in the notes. **[GPP]**

- 1.5.4.3 Because of the potential increased risk of suicidal thoughts and self harm associated with the early stages of SSRI treatment, people with OCD or BDD who are younger adults, are depressed, or are considered to present an increased suicide risk, should be carefully and frequently monitored by healthcare professionals. Where appropriate, other carers – as agreed by the patient and the healthcare professional – may also contribute to the monitoring until the risk is no longer considered significant. This should be recorded in the notes. **[C]**
- 1.5.4.4 For people with OCD or BDD at high risk of suicide, a limited quantity of medication should be prescribed. **[C]**
- 1.5.4.5 When a person with OCD or BDD, especially when combined with depression, is assessed to be at a high risk of suicide, the use of additional support such as more frequent direct contacts with primary care staff or telephone contacts should be considered, especially during the first weeks of treatment. **[C]**
- 1.5.4.6 For people with OCD or BDD, particularly in the initial stages of SSRI treatment, healthcare professionals should actively seek out signs of akathisia or restlessness, suicidal ideation, and increased anxiety and agitation. They should also advise patients to seek help promptly if these are at all distressing. **[C]**
- 1.5.4.7 People with OCD or BDD should be monitored around the time of dose changes for any new symptoms or worsening of their condition. **[C]**

Choice of drug treatment

Selective Serotonin Reuptake Inhibitors (SSRIs)

- 1.5.4.8 For adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: citalopram, fluoxetine, fluvoxamine, paroxetine or sertraline. **[A]**

- 1.5.4.9 For adults with BDD the initial pharmacological treatment should be fluoxetine as there is more evidence for its effectiveness in BDD than other SSRIs. **[B]**
- 1.5.4.10 When prescribing an SSRI for OCD, consideration should be given to using a product in a generic form. Fluoxetine and citalopram, for example, would be reasonable choices because they are generally associated with fewer discontinuation/withdrawal symptoms than fluvoxamine, paroxetine or sertraline. However, fluoxetine is associated with a higher risk for drug interactions. **[C]**
- 1.5.4.11 In the event that a person with OCD or BDD develops marked and/or prolonged akathisia, restlessness or agitation while taking an SSRI, the use of the drug should be reviewed. If the patient prefers, the drug should be changed to a different SSRI. **[C]**
- 1.5.4.12 Healthcare professionals should be aware of the increased risk of drug interactions when prescribing an SSRI to people with OCD or BDD who are taking other medications. **[GPP]**
- 1.5.4.13 When OCD or BDD symptoms fail to respond to a full course of treatment with an SSRI, healthcare professionals should check that the patient has taken the drug regularly and in the prescribed dose and that there is no interference from alcohol or substance use. **[GPP]**
- 1.5.4.14 If the response to a standard dose of an SSRI for a person with OCD or BDD is inadequate and there are no significant side effects after 4 to 6 weeks, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics. **[B]**
- 1.5.4.15 For people with OCD or BDD, the rate at which the dose of an SSRI should be increased should take into account therapeutic response, adverse effects, and patient preference. Patients should be warned

about, and monitored for, the emergence of side effects during dose increases **[GPP]**

1.5.4.16 If treatment for OCD or BDD with an SSRIs is effective, it should be continued for at least 12 months to prevent relapse and allow for further improvements **[B]**

1.5.4.17 When a person with OCD or BDD has taken an SSRI for 1 year after remission, healthcare professionals should review the need for continued treatment with the patient. This review should include consideration of the severity and duration of the initial illness, number of previous episodes, presence of residual symptoms, and concurrent psychosocial difficulties. **[GPP]**

1.5.4.18 If treatment for OCD or BDD with an SSRI is continued for an extended period beyond 12 months, the need for continuation should be reviewed at regular intervals, agreed between the patient and the prescriber, and written in the notes. **[GPP]**

1.5.4.19 For people with OCD or BDD, to minimise discontinuation/withdrawal reactions when reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the person's need. The rate of reduction should take into account starting dose, drug half-life and particular profiles of adverse effects. **[C]**

1.5.4.20 Healthcare professionals should encourage people with OCD or BDD who are discontinuing SSRI treatment to seek advice if they experience significant discontinuation/withdrawal symptoms. **[C]**

Other drugs

With the exception of clomipramine, other antidepressants should not normally be used in the treatment of OCD or BDD. Most other drugs have limited or no use in this context.

Tricyclic antidepressants

1.5.4.21 Tricyclic antidepressants other than clomipramine should not normally be used for treating OCD. **[B]**

Tricyclic related antidepressants

1.5.4.22 Tricyclic related antidepressants should not normally be used for treating OCD. **[C]**

Serotonin and noradrenaline reuptake inhibitors (SNRIs)

1.5.4.23 SNRIs, including venlafaxine, should not normally be used for treating OCD. **[B]**

Monoamine oxidase inhibitors (MAOIs)

1.5.4.24 MAOIs should not normally be used for treating OCD. **[B]**

Anxiolytics

1.5.4.25 Anxiolytics should not normally be used for treating OCD , except cautiously for short periods to counter the early activation of SSRIs. **[B]**

Antipsychotics

1.5.4.26 Antipsychotics as a monotherapy should not normally be used for treating OCD. **[B]**

1.5.4.27 Antipsychotics as a monotherapy should not normally be used for treating BDD or its delusional variant. **[C]**

1.5.5 Poor response to initial treatment for adults

If initial treatment does not result in a clinically significant improvement in both symptoms and functioning, other treatment options should be considered. When additional treatment options also fail to produce an adequate response, multidisciplinary teams with specific expertise in OCD/BDD should become involved.

- 1.5.5.1 If a person with OCD or BDD has not responded adequately to treatment with an SSRI (within 12 weeks) or CBT (of more than 10 therapist hours per patient), he or she should be offered combined treatment with CBT (including ERP) in addition to an SSRI. **[C]**
- 1.5.5.2 If a person with OCD or BDD has not responded adequately after 12 weeks of combined treatment with CBT (including ERP) and an SSRI, or has not responded to an SSRI alone or engaged with CBT, he or she should be offered either a different SSRI or clomipramine. **[C]**
- 1.5.5.3 Clomipramine should be considered in the treatment of OCD or BDD after an adequate trial of at least one SSRI has been ineffective or poorly tolerated, if the patient prefers clomipramine, or if the patient has had a previous good response to it. **[C]**
- 1.5.5.4 If an adult with OCD or BDD has not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, he or she should be referred to a multidisciplinary team with specific expertise in the treatment of OCD/BDD for assessment and further treatment planning. **[GPP]**
- 1.5.5.5 The assessment of people with OCD and BDD referred to multidisciplinary teams with specific expertise in OCD/BDD should include a comprehensive assessment of their symptom profile, previous pharmacological and psychological treatment history, adherence to prescribed medication, history of side effects, comorbid conditions such as depression, suicide risk, psychosocial stressors, relationship with carers and personality factors. **[GPP]**

1.5.5.6 For adults with OCD who have not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, the following treatment options should also be considered (note: there is no evidence of the optimal sequence of the options listed below):

- additional CBT or CT **[C]**
- adding an antipsychotic to an SSRI or clomipramine **[C]**
- combining clomipramine and citalopram. **[C]**

1.5.5.7 For adults with BDD who have not responded to a full trial of at least one SSRI, a full trial of combined treatment with CBT (including ERP) and a full trial of clomipramine, the following treatment options should also be considered (note: there is no evidence of the optimal sequence of the options listed below):

- additional CBT or CT **[GPP]**
- adding buspirone to an SSRI **[C]**
- combining clomipramine and citalopram. **[C]**

1.5.5.8 Treatments such as combined antidepressants and antipsychotic augmentation should not be routinely initiated in primary care. **[GPP]**

How to use clomipramine for adults

Clomipramine can be offered as a second line drug for OCD or BDD. Always do an ECG and check blood pressure before starting treatment if there is significant risk of cardiovascular disease. Dose changes should be gradual.

1.5.5.9 For people with OCD or BDD who are at a significant risk of suicide, healthcare professionals should prescribe only small amounts of clomipramine at a time and monitor the patient regularly until the risk of suicide has subsided because of the toxicity of clomipramine in overdose. **[GPP]**

1.5.5.10 An ECG should be carried out and blood pressure measurement taken before prescribing clomipramine for a person with OCD or BDD at significant risk of cardiovascular disease. **[C]**

1.5.5.11 For people with OCD or BDD, if the response to the standard dose of clomipramine is inadequate, and there are no significant side effects, a gradual increase in dose should be considered in line with the schedule suggested by the Summary of Product Characteristics. **[C]**

1.5.5.12 For people with OCD or BDD, treatment with clomipramine should be continued for at least 12 months if the treatment appears to be effective because there may be further improvement. **[B]**

1.5.5.13 For people with OCD or BDD, when discontinuing clomipramine, doses should be reduced gradually in order to minimise potential discontinuation/withdrawal symptoms. **[C]**

1.5.6 Poor response to initial treatment in children and young people

If CBT involving the family has not produced an adequate response in terms of a clinically significant reduction in symptoms and increase in functioning within 12 sessions, then review and consider further options according to the age of the child as described below.

Current published evidence suggests that SSRIs are effective in treating children and young people with OCD. The only SSRIs licensed for use in children and young people with OCD are fluvoxamine and sertraline. However, with depression SSRIs can cause significant adverse reactions, including increased suicidal thoughts and self-harm, although they may be safer when combined with psychological treatments. The UK regulatory authority has contraindicated all SSRIs except fluoxetine in paediatric depressive illness. Although the risk associated with the use of SSRIs in children and young people with OCD is unclear, appropriate caution should be observed, especially in the presence of comorbid depression.

- 1.5.6.1 If a child or young person with OCD or BDD has not shown an adequate response to a full trial of CBT involving the family within 12 sessions, a multidisciplinary review should be carried out. **[GPP]**
- 1.5.6.2 Following multidisciplinary review, if a **child** (6 to 11 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT involving the family, the addition of an SSRI to ongoing psychological treatment may be **cautiously** considered. **[B]***
- 1.5.6.3 Following multidisciplinary review, if a **young person** (12 to 18 years) with OCD or BDD with moderate to severe functional impairment does not respond adequately to CBT involving the family, an SSRI should be offered in addition to continuing psychological treatment. **[B]**
- 1.5.6.4 If treatment with an SSRI, in combination with CBT involving the family, for a young person (12 to 18 years) with OCD or BDD is unsuccessful or is not tolerated because of side effects, cautious consideration may be given to the use of another SSRI or clomipramine, especially if the young person has had a positive response to these alternatives in the past. **[B]***

1.5.7 How to use pharmacological treatments in children and young people

In adults with OCD treated by medication, there is clinical trial evidence that supports practice on the onset of therapeutic response, dose needed, rate of increase of dose, duration of treatment, likelihood of relapse on discontinuation. Trials of these aspects have not been done in children and/or young people, but the following good practice for prescribing SSRIs or clomipramine is based on adult trials and clinical experience.

How to use SSRIs in children and young people

- 1.5.7.1 When antidepressant medication is prescribed to children and young people with OCD or BDD, it should be in combination with

concurrent CBT. If children and young people are unable to engage with concurrent CBT, specific arrangements must be made for careful monitoring of adverse events. **[C]**

- 1.5.7.2 Children and young people with OCD or BDD started on SSRIs should be carefully and frequently monitored and seen at an appropriate and regular basis agreed by the patient, his or her family and the healthcare professional, and this should be recorded in the notes. **[GPP]**
- 1.5.7.3 If an SSRI is to be prescribed to children and young people with OCD or BDD, it should only be following assessment and diagnosis by a psychiatrist who should also be involved in decisions about dose changes and discontinuation. **[GPP]**
- 1.5.7.4 When an SSRI is prescribed to children and young people with OCD, it should be a licensed medication, sertraline or fluvoxamine, except in cases with significant comorbid depression, when fluoxetine should be used (because of current regulatory requirements). **[A]**
- 1.5.7.5 When an SSRI is prescribed for children and young people with BDD it should be fluoxetine. **[C]**
- 1.5.7.6 For children and young people with OCD or BDD who also have significant depression, the NICE recommendations for the treatment of childhood depression should be followed ('Depression in children: identification and management of depression in children and young people in primary care and specialist services', publication expected August 2005), and caution should be observed with specific monitoring for suicidal thoughts or behaviours. **[GPP]**
- 1.5.7.7 Children and young people with OCD or BDD started on SSRIs should be informed about the rationale for the drug treatment, the delay in onset of effect (up to 12 weeks), the time course of treatment, the possible side effects, and the need to take the medication as prescribed. Discussion of these issues should be supplemented by

written information appropriate to the child/young person's and family's needs. **[GPP]**

1.5.7.8 The starting dose of medication for children and young people with OCD or BDD should be low, especially in younger children. A half or quarter of the normal starting dose may be considered for the first week. **[C]**

1.5.7.9 If a lower dose of medication for children and young people with OCD or BDD is ineffective, the dose should be increased until a therapeutic response is obtained, with careful and close monitoring for adverse events. The rate of increase should be gradual and should take into account the delay in therapeutic response (that is, up to 12 weeks) and the age of the patient. Maximum recommended doses for children and young people should not be exceeded. **[C]**

1.5.7.10 Children and young people prescribed SSRIs should be carefully and closely monitored for agitation, disinhibition, hostility, suicidal ideation and self-harm by the prescribing doctor and the professional delivering the psychological intervention. Children and young people and their families should be informed that if there is any sign of new symptoms of these kinds, they should make urgent contact with the prescribing doctor. **[GPP]**

1.5.7.11 Where children or young people with OCD or BDD respond to treatment with an SSRI, medication should be continued for at least 6 months post remission (symptoms that are not clinically significant and full functioning for at least 12 weeks). **[C]**

How to use clomipramine in young people

1.5.7.12 Young people with OCD or BDD and their parents should be advised about possible side effects of clomipramine, including toxicity in overdose. **[C]**

1.5.7.13 Before starting to treat a young person with OCD or BDD with clomipramine, an ECG and blood pressure monitoring should be carried out to exclude cardiac conduction. **[C]**

1.5.7.14 If the response of the young person with OCD or BDD to the standard dose of clomipramine is inadequate, and there are no significant side effects, a gradual increase in dose may be cautiously considered. **[C]**

1.5.7.15 Treatment of a young person with OCD or BDD with clomipramine should be continued for at least 6 months if the treatment appears to be effective and because there may be further improvement. **[B]**

Stopping or reducing SSRIs and clomipramine in children and young people

1.5.7.16 In children and young people with OCD or BDD, an attempt should be made to withdraw medication if remission has been achieved (that is, symptoms are no longer clinically significant and the child or young person is fully functioning) and maintained for 6 months, and if this is their wish. Patients and their family should be warned that relapse and/or discontinuation/withdrawal symptoms may occur, and to contact their medical practitioner should symptoms of discontinuation/withdrawal arise. **[C]**

1.5.7.17 For children and young people with OCD or BDD, to minimise discontinuation/withdrawal reactions on reducing or stopping SSRIs, the dose should be tapered gradually over several weeks according to the individual's need. The rate of reduction should take into account starting dose, drug half-life and particular profiles of adverse effects. **[C]**

1.5.7.18 Children or young people with OCD or BDD should continue with psychological treatment throughout the period of drug withdrawal because this may reduce the risk of relapse. **[C]**

Other drugs

- 1.5.7.19 Tricyclic antidepressants other than clomipramine should not be used to treat OCD or BDD in children and young people. **[C]**
- 1.5.7.20 Other antidepressants (MAOIs, SNRIs) should not be used to treat OCD or BDD in children and young people. **[C]**
- 1.5.7.21 Antipsychotics should not be used alone in the routine treatment of OCD or BDD in children or young people, but may be cautiously considered as an augmentation strategy. **[C]**

1.6 Step 6: intensive treatment services and inpatient services for people with OCD or BDD

OCD and BDD can usually be treated managed in the community and in primary care. However, people with severe and/or chronic problems that have not responded adequately to treatment should be referred to multidisciplinary teams with specialist expertise in the treatment of OCD/BDD. Occasionally inpatient treatment may be needed for children, young people or adults who are at particular risk or whose ability to function is severely impaired. Special support may be needed, especially for young adults with impaired autonomy and personal functioning as a result of severe OCD with onset in childhood or adolescence. Neurosurgery is not recommended as a treatment for OCD, although it is recognised that some people may wish to consider this option when all else has failed.

- 1.6.1.1 People with severe, chronic, treatment-refractory OCD or BDD should have access to specialist treatment services staffed by multiprofessional teams of healthcare professionals with expertise in the management of the disorders. **[C]**

1.6.1.2 Inpatient services, with specific expertise in OCD/BDD, are appropriate for a small proportion of people with OCD or BDD, and may be considered when:

- there is risk to life
- there is severe self-neglect
- there is extreme distress or impairment
- a person has not responded to adequate trials of pharmacological/psychological/combined treatments over long periods of time in other settings
- a person has additional diagnoses, such as severe depression, anorexia nervosa or schizophrenia, that make outpatient treatment more complex
- a person has a reversal of normal night/day patterns that make attendance at any day-time therapy impossible
- the compulsions and avoidance behaviour are so severe or habitual that they cannot undertake normal activities of daily living. **[GPP]**

1.6.1.3 A small minority of adults with long-standing and disabling obsessive compulsive symptoms that interfere with daily living and have prevented them from developing a normal level of autonomy may, in addition to treatment, need suitable accommodation in a supportive environment that will enable them to develop life skills for independent living. **[GPP]**

1.6.1.4 If neurosurgery were to be considered for severe refractory OCD among adults, the following should be taken into consideration.

- Existing criteria (such as Matthews and Elmajel, 2003) should be used to guide decisions about suitability.
- Multidisciplinary teams with a high degree of expertise in the pharmacological and psychological treatment of OCD should have been recently involved in the patient's care; all pharmacological options should have been considered and every attempt should have been made to engage the individual in CBT and CT, including very intensive and/or inpatient treatments.
- Standardised assessment protocols should be used at pre- and post-operation and follow-up in order to audit the interventions. These assessment protocols should include standardised measures of symptoms, quality of life, and personality as well as comprehensive neuropsychological tests.
- Post-operative care should be carefully considered, including pharmacological and psychological therapies. **[GPP]**

1.6.1.5 Children and young people with severe OCD or BDD with high levels of distress and/or impaired functioning and who have not responded to adequate treatment in outpatient settings, or those with significant self-neglect or risk of suicide should be offered assessment for intensive inpatient treatment in units where specialist treatment for children or young people with OCD or BDD is available. **[GPP]**

1.7 Discharge after recovery

After full recovery, children, young people and adults with OCD or BDD should be followed up for a year. After discharge, those re-referred should be seen quickly and should not be placed on a routine waiting list.

1.7.1.1 When a child, young person or adult with OCD or BDD is in remission (symptoms that are not clinically significant and full functioning for 12 weeks), they should be reviewed regularly for

12 months by a mental healthcare professional. The exact frequency of contact should be agreed between the professional and service user and/ or carer and recorded in the notes. At the end of this period if recovery is maintained the person can be discharged to primary care. **[C]**

- 1.7.1.2 Children, young people or adults who have been successfully treated, discharged but re-referred after a first episode of OCD or BDD should be seen as soon as possible rather than placed on a routine waiting list. **[GPP]**

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/**[NICE will add full URL]**

This guideline is relevant to people aged 8 years and over with OCD or BDD, to their carers, and to all healthcare professionals involved in the help, treatment and care of people with OCD or BDD. These include the following.

- Professional groups who share in the treatment and care for people with a diagnosis of OCD or BDD, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff, and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical practitioners and family/other therapists.
- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with OCD or BDD. These may include prison doctors, the police, and professionals who work in the criminal justice and education sectors.

- Those with responsibility for planning services for people with a diagnosis of OCD or BDD and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address care and treatment not normally available on the NHS.

3 Implementation in the NHS

3.1 Resource implications

Local health communities should review their existing practice for OCD/BDD against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of people with OCD and BDD that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

Information on the cost impact of this guideline in England is available on the NICE website and includes a template that local communities can use (www.nice.org.uk/CGXXXcosttemplate). **[Note: the costing information will be available when the guideline is published.]**

3.2 General

The implementation of this guideline will build on the National Service Framework for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales.

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.dh.gov.

3.3 Audit

Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, on the basis of its review of the evidence. The Group regards these recommendations as the most important research areas to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see Section 5). **[to be completed in Draft 2]**

5 Other versions of this guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The guideline development process – an overview for stakeholders, the public and the NHS* has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

5.1 Full guideline

The full guideline, *Obsessive compulsive disorder: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*, is published by the National Collaborating Centre for Mental Health; it is available from [website details to be added], the NICE website (www.nice.org.uk/CGXXXfullguideline) and the website of the National Library for Health (www.nlh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for health professionals is also available from the NICE website (www.nice.org/CGXXXquickrefguide) or from the Department of Health Publications Order Line (telephone 0870 1555 455; quote reference number N0XXX). **[Note: these details will apply when the guideline is published.]**

5.3 Information for the public

A version of this guideline for people with OCD or BDD and their carers, and for the public, is available from the NICE website (www.nice.org.uk/CGXXXpublicinfo) or from the Department of Health Publications Order Line (0870 1555 455); quote reference number N0xxx for an English version and N0XXX for an English and Welsh version). **[Note: these details will apply when the guideline is published.]**

6 Related NICE guidance

Computerised cognitive behaviour therapy (CCBT) for the treatment of depression and anxiety (review of existing NICE Technology Appraisal No.51). (Publication expected September 2005.)

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Box 1). Recommendations were then graded A to C based on the level of associated evidence. This grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

Box 1: Hierarchy of evidence

Hierarchy of evidence and recommendations grading scheme			
Level	Type of evidence	Grade	Evidence
I	Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials	A	At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation
IIa	Evidence obtained from at least one well-designed controlled study without randomisation	B	Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence
IIb	Evidence obtained from at least one other well-designed quasi-experimental study		
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies		
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities	C	Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available
		GPP	Recommended good practice based on the clinical experience of the GDG.
Adapted from Eccles, M. & Mason, J (2001). How to develop cost-conscious guidelines. <i>Health Technology Assessment</i> 5: 16; Mann T (1996) <i>Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS</i> . London: Department of Health.			

Appendix B: The Guideline Development Group

Professor Mark Freeston (Chair Guideline Development Group)

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Mr Rowland Urey

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Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and take responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

[To be added at second consultation]

Appendix D: Technical detail on the criteria for audit

Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- individuals with OCD or BDD are involved in their care
- treatment options are appropriately offered and provided for individuals with OCD or BDD.

People that could be included in an audit and time period for selection

A single audit could include all individuals with OCD or BDD. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people with OCD or BDD at a particular stage (for example, to study assessment)
- a sample of people with OCD or BDD from particular populations in primary care.

Measures that could be used as a basis for an audit

Please see tables overleaf

Recommendation	Measured by	Exception	Definition
<p>1. Access to specialist OCD/BDD multidisciplinary team</p> <p>PCTs, mental healthcare trusts, and children’s trusts which provide mental health services should have access to a specialist OCD/BDD multidisciplinary healthcare team that can help increase the skills of mental health practitioners in the assessment and evidenced-based treatment of children and adults with OCD or BDD, provide high quality advice, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment across the lifespan</p>	<p>100% of PCTs, mental healthcare trusts, and children’s trusts which provide mental health services will have access to a specialist OCD/BDD team</p>	<p>None</p>	<p>Operational policies in PCTs, mental healthcare trusts, and children’s trusts which provide mental health services will specify procedure for accessing specialist OCD/BDD team.</p>
<p>2. Collaboration with voluntary organisations to increase access to high quality information</p> <p>Specialist mental healthcare professionals who work with children, young people, and adults with OCD or BDD should collaborate with local and national voluntary organisations to increase awareness and understanding, and to improve access to high quality information about OCD and BDD. Such information should also be made available to primary and secondary care professionals, and to professionals from other public services who may come into contact with people of any age with OCD or BDD</p>	<p>100% of specialist mental healthcare teams who work with children and young people and adults with OCD/BDD will collaborate with voluntary organisations.</p>	<p>None</p>	<p>Operational policies will identify and specify the collaborative links with voluntary organisations</p>

<p>3. Explanation about OCD or BDD</p> <p>People with OCD or BDD are often ashamed and embarrassed by their condition and may find it very difficult to discuss their symptoms with healthcare professionals, friends or family. Healthcare professionals should help people with OCD or BDD, and their families where appropriate, understand the involuntary nature of the symptoms caused by the disorder, and the shame and distress experienced</p>	<p>100% of healthcare professionals will provide a detailed explanation of OCD/BDD including course, nature and distress of the disorder to people with OCD and where appropriate families and carers</p>	<p>None</p>	<p>Clinical notes will indicate that a detailed explanation has occurred and that the person with OCD or BDD and families/carers have been offered the opportunity to ask questions regarding the disorder</p>
<p>4. Collaborative approach with family and/or carers</p> <p>A collaborative approach should be considered for people with OCD or BDD and their carers wherever this is appropriate and possible.</p>	<p>100% of healthcare professionals working with people with OCD or BDD will promote a collaborate approach with family/carers</p>	<p>Where a person with OCD or BDD explicitly states that they do not want family/carer involvement</p>	<p>Clinical notes will indicate that a discussion has taken place with carer's/families and the level of involvement will be specified.</p>
<p>5. Timeframe for re-referral</p> <p>Seeing children, young people or adults who have been successfully treated, discharged but re-referred after a first episode of OCD or BDD should be initiated as soon as possible rather than placing them on a routine waiting list.</p>	<p>100% of people with OCD or BDD who have lapsed following successful treatment should be seen by a</p>	<p>Person with OCD or BDD refuses re-referral</p>	<p>Operational policies will indicate the re re-referral pathway within a 6 week timeframe.</p>

	healthcare professional within 6 weeks of re-referral		
6. CBT for children and young people with moderate to severe functional impairment CBT (including ERP) involving the family and adapted to suit the developmental age of the child, should be offered as the treatment of choice for children and young people with OCD with moderate to severe functional impairment, and for those with OCD with mild functional impairment for whom guided self help has been ineffective or refused Group or individual formats should be offered depending upon preference of the child or young person and their family/carers.	100% of people with OCD or BDD who have moderate/severe impairment or not responded/refused GSH will be offered CBT (including exposure and response prevention)	People who refuse CBT	Clinical notes indicate that person was informed of possibility of CBT. Clinical notes will identify the clinical outcome of CBT.
7.			
8. SSRI for child with moderate to severe functional impairment who does not respond to CBT Offering an SSRI in addition to ongoing psychological treatment should be cautiously considered for children (6 to 11 years) with OCD or BDD with moderate to severe functional impairment who has not responded adequately to CBT involving the family, following multidisciplinary review	100% of children with OCD or BDD who fail to respond to CBT will attend a multi disciplinary review (with families/carers) where the use of an SSRI will be considered in addition to ongoing	Children who respond to CBT	Clinical notes will indicate a multidisciplinary review occurred and identify that the use of an SSRI in addition to ongoing psychological treatment was explored in detail

	psychological treatment		
<p>9. SSRI for young person with moderate to severe functional impairment who does not respond to CBT Offering an SSRI in addition to continuing psychological treatment. Should be considered for a young person (12 to 18 years) with OCD or BDD with moderate to severe functional impairment who does not respond adequately to CBT involving the family, following multidisciplinary review</p>	<p>100% of young people with OCD or BDD who fail to respond to CBT including ERP will attend a multi disciplinary review where the use of an SSRI will be considered in addition to ongoing psychological treatment</p>	<p>Young people who respond to CBT</p>	<p>Clinical notes will indicate a multidisciplinary review occurred and identify that the use of an SSRI in addition to ongoing psychological treatment was explored in detail</p>
<p>10. Initial low intensity psychological treatments for adults Low intensity psychological treatments including ERP (up to 10 therapist hours per patient) may should be offered to people with OCD or BDD if the degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:</p> <ol style="list-style-type: none"> 1. Computer guided exposure and response prevention with brief scheduled contacts with a trained support worker 	<p>100% of people with mild OCD or BDD, or those who express a preference will receive a low intensity CBT including ERP intervention</p>	<p>People with moderate severe OCD or BDD</p>	<p>Clinical notes will indicate that people are informed of low intensity treatment options.</p> <p>Clinical notes will indicate the clinical outcome of low intensity interventions</p>

<p>2. Brief individual CBT (including exposure and response prevention) using structured self-help materials</p> <p>3. Brief individual CBT (including exposure and response prevention) by telephone group CBT (including exposure and response prevention)</p>			
<p>11. SSRI or more intensive CBT for adults with OCD with mild functional impairment who fail to respond or refuse low intensity treatment</p> <p>A course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP should be offered to adults with OCD with mild functional impairment who are unable to engage in low intensity CBT or for whom low intensity treatment has proved to be inadequate</p>	<p>100% of people with mild OCD who fail to respond /refuse low intensity treatment will be offered intensive CBT including ERP or an SSRI</p>	<p>People improved with low intensity interventions</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p> <p>Clinical notes will indicate the clinical outcome of the intervention offered.</p>
<p>12. SSRI or more intensive CBT for adults with OCD with moderate functional impairment</p> <p>A course of an SSRI or more intensive CBT (of more than 10 therapist hours per patient) that includes ERP should be offered to adults with OCD with moderate functional impairment</p>	<p>100% of people with moderate OCD will be offered intensive CBT including ERP or an SSRI</p>	<p>None</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p>

			Clinical notes will indicate the clinical outcome of the intervention offered.
<p>13. CBT with ERP for children and young people with BDD CBT (including ERP) involving the family and adapted to the developmental age of the child should be offered to all children and young people with BDD as first line treatment</p>	<p>100% of children and young people with BDD should be considered for CBT including ERP</p>	<p>Those who request or have taken up the offer of another intervention.</p>	<p>The notes should indicate that the healthcare professional responsible has discussed the need for CBT with ERP and an arrangement has been made.</p>
<p>14. CBT with ERP or an SSRI for adults with BDD with mild to moderate functional impairment CBT (including ERP that addresses key features of BDD such as checking, comparing, avoidance and preoccupation) or an SSRI, should be offered to adults with BDD with mild to moderate functional impairment depending upon the patient's preference</p>	<p>100% of people with mild to moderate BDD will be offered intensive CBT including ERP or an SSRI</p>	<p>None</p>	<p>Clinical notes will indicate that people have been informed of the possibility of intensive CBT or an SSRI.</p> <p>Clinical notes will indicate the clinical outcome of the intervention offered.</p>

Calculation of compliance

Compliance (%) with each measure described in the table above is calculated as follows.

$$\frac{\text{Number of patients whose care is consistent with the **criterion** **plus** number of patients who meet any **exception** listed}{\text{Number of patients to whom the **measure** applies}} \times 100$$

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.