NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Issue date: November 2005

Obsessive-compulsive disorder

Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder

NICE Clinical Guideline 31

Contents

Grading of the recommendations

This quick reference guide summarises the recommendations in the NICE clinical guideline 'Obsessive-compulsive disorder'. The recommendations are based on the best available evidence and are graded A, B, C or good practice point GPP, depending on the type of evidence they are based on. For more information on the grading system, see the NICE guideline (www.nice.org.uk/CG031NICEguideline).

This guidance is written in the following context

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgment. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

National Institute for Health and Clinical Excellence
MidCity Place
71 High Holborn
London WC1V 6NA

ISBN 1-84629-088-0

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

All people with OCD or BDD

- Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.
- OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

Adults with OCD or BDD

- 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 cognitive behavioural therapy (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).
- Adults with OCD with 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 a selective serotonin re-uptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

Children and young people with OCD or BDD

- Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child 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 or carers.
- Following multidisciplinary review, for a child (aged 8–11 years) with OCD or 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. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- Following multidisciplinary review, for a young person (aged 12–18 years) with OCD or 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 should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

OCD and BDD

OCD: characterised by the presence of either obsessions or compulsions, but commonly both. Symptoms can cause significant functional impairment and/or distress. An obsession is an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform. These can be either 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 one's mind.

It is thought that 1–2% of the population have OCD, although some studies have estimated 2–3%.

BDD: characterised by a preoccupation with an imagined defect in 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.

It is thought that 0.5–0.7% of the population have BDD.

Principles of care for all people with OCD or BDD and their families/carers

Understanding

- Provide accurate information in an appropriate format on current understanding of OCD or BDD from psychological and/or biological perspectives to people with the disorders and their families/carers where appropriate, to help them understand the involuntary nature of the symptoms. GPP
- When assessing people with OCD or BDD, sensitively explore the hidden distress and disability commonly associated with the disorders.
  - Provide information and explanation where necessary.
  - Inform people with OCD distressed by their obsessive thoughts that such thoughts are occasionally experienced by almost all people, and when frequent and distressing are a typical feature of OCD. GPP

Continuity of care

- Ensure continuity of care and minimise the need for multiple assessments by different healthcare professionals. GPP
- Provide appropriate care for all ages and a seamless transition between services for different age groups. GPP
- Give careful consideration to effective integration and coordination of care of people with OCD and BDD across both primary and secondary care.
  - Ensure clear written agreement among individual healthcare professionals about responsibility for monitoring and treatment. This should be agreed in collaboration with the patient. Give a written copy to the patient. Where appropriate: GPP
    - use the Care Programme Approach (CPA)
    - involve the family/carers
    - liaise with other professionals involved in providing care and support to the patient.

Religion and culture

- Consider seeking, with the patient's consent, the advice of an appropriate religious or community leader to support the therapeutic process if the boundary between religious or cultural practice and obsessive-compulsive symptoms is unclear. GPP

Information and support

- Take account of the individual's needs and preferences.
  - For patients who do not have capacity to make decisions, or for children or young people who are not old enough to do so, follow the Department of Health guidelines *Reference guide to consent for examination or treatment* (2001). Available from www.dh.gov.uk GPP
- Information, treatment and care should be tailored to the individual, culturally appropriate and accessible to people with additional needs (such as learning difficulties, physical or sensory disabilities, or limited competence in speaking or reading English). GPP
- Consider informing people with OCD or BDD and their family/carers about local self-help and support groups, and encourage them to participate where appropriate. GPP

Families/carers

- Promote a collaborative approach with the patient and their family/carers wherever possible and appropriate. GPP
- Provide family/carers with good written and verbal information about the disorder, its likely causes, course and its treatment. GPP
- Where appropriate, involve relevant family/carers in assessment and treatment plans.
  - For some patients, particularly children and young people, if symptoms interfere with academic or workplace performance, consider liaising with professionals from these organisations.
  - Assess the impact of rituals and compulsions on others (especially dependent children) and how much family/carers are involved in supporting or carrying out behaviours related to the disorder. GPP
- Request independent assessment of dependent children considered to be at risk of emotional, social or mental health problems as a result of the behaviour of a parent with OCD or BDD and/or the child's involvement in related activity.
  - If carried out, inform the parent at every stage of assessment. GPP
- Offer assessment of a carer's social, occupational and mental health needs, particularly when the patient's disorder is moderate, severe or chronic. GPP

Stepped care aims to provide the most effective but least intrusive treatment appropriate to an individual's needs. It assumes that the course of the disorder is monitored and referral to the appropriate level of care is made depending on the person's difficulties. Each step introduces additional interventions; the higher steps normally assume interventions in previous steps have been offered and/or attempted. However, there may be situations where an individual may be referred to any appropriate care level. This quick reference guide follows the steps in this figure.

The stepped-care model

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 risk to life, severe self-neglect or severe distress or disability	Reassess, discuss options, care coordination SSRI or clomipramine, CBT (including ERP), or combination of SSRI or clomipramine and CBT (including ERP), augmentation strategies; consider admission or special living arrangements
Step 5 Multidisciplinary care with expertise in OCD/BDD CAMHS Tier 3 and 4	OCD or BDD with significant comorbidity, or more severely impaired functioning and/or treatment resistance, partial response or relapse	Reassess, discuss options **For adults:** SSRI or clomipramine, CBT (including ERP), or combination of SSRI or clomipramine and CBT (including ERP); consider care coordination, augmentation strategies, admission, social care **For children and young people:** CBT (including ERP), then consider combined treatments of CBT (including ERP) with SSRI, alternative SSRI or clomipramine. For young people consider referral to specialist services outside CAMHS if appropriate
Step 4 Multidisciplinary care in primary or secondary care CAMHS Tier 2 and 3	OCD or BDD with comorbidity or poor response to initial treatment	Assess and review, discuss options **For adults:** CBT (including ERP), SSRI, alternative SSRI or clomipramine, combined treatments **For children and young people:** CBT (including ERP), then consider combined treatments of CBT (including ERP) with SSRI, alternative SSRI or clomipramine
Step 3 GPs, primary care team, primary care mental health workers, family support team CAMHS Tier 1 and 2	Management and initial treatment of OCD or BDD	Assess and review, discuss options **For adults according to impairment:** Brief individual CBT (including ERP) with self-help materials (for OCD), individual or group CBT (including ERP), SSRI, or consider combined treatments; consider involving the family/carers in ERP **For children and young people:** Guided self-help (for OCD), CBT (including ERP), involve family/ carers and consider involving school
Step 2 GPs, practice nurses, school health advisors, health visitors, general health settings (including hospitals) CAMHS Tier 1	Recognition and assessment	Detect, educate, discuss treatment options, signpost voluntary support organisations, provide support to individuals/families/carers/work/schools, or refer to any of the appropriate levels
Step 1 Individuals, public organisations, NHS	Awareness and recognition	Provide, seek and share information about OCD or BDD and its impact on individuals and families/carers

Step 1: Awareness and recognition (any age group)

PCTs, mental healthcare trusts and children's trusts providing mental health services should: GPP

- have access to a specialist OCD/BDD multidisciplinary team offering age-appropriate patient care and appropriate services.

Specialist mental healthcare professionals/teams in OCD/BDD should: GPP

- collaborate with local and national voluntary organisations to increase awareness and understanding of the disorders and improve access to high-quality information about them (make this available to primary and secondary healthcare professionals and other public services who may come into contact with people of any age with OCD or BDD).
- collaborate with people with the disorders and their family/carers to provide training for all mental health professionals, cosmetic surgeons and dermatology professionals.

Step 2: Recognition and assessment (any age group)

OCD

Routinely consider and explore possibility of comorbid OCD for people: C

- at higher risk of OCD, such as those with symptoms of:
  - depression
  - anxiety
  - alcohol or substance misuse
  - BDD
  - an eating disorder.
- attending dermatology clinics.

→

Ask direct questions about possible symptoms, such as those below. C

- 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 putting things in a special order or are you very upset by mess?
- Do these problems trouble you?

Assessment for any person diagnosed with OCD GPP

- Assess risk of self-harm and suicide (particularly if depression already diagnosed).
- Include impact of compulsive behaviours on the patient and others in risk assessment.
- Consider other comorbid conditions or psychosocial factors that may contribute to risk.
- Consult mental health professional with specific expertise in OCD if uncertain about risks associated with intrusive sexual, aggressive or death-related thoughts. (These themes are common in OCD and are often misinterpreted as indicating risk.)

BDD

Routinely consider and explore possibility of comorbid BDD for people: GPP

- at higher risk of BDD such as those with symptoms of:
  - depression
  - social phobia
  - alcohol or substance misuse
  - OCD
  - an eating disorder.
- with mild disfigurements/blemishes seeking cosmetic surgery or attending dermatology clinics.

Ask the five questions below to help identify BDD. GPP

- Do you worry a lot about the way you look 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? (Consider > 1 hour excessive.)
- What effect does it have on your life?
- Does it make it hard to do your work or be with your friends?

For people with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment:

- refer for assessment by a mental health professional with specific expertise in the management of BDD. GPP

Specialist mental health professionals in BDD should: GPP

- work with cosmetic surgeons and dermatologists to ensure an agreed screening process is in place and agreed referral criteria have been established
- help provide training opportunities for cosmetic surgeons and dermatologists to aid recognition of BDD.

Assessment for adults diagnosed with BDD GPP

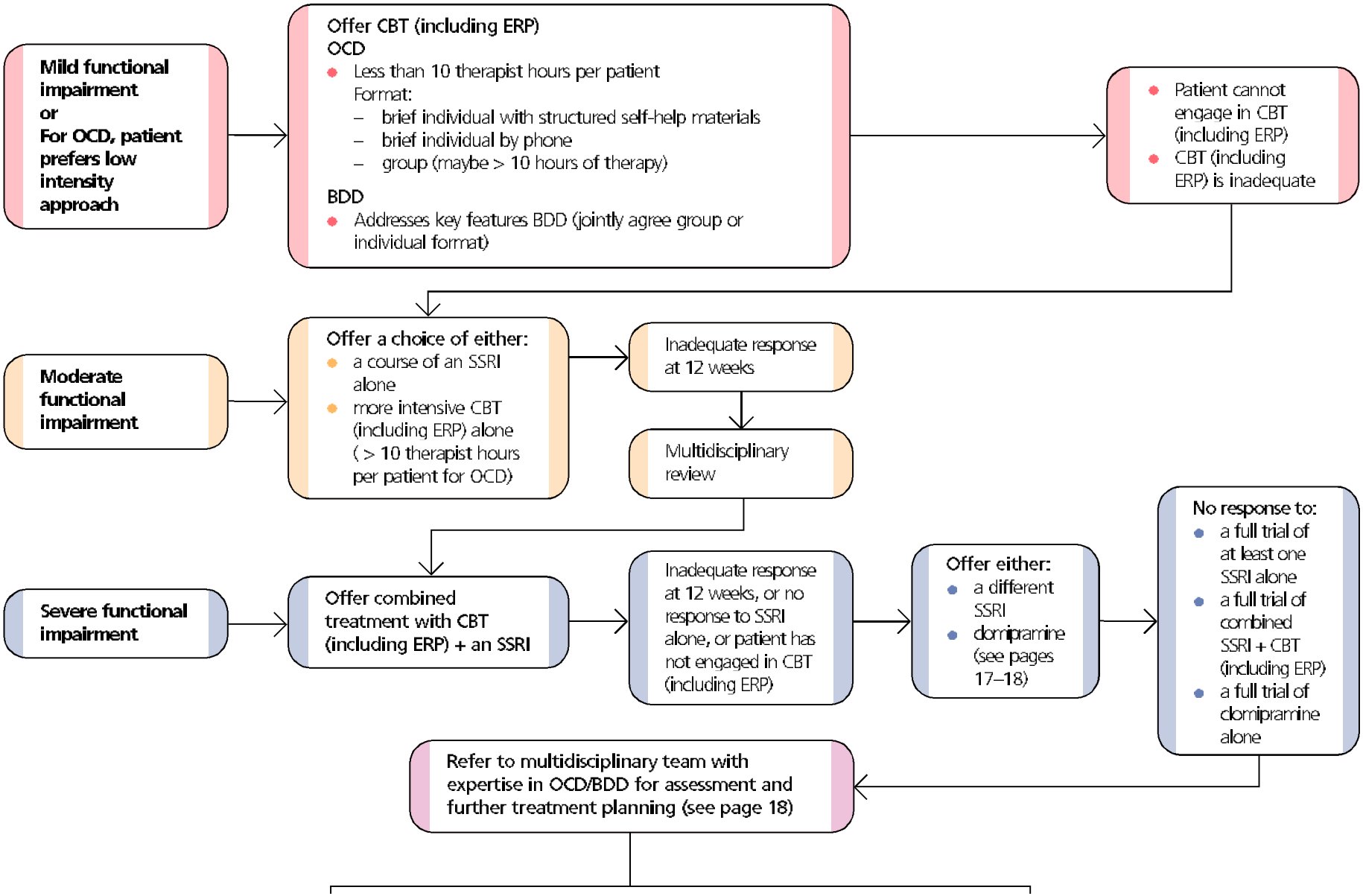
- Assess risk of self-harm and suicide (particularly if depression already diagnosed).
- Consider other comorbid conditions or psychosocial factors that may contribute to risk.

Assessment for children and young people diagnosed with BDD GPP

- Assess for suicidal ideation.
- Undertake full risk assessment before treatment. If risks identified, inform all primary and secondary care professionals involved and put risk management strategies in place.

Steps 3–5: Treatment options for people with OCD or BDD

Adults: overview of treatment pathway for OCD and BDD



OCD

Consider:

- additional CBT (including ERP), or cognitive therapy
- adding an antipsychotic to an SSRI or clomipramine
- combining clomipramine and citalopram[1]

Note there is no evidence of the optimal sequence

Do not routinely initiate treatments such as combined antidepressant and antipsychotic augmentation in primary care

BDD

Consider:

- additional CBT (including ERP), or cognitive therapy by a different multidisciplinary team with expertise in BDD
- adding buspirone[2] to an SSRI

Note there is no evidence of the optimal sequence

Do not routinely initiate treatments such as combined antidepressant and antipsychotic augmentation in primary care

CBT including ERP

For OCD, consider: B

- involving a family member/carer as a co-therapist in ERP for adults living with their family/carer where appropriate C
- home-based treatment if patient has more severe functional impairment and is housebound, reluctant or unable to attend a clinic, or has significant problems with hoarding C
  - or CBT by telephone if symptoms prevent home-based treatment. C

SSRIs

OCD – use initially one of: A

- fluoxetine
- fluvoxamine
- paroxetine
- sertraline
- citalopram[1].

BDD (including for beliefs of delusional intensity) – use initially: B

- fluoxetine[3].

Drugs not recommended for OCD or BDD

The following should not normally be used without comorbidity. C

- Tricyclic antidepressants (except clomipramine).
- Tricyclic-related antidepressants.
- SNRIs (including venlafaxine).
- MAOIs.
- Anxiolytics (except cautiously for short periods to counter early activation of SSRIs).

Antipsychotics as monotherapy should not normally be used for OCD or BDD (including for beliefs of delusional intensity). C

Monitoring risk (see also page 16)

Actively seek out (particularly in initial stages): C

- signs of akathisia or restlessness
- suicidal ideation
- increased anxiety and agitation.

Advise patients to seek help promptly if these are at all distressing. C

Monitor carefully and frequently because of increased risk of suicide and self-harm (particularly in early stages SSRI treatment): C

- adults younger than 30 years
- people with comorbid depression
- people at increased risk of suicide.

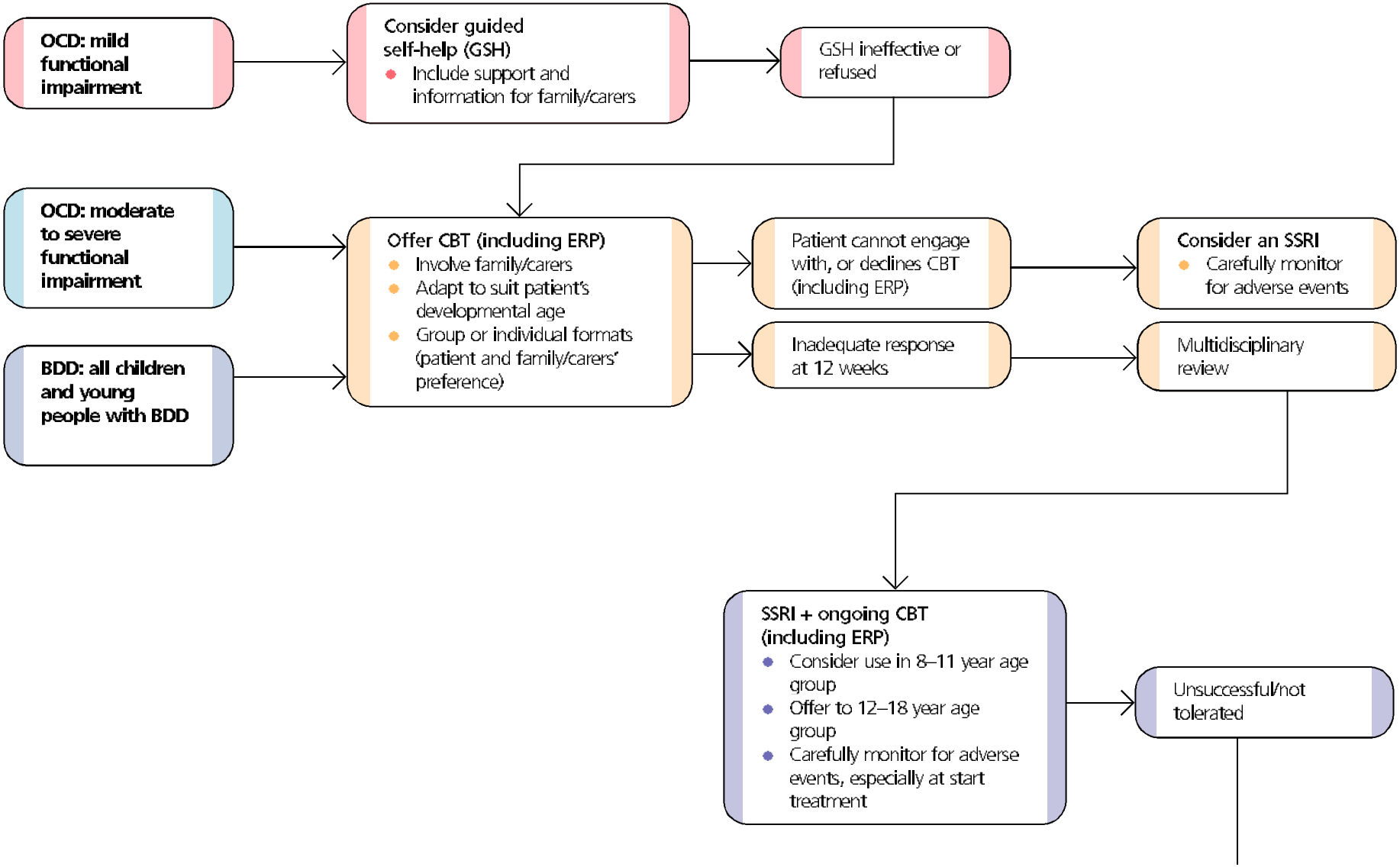
Consider involving family/carers, where appropriate, until risk is not significant. Agree arrangements for monitoring with patient and record in notes. C

See also pages 14–18 on using psychological and pharmacological treatments in adults

[1, 2, 3] At the date of publication (November 2005) the following do not have a UK Marketing Authorisation: citalopram for use in OCD in adults; buspirone for use in BDD; fluoxetine for use in BDD.

Steps 3–5: Treatment options for people with OCD or BDD *(cont'd)*

Children and young people: overview of treatment pathway for OCD and BDD



Non-response to any treatment

Be aware of comorbid conditions, learning disorders, persisting psychosocial risk factors (e.g. family discord), paternal mental health problems.

- Consider additional/alternative interventions for these factors.
- Evidence-based treatment is still required. C

SSRIs

If SSRI prescribed, use in combination with concurrent CBT (including ERP). C

SSRIs should only be used after assessment and diagnosis by a child/adolescent psychiatrist who should be involved in decisions about dose changes and discontinuation. GPP

Use low starting dose, especially for young children (consider quarter or half normal starting dose in week 1). C

OCD – use licensed medication, either: A

- sertraline[5]
- fluvoxamine[6].

OCD + significant comorbid depression – use: A

- fluoxetine[7].

BDD – use: C

- fluoxetine[8].

Drugs not recommended for OCD or BDD

The following should not be used.

- Tricyclic antidepressants (except clomipramine). C
- Other antidepressants (SNRIs, MAOIs). C
- Antipsychotics alone for routine treatment (may be considered as augmentation strategy). C

Treatments such as combined antidepressant and antipsychotic augmentation should not routinely be initiated in primary care. GPP

Consider either (especially if previous good response to):

- a different SSRI
- clomipramine[4]

Use in combination with ongoing CBT (including ERP). Carefully monitor for adverse events. See also page 20.

Monitoring

If SSRI prescribed and patient unable to engage in concurrent CBT (including ERP), make specific arrangements for careful monitoring for adverse effects. Record arrangement in notes. C

For patients starting on SSRIs

Carefully and frequently monitor them and see them on an appropriate and regular basis.

- Agree arrangement with patient and record in notes. GPP

Inform patient and their family/carers about the possibility of the following at the start of treatment: GPP

- suicidal behaviour
- self-harm
- hostility.

Advise the patient's family to make urgent contact with the medical practitioner if new symptoms such as these develop. GPP

If significant comorbid depression, monitor specifically for suicidal thoughts or behaviours. GPP

See also pages 15 and 19–20 on using psychological and pharmacological treatments in children and young people

At the date of publication (November 2005):

[4, 7, 8] clomipramine for use in OCD and BDD in children and young people; fluoxetine for OCD in children and young people; fluoxetine for BDD do not have a UK Marketing Authorisation

[5] sertraline has a UK Marketing Authorisation for use in OCD in children older than age 6 years

[6] fluvoxamine has a UK Marketing Authorisation for use in OCD in children older than age 8 years.

Psychological interventions

All healthcare professionals offering psychological treatments for OCD or BDD to people of any age should: GPP

- receive appropriate training in these interventions
  - there should be ongoing clinical supervision in line with recommendations in *Organising and Delivering Psychological Therapies* (Department of Health, 2004). Available from www.dh.gov.uk
- advise patients who request other forms of psychological therapy, such as psychoanalysis, transactional analysis, hypnosis or marital/couple therapy, that there is no convincing evidence to support their use. C

Using psychological interventions in adults

Obsessive thoughts without overt compulsions

- Consider CBT (including exposure to obsessive thoughts and response prevention of mental rituals and neutralising strategies). B

OCD

- Consider cognitive therapy adapted for OCD: C
  - as an addition to ERP to enhance long-term symptom reduction
  - for people who refuse or cannot engage with treatments that include ERP.

OCD and BDD

- For people with significant functional impairment, access to appropriate support for travel and transport may be necessary to allow them to attend for treatment. GPP
- Towards the end of treatment, inform patients how the principles learned can be applied to the same or other symptoms if they occur in the future. GPP

Family/carers

- If a family member/carer of a person with OCD or BDD is involved in compulsive behaviours, avoidance or reassurance seeking, treatment plans should help them to reduce their involvement in a sensitive and supportive way. GPP

Using psychological interventions in children and young people

The recommendations on the use of psychological interventions for adults may also be considered, where appropriate.

- Pay particular attention to the following.
  - Developing and maintaining a good therapeutic alliance and optimism with the patient and their family/carers.
  - Identifying initial and subsequent treatment targets collaboratively with the patient.
  - Actively engaging the family/carers in the planning and the process of treatment (especially in ERP, where they may be asked to assist).
  - Encouraging use of ERP if new or different symptoms emerge after successful treatment.
  - Liaising with other professionals involved with the patient (such as teachers, social workers and other health professionals) especially when compulsive behaviour interferes with the patient's ordinary functioning.
  - Offering one or more additional sessions after completion of CBT, if needed, at review appointments. GPP
- Consider including rewards to enhance motivation and reinforce desired behaviour changes. C

Pharmacological interventions

Using SSRIs in adults

- Advise patients verbally and in writing that:
  - craving and tolerance do not occur C
  - discontinuation/withdrawal symptoms may occur on stopping the drug, or missing or reducing doses C
  - there is a range of potential side effects (including worsening anxiety, suicidal thoughts and self-harm) that need to be carefully monitored, especially in the first few weeks of treatment C
  - onset of effect is commonly delayed for up to 12 weeks (although depressive symptoms improve more quickly) C
  - taking medication should not be seen as a weakness. GPP

Monitoring

- Be aware of the increased risk of drug interactions when prescribing SSRIs if the patient is using other medication. GPP
- For adults who are not considered to be at increased risk of suicide or self-harm, monitor closely and see them on an appropriate and regular basis (agree this with the patient and record in the notes). GPP
- For people at high risk of suicide: C
  - prescribe a limited amount of medication
  - consider, particularly in patients with comorbid depression, additional support such as more frequent direct contacts with primary care staff, or telephone contacts, especially in first few weeks of treatment.
- Around the time of dose change, monitor for any new symptoms or worsening of the condition. C
- If marked and/or prolonged akathisia, restlessness or agitation develop, review use of the drug. Change to a different SSRI if the patient prefers. C
- Monitor more intensively adults with BDD not receiving appropriate treatment or not responding to treatment, because of the high risk of suicide in people with BDD. GPP

Non-response to SSRIs

- If there has been no response to a full course of SSRI treatment, check that: GPP
  - the patient has taken the drug regularly and in the prescribed dose
  - there is no interference from alcohol or substance use.
- If there has not been an adequate response to a standard SSRI dose and there are no significant side effects at 4–6 weeks:
  - consider a gradual dose increase in line with the Summary of Product Characteristics. C
    - Dose increase rate should take account of therapeutic response, adverse effects and patient preference. GPP
    - Warn patients about and monitor for side effects during dose increases. GPP

Continuing treatment

- If effective, continue treatment for at least 12 months to prevent relapse and allow for further improvement. C
- Review continued use of the drug with the patient 12 months after remission (symptoms are not clinically significant and the patient is fully functioning for at least 12 weeks). Consider: GPP
  - the severity and duration of the initial illness
  - the number of previous episodes
  - the presence of residual symptoms
  - concurrent psychosocial difficulties.
- If continued beyond 12 months after remission, regularly review the need for continued treatment, agree this with the patient and record in the notes. GPP

Discontinuing treatment

- When reducing or stopping SSRI treatment, taper the dose gradually over several weeks, according to the patient's need.
  - Take account of the starting dose, drug half-life and particular profile of adverse effects when determining rate of reduction. C
- Encourage the patient to seek advice if they experience significant discontinuation/withdrawal symptoms. C

Using clomipramine in adults

Consider clomipramine when: C

- an adequate trial of at least one SSRI was ineffective, or
- an SSRI was poorly tolerated, or
- the patient prefers clomipramine, or
- there has been a previous good response to clomipramine.

For people at significant risk of cardiovascular disease: C

- carry out an ECG and a blood pressure measurement before prescribing clomipramine.

For people at significant risk of suicide: GPP

- prescribe only a small amount of clomipramine because of its toxicity in overdose[9]
- monitor the patient regularly until risk has subsided.

Non-response to clomipramine

- If response to a standard clomipramine dose is inadequate and there are no significant side effects: C
  - consider a gradual dose increase in line with the Summary of Product Characteristics.

Continuing treatment

- Continue treatment for at least 12 months if it appears to be effective and because there may be further improvement. B

Discontinuing treatment

- Reduce the dose gradually to minimise potential discontinuation/withdrawal symptoms. C

Assessment by multidisciplinary teams

Assessment by multidisciplinary teams with specific expertise in OCD/BDD should include: GPP

- comprehensive assessment of symptom profile
- previous pharmacological and psychological treatment
- adherence to prescribed medication
- history of side effects
- comorbid conditions, such as depression
- suicide risk
- psychosocial stressors
- relationship with family/carers
- personality factors.

[9] Please refer to the Summary of Product Characteristics for details about appropriate dosage.

Using SSRIs in children and young people

The following good practice for prescribing SSRIs or clomipramine is based on adult trials and clinical experience.

- When starting treatment, inform the patient of the:
  - rationale for drug treatment
  - delay in onset of therapeutic response of up to 12 weeks
  - time course for treatment
  - possible side effects
  - the need to take the medication as prescribed.

  Supplement discussion with written material appropriate to the needs of the patient and their family/carers. GPP
- For patients who also have significant depression, follow the NICE recommendations for the treatment of childhood depression[10].
  - Specifically monitor for suicidal thoughts or behaviours. GPP

Non-response to SSRIs in children and young people

- If a lower dose of medication is ineffective, increase the dose until a therapeutic response is obtained.
  - Monitor carefully and closely for adverse events.
  - Increase the dose gradually, taking into account delayed therapeutic response (up to 12 weeks) and the patient's age.
  - Do not exceed maximum recommended doses for children and young people. C

Continuing SSRI treatment in children and young people

- If the patient responds to an SSRI, continue treatment for at least 6 months after remission (symptoms are not clinically significant and the patient is fully functioning for at least 12 weeks). C

[10] Depression in children: identification and management of depression in children and young people in primary care and specialist services. *NICE Clinical Guideline* No. 28, available from www.nice.org.uk/CG028

Using clomipramine in children and young people

- Advise the patient and their family/carers about the possible side effects, including toxicity in overdose. C
- Carry out an ECG before starting treatment, to exclude cardiac conduction abnormalities. C

Non-response to clomipramine

- Cautiously consider a gradual dose increase if there has not been an adequate response to the standard clomipramine dose and there are no significant side effects. C

Continuing treatment

- If effective, continue treatment for at least 6 months because there may be further improvement in symptoms. B

Discontinuing SSRIs and clomipramine in children and young people

- Attempt to withdraw medication if remission (symptoms are not clinically significant and the patient is fully functioning) is achieved and maintained for at least 6 months, and if the patient agrees.
  - Warn the patient and their family/carers that relapse and/or discontinuation/withdrawal symptoms may occur.
  - Advise the patient and their family/carers to contact their medical practitioner if discontinuation/withdrawal symptoms develop. C
- When stopping or reducing antidepressants, particularly SSRIs, taper the dose gradually over several weeks, according to the patient's need, to minimise discontinuation/withdrawal symptoms.
  - Take account of the starting dose, drug half-life and particular profiles of adverse effects when determining rate of reduction. C
- Continue psychological treatment through the period of drug discontinuation because this may reduce the risk of relapse. C

Step 6: Intensive treatment and inpatient services (any age group)

- For people with severe, chronic, treatment-refractory OCD/BDD: C
  - continuing access to specialist treatment services staffed by multidisciplinary teams of healthcare professionals with expertise in the management of the disorders should be available.
- Consider inpatient services with specific expertise in OCD/BDD when: GPP
  - there is risk to life
  - there is severe self-neglect
  - there is extreme distress or functional impairment
  - adequate trials of psychological, pharmacological and combined treatment over long periods of time have not been successful in other settings
  - there are additional diagnoses making outpatient treatment more complex, such as severe depression, anorexia nervosa or schizophrenia
  - the person has reversal of normal night/day patterns, making attendance for daytime therapy impossible
  - compulsions and avoidance behaviour are so severe or habitual, normal activities of daily living cannot be undertaken.
- In addition to treatment, suitable accommodation in a supportive environment may be necessary for some adults with long-standing and disabling obsessive-compulsive symptoms that interfere with daily living, to enable them to develop life skills for independent living. GPP
- Neurosurgery is not recommended in the treatment of OCD. However, if a patient requests neurosurgery for severe OCD that is refractory to other forms of treatment, healthcare professionals should refer to recommendation 1.6.1.4 in the NICE guideline. GPP
- Offer assessment for intensive inpatient treatment in units that can provide specialist treatment for children and young people with OCD or BDD to those who: GPP
  - have severe OCD or BDD with a high level of distress and/or functional impairment and where there has been no response to outpatient treatment
  - show significant self-neglect or risk of suicide.

Discharge after recovery

- A mental healthcare professional should regularly review a person of any age with OCD or BDD who is in remission (symptoms are not clinically significant and the person is fully functioning for 12 weeks).
  - Review for 12 months.
  - Agree frequency of contact with the patient and/or family/carers and record in the notes.
  - Patients can be discharged to primary care after 12 months if recovery is maintained. C
- If a person needs to be re-referred because of further occurrences of OCD or BDD after successful treatment and discharge, the person should be seen as soon as possible and not placed on a routine waiting list.
  - For patients in whom there has been no response to treatment, use care coordination (or other suitable processes) at the end of any specific treatment programme to identify any need for continuing support and the appropriate services to address it. GPP

Implementation

Resource implications

Local health communities should review their existing practice for OCD and BDD against this guideline. The review should consider the resources required to implement the recommendations summarised in this booklet, the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of people with OCD or BDD that implementation 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/CG031costtemplate).

General

The Department of Health considers implementation of clinical guidelines to be a developmental standard and this will be monitored by the Healthcare Commission. 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.uk

Further information

Quick reference guide

This quick reference guide to the Institute's guideline on obsessive-compulsive disorder contains the key priorities for implementation, summaries of the guidance, and notes on implementation. It has been distributed to health professionals in England (see www.nice.org.uk/CG031distributionlist).

It is also available from www.nice.org.uk/CG031quickrefguide

For printed copies, phone the NHS Response Line on 0870 1555 455 and quote reference number N0919.

NICE guideline

The NICE guideline, 'Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder', is available from www.nice.org.uk/CG031NICEguideline

The NICE guideline contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Research recommendations; 5 Other versions of this guideline; 6 Related NICE guidance; 7 Review date. It also gives details of the grading scheme for the evidence and recommendations, the Guideline Development Group and the Guideline Review Panel and technical detail on the criteria for audit.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline. It is published by the National Collaborating Centre for Mental Health. It is available from www.rcpsych.ac.uk, the website of the National Library for Health (www.nlh.nhs.uk), and from www.nice.org.uk/CG031fullguideline

Information for the public

NICE has produced a version of this guideline for people with OCD or BDD, their families and carers and the public, which is available from www.nice.org.uk/CG031publicinfo

For printed copies, phone the NHS Response Line on 0870 1555 455 and quote reference number N0920.

Implementation tools

This guideline is supported by the following implementation tools available on the NICE website from November 2005:

- implementation advice
- a national costing report
- a local costing template
- a slide set.

Further information

Related guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

Computerised cognitive behaviour therapy (CCBT) for the treatment of depression and anxiety (review of existing *NICE Technology Appraisal* No. 51). (Publication expected early 2006.)

Depression. *NICE Clinical Guideline* No. 23 (2004). Available from www.nice.org/CG023

Depression in children. *NICE Clinical Guideline* No. 28 (2005). Available from www.nice.org.uk/CG028

Anxiety. *NICE Clinical Guideline* No. 22 (2004). Available from www.nice.org/CG022

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 before this if significant evidence that affects the guideline recommendations is identified. The updated guideline will be available within 2 years of the start of the review process.

National Institute for
Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

N0919 70k 1P Nov 2005