NICE National Institute for Health and Care Excellence

NICE Pathways

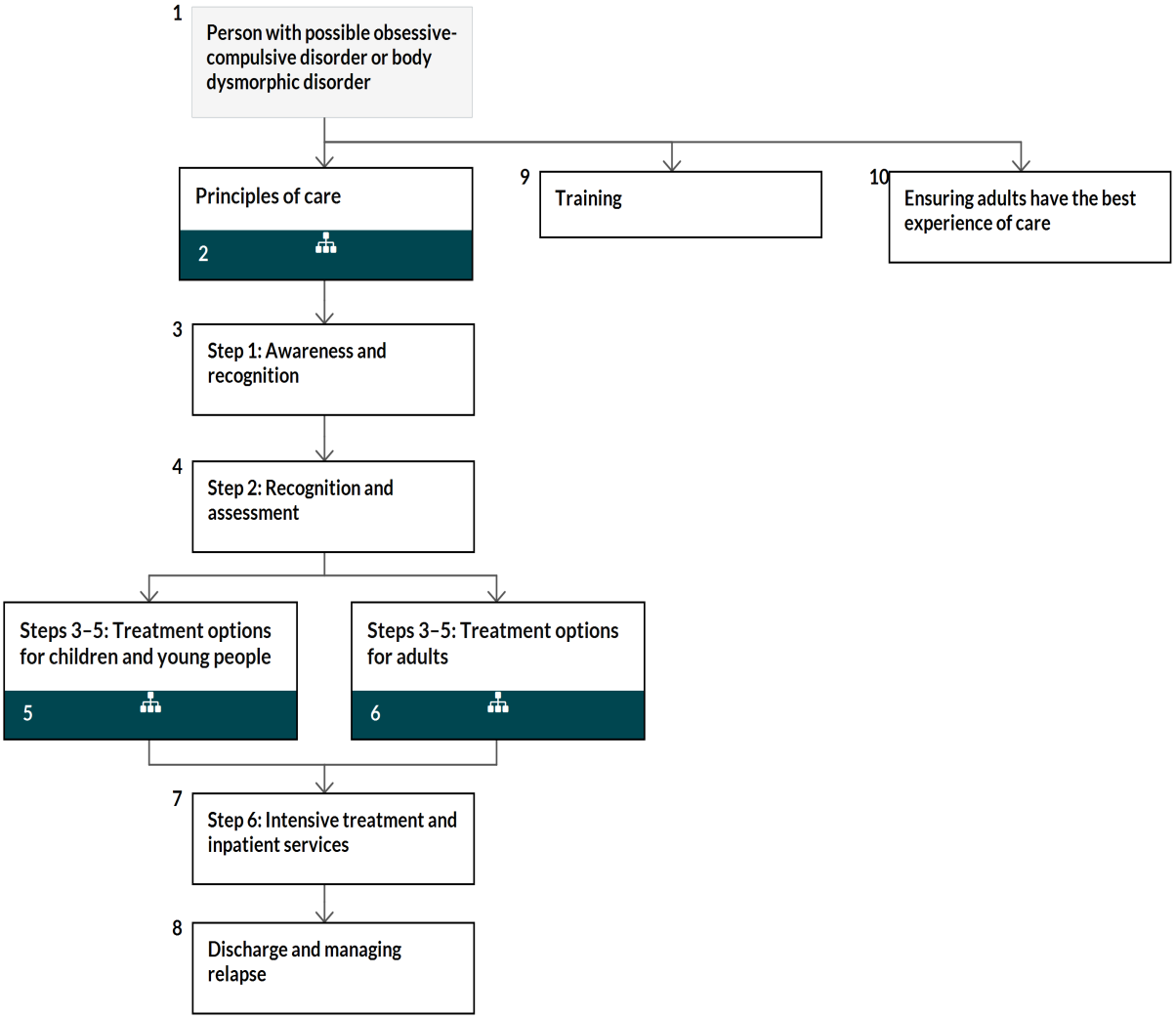
Obsessive-compulsive disorder and body dysmorphic disorder overview

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/obsessive-compulsive-disorder-and-body-dysmorphic-disorder
NICE Pathway last updated: 05 August 2020

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person with possible obsessive-compulsive disorder or body dysmorphic disorder

No additional information

2 Principles of care

See Obsessive-compulsive disorder and body dysmorphic disorder / Principles of care for people with obsessive-compulsive disorder or body dysmorphic disorder

3 Step 1: Awareness and recognition

The stepped-care model [See page 9] provides a model for the most effective but least intrusive treatments appropriate to a person's needs.

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 or GPs have expertise in the recognition, assessment, diagnosis and treatment of the less common forms of OCD and BDD.

Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist OCD/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.

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

Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families or carers to provide training for all mental health professionals, cosmetic surgeons and

dermatology professionals.

4 Step 2: Recognition and assessment

The stepped-care model [See page 9] provides a model for the most effective but least intrusive treatments appropriate to a person's needs.

Obsessive-compulsive disorder

For people known to be at higher risk of OCD (such as individuals 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 by asking direct questions about possible symptoms such as the following:

- Do you wash or clean a lot?
- Do you check things a lot?
- Is there any thought that keeps bothering you that you would like to get rid of but can not?
- 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?

In people who have been diagnosed with OCD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Part of the risk assessment should include the impact of their compulsive behaviours on themselves or others. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.

If healthcare professionals are uncertain about the risks associated with intrusive sexual, aggressive or death-related thoughts reported by people with OCD, they should consult mental health professionals with specific expertise in the assessment and management of OCD. These themes are common in people with OCD at any age, and are often misinterpreted as indicating risk.

Body dysmorphic disorder

For people known to be at higher risk of BDD (such as individuals with symptoms of depression, social phobia, alcohol or substance misuse, OCD or an eating disorder), or for people with mild

disfigurements or blemishes who are seeking a cosmetic or dermatological procedure, healthcare professionals should routinely consider and explore the possibility of BDD.

For further information, see the NICE Pathways on depression, social anxiety disorder, alcohol-use disorders and eating disorders.

In the assessment of people at higher risk of BDD, the following five questions should be asked to help identify individuals with BDD:

- 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 your appearance on your mind? (More than 1 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 your friends?

People with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific expertise in the management of BDD.

In people who have been diagnosed with BDD, healthcare professionals should assess the risk of self-harm and suicide, especially if they have also been diagnosed with depression. Other comorbid conditions and psychosocial factors that may contribute to risk should also be considered.

All children and young people who have been diagnosed with BDD should be assessed for suicidal ideation and a full risk assessment should be carried out before treatment is undertaken. If risks are identified, all professionals involved in primary and secondary care should be informed and appropriate risk management strategies put into place.

Specialist mental health professionals 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 and that agreed referral criteria have been established. They should help provide training opportunities for cosmetic surgeons and dermatologists to aid in the recognition of BDD.

5 Steps 3–5: Treatment options for children and young people

See Obsessive-compulsive disorder and body dysmorphic disorder / Steps 3–5: Treatment

options for children and young people with obsessive-compulsive disorder or body dysmorphic disorder

6 Steps 3–5: Treatment options for adults

See Obsessive-compulsive disorder and body dysmorphic disorder / Steps 3–5: Treatment options for adults with obsessive-compulsive disorder or body dysmorphic disorder

7 Step 6: Intensive treatment and inpatient services

The stepped-care model [See page 9] provides a model for the most effective but least intrusive treatments appropriate to a person's needs.

People with severe, chronic, treatment-refractory OCD or BDD should have continuing access to specialist treatment services staffed by multidisciplinary teams of healthcare professionals with expertise in the management of the disorders.

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

- there is risk to life
- there is severe self-neglect
- there is extreme distress or functional impairment
- there has been no response 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 daytime therapy impossible
- the compulsions and avoidance behaviour are so severe or habitual that they cannot undertake normal activities of daily living.

See also the NICE Pathway on transition between community or care home and inpatient mental health settings.

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.

Neurosurgery is not recommended in the treatment of OCD. However, if a patient requests neurosurgery because they have severe OCD that is refractory to other forms of treatment, the following should be taken into consideration.

- Existing published criteria Matthews and Eljamel's Status of neurosurgery for mental disorder in Scotland 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 (including ERP) and cognitive therapy, including very intensive and/or inpatient treatments.
- Standardised assessment protocols should be used pre- and post-operation and at medium- and long-term follow-ups in order to audit the interventions. These assessment protocols should include standardised measures of symptoms, quality of life, social and personality function, as well as comprehensive neuropsychological tests.
- Services offering assessment for neurosurgical treatments should have access to independent advice on issues such as adequacy of previous treatment and consent and should be subject to appropriate oversight.
- Post-operative care should be carefully considered, including pharmacological and psychological therapies.
- Services offering assessment for neurosurgical treatments should be committed to sharing and publishing audit information.

For children and young people with severe OCD or BDD with high levels of distress and/or functional impairment, if there has been no response to adequate treatment in outpatient settings, or there is significant self-neglect or risk of suicide, assessment for intensive inpatient treatment in units where specialist treatment for children or young people with OCD or BDD is available should be offered.

8 Discharge and managing relapse

When a person of any age with OCD or BDD is in remission (symptoms are not clinically significant and the person is fully functioning for 12 weeks), he or she should be reviewed regularly for 12 months by a mental health professional. The exact frequency of contact should be agreed between the professional and the person with OCD or BDD and/or the family and/or carer and recorded in the notes. At the end of the 12-month period if recovery is maintained the person can be discharged to primary care.

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.

9 Training

All healthcare professionals offering psychological treatments to people of all ages with OCD or BDD should receive appropriate training in the interventions they are offering and receive ongoing clinical supervision in line with the recommendations in the Department of Health's Organising and delivering psychological therapies.

10 Experience of care

Use these recommendations together with the recommendations in the NICE Pathways on:

- patient experience in adult NHS services
- service user experience in adult mental health services.

Stepped-care model

The stepped-care model draws attention to the different needs of people with OCD and BDD, depending on the characteristics of their disorder, their personal and social circumstances, their age, 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: The stepped-care model in NICE's full guideline on obsessive-compulsive disorder and body dysmorphic disorder: treatment).

Stepped care attempts to provide the most effective but least intrusive treatments appropriate to a person'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 the previous step have been offered and/or attempted, but there are situations where an individual may be referred to any appropriate level. This guidance follows the steps in the figure.

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

Glossary

OCD

obsessive-compulsive disorder

BDD

body dysmorphic disorder

CBT

cognitive behavioural therapy

ERP

exposure and response prevention

Sources

Obsessive compulsive disorder and body dysmorphic disorder: treatment (2005) NICE guideline CG31

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the

recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not 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.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.