Menu of Care and Interventions for Obsessive Compulsive Disorder (OCD)
Mood and Anxiety Clinical Academic Group (maCAG)
Mood and Anxiety Clinical Academic Group

Menu of Care and Interventions for Obsessive Compulsive Disorder (OCD)

Children and Young People’s Services, Adult Primary Care, Adult Secondary Care and Adult Inpatient Services

Full Document
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1. Aims and Objectives

The purpose of this document is to outline evidence-based care and interventions for people living with Obsessive Compulsive Disorder (OCD). This is not a standalone document but should be considered with reference to the Trust’s Clinical Strategy and in relation to Core Standards and Cluster-Based Care Packages (see Figure 1). The Core Standards specify the nature of care and care approaches that all people should expect to receive when receiving care from the Trust. The cluster-based care packages describe the types of care that we offer in relation to service user needs. This includes more detailed guidance on assessment, care planning and providing continuity of care for someone receiving care in the Trust.

The menus of care and interventions identify evidence-based bio-psycho-social interventions for particular mental health conditions that should help to inform care pathways. A care pathway refers to an individual’s journey through the service, drawing down from the menus of care and interventions and underpinned by cluster-based care packages and the core standards. An individual’s care pathway will be collaboratively agreed within a care planning process between the service user and their care team, and involving friends and family members where appropriate.

![Diagram of care pathways](image-url)

Figure 1: Service-user individual care pathway as guided by Menus of Care and Intervention, Cluster-Based Care Packages and Core Standards.
The Menu of Care and Interventions for OCD has been co-produced with people with lived experience of OCD and other mental health conditions, working together with a multi-disciplinary group of staff including nurses, pharmacists, psychologists, occupational therapists, and psychiatrists.

The menu specifies the range of evidence-based, NICE-consistent care and interventions that can help people overcome OCD and support their recovery¹, whilst taking account of resources available in the trust. It describes the biopsychosocial care and treatment of OCD across the life span - for adults receiving care from primary care, secondary care and acute care services and for children and young people receiving care from SPFT services. The plan is to extend the menu to include people with learning disabilities and for people in receipt of care from forensic services. We expect that an updated version of the menu which will apply across the lifespan and across all SPFT services will be available by the end of 2018.

The menu is presented within a stepped care framework, to facilitate equitable access to evidence-based care and interventions and to recommend lighter-touch interventions, where these are well-evidence and appropriate. Care and interventions are described at varying levels of intensity within five domains: daily life, family and friends, medication, physical health care and psychological interventions. This aims to ensure that a whole-person approach is considered.

Care and interventions are defined in terms of domain (e.g. daily life, physical health care) and not in terms of professional group involved, as this recognises the wide range of skills that staff have to work across these domains (with additional training and supervision where necessary).

We recognise that many people might be experiencing more than one form of difficulty and that in many cases there will not be a straightforward fit between a person’s needs and a single menu of care and interventions. As such, our aim is not to fit the person to a menu, but rather to fit the menu(s) to the person; following a comprehensive assessment, identification of presenting difficulties and formulation (see figure 1 for illustration of individual care pathways). Care planning will be vital to ensure that needs are appropriately addressed, in order to provide continuity of care and an individualised care pathway.

2. Initial Assessment and Review

Before considering which menus of care and interventions are most relevant, a comprehensive assessment should be carried out. Assessment may be facilitated by a proforma where these are available in a service.

For OCD in particular, it is particularly considered good practise to involve nominated friends and family members in the assessment process - with the service-user’s consent. This is because friends and family members can inadvertently reinforce OCD in their efforts to help, and research suggests that involving friends and family members in assessment and treatment leads to better outcomes.

Assessment should include, where relevant, physical and medical checks in order to identify possible biological contributing to OCD and other mental health difficulties. Assessment information should inform identification of the person’s primary presenting difficulty and secondary presenting difficulties and lead to a whole person formulation and care plan. This process should be revisited at regular intervals, specified in each service, in order to identify changes and to amend care planning where necessary.

3. Identifying Obsessive Compulsive Disorder

OCD might be a person’s primary presenting difficulty or it may be in the context of other difficulties such as depression or a long-term physical health condition. Service-users experiencing clinically significant OCD difficulties should be given access to evidence-based care and interventions for OCD in line with this document, regardless of co-occurring difficulties. The timing of interventions specifically for OCD should be detailed in the care plan (see section 6.0 of this document for further details where OCD co-occurs alongside other difficulties).

The measures below should be used in addition to a clinical interview. Tools are shown in the Appendix.

What is OCD?

Obsessive Compulsive Disorder (OCD) is a condition where people experience unwanted, intrusive and unpleasant thoughts and/or compulsive behaviours. People often live with OCD for many years before coming forward for help, with some estimates suggesting an average of ten years between first experiencing OCD and seeking help. This may be because OCD can be hard to identify, particularly when it presents in its less typical forms, and because people with OCD often experience a great deal of shame in relation to their experiences. OCD can affect people across the lifespan, including children, young people and adults.

The following description of obsessions and compulsions is adapted from Goodman et al. (2006):

OBSESSIONS are unwelcome and distressing ideas, thoughts, images or impulses that enter our mind again and again. They may seem to occur against our will. They may be repugnant to us, we may recognise them as senseless, and they may not fit

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our personality or value system. Example obsessions are: the recurrent thought you might be responsible for making a loved one ill because you weren’t careful enough about washing your hands, unwanted and recurrent violent or sexual thoughts, recurrent doubts about someone you love, repeated images of accidents occurring.

**COMPULSIONS** or rituals are behaviours or mental acts that we feel driven to perform although we may recognise them as senseless or excessive. At times, we may try to resist doing them but this may be difficult. We may experience anxiety that does not go away until the behaviour or mental act is completed. Common compulsions include repeatedly checking doors, taps and electrical or gas appliances or repeatedly cleaning or washing. Mental compulsions include saying a certain phrase over and over again or counting to a certain number with the idea that this might prevent something bad from happening.

Please see Appendix 1 for the OCD Clinic screening leaflet. This provides guidance on identifying OCD for clinicians.

DSM-5 (300.3) criteria (Appendix 2) also provide a useful guide for determining if OCD is a significant problem for the person.

It is important to note that **OCD is often missed**, particularly when OCD occurs in the form of obsessions with mental (internal) compulsions (i.e. counting, praying, self-reassurance) or when the person experiences shame in relation to OCD (so they are understandably ambivalent about disclosing their difficulties to health professionals). The Screening Leaflet (Appendix 1) can help to avoid missing OCD where it is a problem for the person. In some instances, a longer period of assessment may be required to enable sufficient trust to be established for someone to disclose their difficulties.

**Primary Outcome Measures**

**Adults**

The Obsessive Compulsive Inventory (OCI) (Appendix 3) is a 42-item questionnaire comprising of 7 subscales; Washing, checking, doubting, ordering, obsessing (i.e. having obsessional thoughts), hoarding, and Mental Neutralising. It is important to only use the ‘Distress’ ratings for the OCI.

It is suggested that scores of 40 or above on the OCI Distress scale indicate clinical significance. However, the OCI has **limited accuracy** in detecting if OCD is a clinically significant problem. Research suggests that around one third of people meeting diagnostic criteria for OCD following a formal diagnostic assessment score below 40 on the OCI and around one third of people not meeting diagnostic criteria for OCD score 40 or above. Therefore, **the OCI should only be used to inform an assessment with a clinician experienced in working with people with OCD**.

Despite these limitations, the OCI is widely used and is a reasonable indicator of OCD symptom severity. It is the OCD measure mandated for use in IAPT. The OCI should be used at the start of treatment, at review sessions and at the end of treatment to evaluate treatment effectiveness, with the aim that scores will come below 40 after treatment.
Children and Young People

The Obsessive Compulsive Inventory for children and young people (Child OCI) is the same 42-item questionnaire for adults, but has been specifically adapted for children and young people (Appendix 4). Like the adult version, the Child OCI is not a diagnostic tool but is able to assess areas that OCD affects (i.e. washing, checking, doubting, ordering, obsessing) etc. As above, a clinical cut-off of 40 is recommended on the Distress scale but as with the adult version this cut-off is unreliable and should not be used to determine if treatment if needed. Instead, the children and young people’s version of the OCI should be used to inform an assessment with a clinician experienced in working with children and young people with OCD.

The Children’s Yale-Brown Obsessive Compulsive Scale (CY-BOCS) is a 10-item, clinician-administered assessment for children and young people (Appendix 5). Like the OCI, the CYBOCS is not a diagnostic tool, but is able to identify the presence of various obsessions and compulsions and evaluates the distress experienced as a result of these symptoms. As it is administered by a clinician, it is more suitable than the Child OCI for children and for young people where a self-report questionnaire would not be suitable.

The Child OCI or the CY-BOCS should be used at the start of treatment, at review sessions and at the end of treatment to evaluate progress and treatment effectiveness.

Evaluation of OCD-Related Beliefs

The Obsessive Beliefs Questionnaire short form (OBQ-SF) (Appendix 6) is a 20 item self-report measure of the kinds of beliefs that are implicated in the onset and maintenance of OCD; beliefs about threat, responsibility, importance of thoughts and perfectionism. The OBQ-SF is not a diagnostic tool but it is useful for identifying specific OCD-related beliefs that might be playing a role in maintaining OCD. It was developed for completion by adults, but could be used by teenagers where appropriate. A version adapted for children could not be found.

Family Accommodation

The self-report version of the Family Accommodation Scale (FAS-SF) (Appendix 7) is a measure which identifies the extent to which family members/loved ones are inadvertently reinforcing OCD. This can be useful to guide involving family members or other people in the person’s support network in treatment.

4. Care Planning and Role of Lead Practitioner

The assessment/review process will inform care planning and the development of an individualised care pathway for the person concerned. This will include, but is not limited to, appropriate care and interventions from the OCD menu – remembering that the intention is to fit the menu(s) to the person, and not the other way around.
Where a key worker or lead practitioner is allocated\(^3\), they will be responsible for developing the care plan and care pathway with the service user; overseeing its implementation; monitoring and reviewing progress; and amending the care plan and care pathway as necessary. They will also play a crucial role in providing continuity of care. Please refer to the Trust CPA policy for details of this process.

5. Menu of Care and Interventions for OCD

Please note that this menu refers only to care and intervention for OCD. OCD often co-occurs with depression and can co-occur with other mental difficulties such as psychosis. Please refer to all menus of care and interventions that are appropriate to the person when collaboratively developing their care plan. This could mean, for example, that this present menu is considered alongside the menu for psychosis when developing a care plan (see section 6.0 of this document for more discussion on co-occurring difficulties).

The menu diagram illustrates intervention for OCD in five domains:

1. Daily Life
2. Family and Friends
3. Medication
4. Physical Health
5. Psychological interventions

Each of these domains and levels will be described in more detail below.

Please note that where there are concerns about risk to oneself or others, these should be attended to as a priority. Where necessary, please follow guidelines specified in the trusts risk assessment and monitoring policies and procedures, taking immediate actions where risk is deemed to be imminent. Where risk is not deemed to be imminent, following the menu of care and interventions may help to alleviate the service-user’s OCD and reduce levels of risk.

5.1 Daily Life

Where social, educational, employment or housing needs are related to OCD the following should be considered:

\(^3\) A lead practitioner is not allocated in primary care services. In this case, the person assessing difficulties will work with the person to plan their care.
1. Primary Care Services (including IAPT)

- If available, signpost to Recovery / Wellbeing / Discovery College for the person and their friends, family, supporters to enrol on courses, taster sessions and workshops.

- Signpost to Third Sector organisations for education and employment support including job centre or offer in house (IAPT) education and employment support.

- Signpost to group-based peer support and self-management programmes to aid occupational re-engagement.

2. Secondary Care

Research suggests that occupational, educational and employment interventions can provide valuable benefits for all mental health conditions. OCD often impacts on people’s emotional, educational, social, family, academic and financial situation. Early occupational, educational and employment interventions may reduce symptoms, improve quality of life and support people’s recovery journeys.

*Occupational Interventions (where appropriate)*

The choice of intervention should be based on person’s goals/personal choice and based on Garnham’s key Occupational Therapy interventions.

Key Interventions that can be delivered in group or one to one work:

- Specialist Occupational Therapy assessment where appropriate e.g. the Assessment of Motor and Process Skills (AMPS) to identify service users occupational and support needs.

- Developing/maintaining activities of daily living

- Environmental adaptation including equipment and use of assistive technology

- Specific skills development to support engagement in activities, e.g. planning, communication and sensory integration work

- Vocational support, signposting and advice linking with employment specialists.
• Establishing daily routines and roles that support recovery and social inclusion.

• Motivational work to support engagement in meaningful activity

• Enabling recovery and discharge by linking to other community resources in order to develop supportive social relationships and networks.

Employment Interventions

• Referral to Employment specialists to undertake Individual Placement and Support (IPS), support with finding work and job retention.

Educational Interventions

• Where OCD is a barrier to attending educational institutions, emphasis should be given to support children, young people and adults to attend school, college or university, where this is relevant. This may include direct liaison with schools, colleges or universities to ensure that the person is adequately supported.

• Individual or group psychoeducation within secondary care services. Supportive and interactive learning about condition and coping strategies. Group approaches aim to provide social support.

• Self-referral to Recovery / Wellbeing College / Discovery College for education, coping strategies and support. Open to service user, family, friends and supporters.

3. Housing Needs

Under the Care Act 2014, all local authorities have a duty to assess people who may have care and support needs. This includes a range of provision from residential care and home support, through to supported housing. It may also include access to personalised support and could encompass referrals to projects in the community offering support and activity for people with mental health problems or disabilities.

Each local authority will have a separate assessment process and will offer specific services in the local authority area. It is important to consider the care and support needs of individuals using our services. In areas where services are integrated, the assessments may be undertaken within the integrated mental health teams.
5.2 Friends and Family

Friends and family members should be welcomed to support and encourage their loved ones with engaging in interventions for OCD, particularly with psychological interventions. Friends and family members should feel involved and welcomed at all levels of care for OCD, as involvement leads to better outcomes. This is particularly important for people living with the person with OCD (parents, partners, children etc.) Service-users should decide whom to involve from their friendship, family and support network: this may or may not include close family members - the choice will be discussed. In some cases, adult service-users may prefer not to involve anyone from their social network in their care and this decision should be respected. For children and young people this will be discussed.

5.3 Medication

This section is divided into recommendations for adult and recommendations for children and young people.

1. Recommendations for Adults with OCD

Mild or Moderate OCD (Adults)

If an adult presents with mild OCD symptom severity, i.e. mild impairment of daily functioning and the person expresses a preference for a low intensity approach in primary care services, IAPT or ATs then:

- Do not offer any selective serotonin reuptake inhibitor (SSRI) medication in the first instance.

However, if an adult with mild or moderate OCD symptom severity (i.e. mildly/moderately impairs daily functioning) in primary care services, IAPT or ATs fails to engage in a psychological intervention/has shown no improvement in symptoms then:

- SSRI medication could be offered as an alternative to psychological treatment.

Prescribing for adults:

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• 1st Line: Generic SSRI (fluoxetine, paroxetine, sertraline or citalopram, escitalopram).

• 2nd Line: Different SSRI or clomipramine (if an adequate trial of at least one SSRI has been ineffective or poorly tolerated/if the service-user prefers clomipramine or has had a previous good response to it).

• 3rd Line: Adding an antipsychotic to an SSRI or clomipramine or combining clomipramine and citalopram (antipsychotic alone should not only be prescribed to a child/young person with OCD).

Review medication if OCD symptoms have not responded adequately to initial treatment within 12 weeks. In particular the review should elicit service-user feedback about any adverse effects, including increased anxiety, suicidal thoughts (especially those with co-morbid depression) self-harm and agitation.

Severe OCD (Adults)

If an adult presents to primary care services, or ATSs with severe OCD symptom severity then:

• SSRI medication should be offered as a first line of treatment in addition to psychological therapy.

• Consider generic SSRI (i.e. fluoxetine, paroxetine, sertraline, citalopram or escitalopram).

• Discuss the choice of medication with service-user; discussion should address therapeutic, adverse or discontinuation effects and the onset of medication benefits.

•Titrate the medication to the recognised therapeutic dose.

• Assess efficacy up from 6-12 weeks from initial start date of medication.

• Take into account toxicity in overdose if service-user is taking any other medication, i.e. antipsychotic.

In addition, the following drugs should not normally be used to treat OCD without comorbidity:

• Tricyclic antidepressants other than clomipramine, tricyclic-related antidepressants.
• SNRIs including venlafaxine, monoamine oxidase inhibitors (MAOIs).

• Anxiolytics (except cautiously for short periods to counter the early activation of SSRIs).

• Antipsychotics as a monotherapy should not normally be used to treat OCD.

If there has still been no response to a full trial of combined psychological and pharmacological treatment, and a full trial of clomipramine alone, the adult service-user should be discussed by the multidisciplinary team for assessment and further treatment planning.

When discussing this service-user during the MDT meeting the following should be considered:

• Additional psychological treatment (see below)

• Adding an antipsychotic to an SSRI or clomipramine

• Combining clomipramine or citalopram.

Supporting Recovery (Adults)

If an adult service-user demonstrates a significant reduction in symptom severity and appears to be recovered (i.e. no longer scoring above the clinical cut-off score on the relevant OCD outcome measure) they should continue to take medication for up to 12 months from when treatment was initiated. Review appointments with GP should occur at regular intervals for monitoring purposes.

2. Recommendations for Children and Young People with OCD

• The NNT or “Number Needed to Treat” is the average number of patients who need to be treated to prevent one additional bad outcome (e.g. the number of patients that need to be treated for one to benefit compared with a control in a clinical trial). The NNT for the use of SSRI medications (e.g. sertraline or fluoxetine) in Obsessive Compulsive Disorder is 6; this means that 6 children or young people would need to be treated with a SSRI for 1 of them to benefit.

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5 This is a summary of British Association for Psychopharmacotherapy (BAP) recommendations for the use of medication in the treatment of OCD in children and young people, adapted Dr Michael Hobkirk, Consultant Child Psychiatrist, and Graham Brown, SPFT Pharmacist. The reader is invited to consider the information provided on medication alongside NICE guidance, SPFT patient information leaflets and product licensing.
• Higher doses of sertraline (e.g. 150-200mg) or fluoxetine (60mg) are likely to be more effective for the treatment of OCD. Sertraline would be the drug of first choice due to it being licensed in over 6 year olds

• If there is no clear response to sertraline or fluoxetine after 12 weeks consideration should be given to increasing the dose or switching to a 2nd line medication such as Escitalopram (also a SSRI), fluoxetine or clomipramine; escitalopram is licensed for the treatment of Social Anxiety Disorder and Obsessive Compulsive Disorder in adults and can be prescribed safely in 16 and 17 year olds; anecdotally, it can be efficacious and appears less likely than other SSRI medications to cause side-effects

• Paroxetine should not be offered to people younger than 18 due to increased suicidal ideation and concerns about withdrawing it due to short half life

• Treatment with a SSRI should be augmented with CBT if CBT was not used as a 1st line treatment

SSRI side-effects

• Side-effects are common (affecting 10% of those prescribed SSRI medications); they are usually mild and transient (typically occurring in the first 7-10 days of use before wearing off)

• Common side-effects include:
  • Gastrointestinal disturbance (e.g. nausea; vomiting)
  • Headaches
  • Worsened tiredness (this may persist) or insomnia
  • Worsened anxiety
  • Erectile dysfunction / difficulties achieving orgasm (this side-effect is not often disclosed by young people and may led to them not taking medication)

• Rare side-effects include:
  • Seizures
  • Galactorrhoea (the term usually refers to milk secretion from the breasts not due to breast-feeding)
  • Clotting problems
  • Anaphylactic reaction
  • Mania
  • Suicidal thinking (in 1 in 112 people prescribed an SSRI; SSRIs are more likely to reduce suicidal thinking)
  • Serotonin syndrome (see below)

Serotonin syndrome
• Serotonin syndrome is the name given to the symptoms that can occur with an over-effect from medicines that boost serotonin in the brain

• Serotonin syndrome most often happens a day or two after a change in dose (nearly always an increase) of a serotonin-boosting drug e.g. a SSRI, when another serotonin-boosting medicine is added or after an overdose. It can rarely occur with just a single drug. Most cases are mild and probably never get recognised or reported

• The symptoms are:
  • Changes to mental state e.g. feeling confused, agitated, and feeling restless
  • Physical symptoms e.g. sweating, diarrhoea, fever, very sensitive reflexes, fast heartbeat, twitching, poor co-ordination, shivering and shakes
  • Other symptoms can include feeling or being sick. At worst this can then include seizures or fits

Discontinuation reaction

• Discontinuation reaction (or “discontinuation syndrome”) can occur if SSRIs are stopped quickly or patients are sensitive to the drug

• More common symptoms include:
  • Gastrointestinal disturbance (e.g. nausea; vomiting)
  • Headache
  • Dizziness
  • Anxiety
  • Tingling / electric shock sensations
  • Flu-like symptoms

• Discontinuation reactions tend to come on quickly

Recommendations around the use of medication in children and young people

• The use of and response to medication should be reviewed regularly (e.g. a week after commencing a new medication or an increase in dose; weekly follow-up for 2 weeks is recommended if a child is commenced on Fluoxetine; children should be monitored for 6 weeks after stopping SSRI medication)

• Paroxetine should not be offered to an under 18 year old due to increased suicidal ideation and concerns about withdrawing it due to short half life

• Sertraline would be the drug of first choice in CAMHS due to it being licensed in over 6-year olds. Rating scales are useful in assessing response to treatment (see section in this document on outcome monitoring)
• Stopping the use of a SSRI should be done slowly especially if there is a short half-life (the time required for the amount of drug in the body to be reduced by half) e.g. by reducing the total dose of Sertraline by 25mg every week; the rate of reduction should be slowed down further if the patient experiences symptoms of a discontinuation reaction

• To “switch” from an old to a new SSRI:
  o Reduce the dose of the old SSRI (if originally prescribed at a therapeutic dose such as Sertraline 100mg daily) to a low dose (e.g. Sertraline 25mg daily)
  o Stop the old SSRI
  o Start the new SSRI the next day (if not switching from Fluoxetine e.g. switching from Sertraline to Escitalopram) or 7-14 days later (if switching from Fluoxetine e.g. switching from Fluoxetine to Sertraline)
  o The duration of withdrawal will depend on the urgency for switching to a new antidepressant
  o The new SSRI should be commenced at a low strength and gradually increased in strength to minimise the risk of Serotonin Syndrome and to find the minimal effective dose

• If there is a clear response to a trial of a SSRI the young person should continue to take the medication for 6 months after symptoms are not clinically significant and the young person has been fully functional for 12 weeks; they should be reviewed for 12 months following completion of treatment; symptoms may return after medication is stopped and the likelihood of this can be reduced by practicing psychological skills; if there is an increase in symptoms when withdrawing medication, CBT / psychological therapy top-up sessions should be used to consolidate the skills gained in therapy and to prevent relapse; when relapse occurs early treatment intervention is recommended

• Patients and their families should be given sufficient time and information to allow them to weigh up the benefits and side-effects of medication; these should be compared against talking therapies and waiting–lists (on occasion it is prudent to use a SSRI if there is a long waiting list for accessing CBT)

• Patients and their families should be provided with patient information sheets about their medication and Serotonin Syndrome; copies of these and other relevant information sheets can be found at http://www.choiceandmedication.org/sussex; an additional excellent resource is www.headmeds.org.uk (hosted by Young Minds)

• SSRI medications can be taken with food to minimise the risk of side-effects
• Caution should be taken if considering using other medication alongside a SSRI (especially Warfarin, anti-migraine medication and St John’s Wort); advice should be sought from a prescriber or pharmacist

• SSRIs should be used cautiously with alcohol; ideally young people should avoid using alcohol whilst taking an SSRI

• Young people should not take extra doses of SSRIs to “boost” their mood

• A young person’s care should encompass more than just prescribing and monitoring and include:
  
  o A clear formulation (i.e. understanding of predisposing, precipitating, maintaining and protective factors)
  o Psycho-education (education offered to individuals with a mental health condition and their families to help empower them and deal with their condition in an optimal way; this might include advice about a healthy lifestyle)
  o Listening
  o Encouraging
  o Assessing, reassessing and reducing risks
  o Psychological therapy

5.4 Physical Health Care

Appropriate physical health checks should be made appropriate to the person’s level of care. OCD can impact on physical health in a number of ways. For example, some people may restrict the type of foods they eat which can lead to low calorie intake and/or to inadequate nutrition and some people may wash for many hours each day, leading to broken skin that is vulnerable to infection.

5.5 Psychological Interventions

**Exposure and Response Prevention (ERP)** is a form of behaviour therapy involving facing triggers for obsessive thoughts/anxiety (‘exposure’) whilst not engaging in usual compulsions (‘response prevention’). ERP has the strongest evidence of any psychological approach for helping adults, children and young people to overcome OCD, no other psychological approach is more effective. Consequently, NICE (2005) recommend ERP as the psychological intervention that people experiencing OCD should be offered regardless of level of impact or severity or age (including children, young people and adults). What changes as severity of OCD changes is the degree of clinician/therapist support that is needed. For people experiencing mild OCD, self-

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6 Adapted from NICE guidelines for Obsessive-Compulsive Disorder and Body Dysmorphic Disorder (https://www.nice.org.uk/guidance/cg31/)
help ERP resources (e.g. self-help books, online resources) can be effective alongside some support from a mental health practitioner. Where OCD is moderate in severity, weekly ERP sessions (with daily home tasks) with a therapist either individually or in a group is effective. Where OCD is severe and hasn’t responded to less intensive ERP, a more intensive approach can be helpful, with multiple sessions a week.

**Cognitive therapy** strategies specifically for OCD can help to improve engagement in ERP for some people and so cognitive therapy is often included alongside ERP. These strategies are not helpful for everyone. In particular, cognitive therapy strategies may not be helpful for people on the autistic spectrum, children or people with learning disabilities. Involving family/friends in therapy sessions can be extremely helpful, with the service user’s consent.

**Family and friends** often inadvertently support OCD and their involvement in helping with ERP tasks can be invaluable. Research shows that involving friends or family members in ERP leads to better outcomes and this is strongly recommended where appropriate, in particular when working with children or young people with OCD.

The **OCD Clinic** ([www.sussexpartnership.nhs.uk/service-ocd-clinic](http://www.sussexpartnership.nhs.uk/service-ocd-clinic)) is the psychological intervention service for adults experiencing OCD in our IAPT (Improving Access to Psychological Therapies) services in Brighton and Hove (Brighton and Hove Wellbeing Service) and in East Sussex (Health in Mind). The OCD Clinic also operates in the Assessment and Treatment Service (ATS) in Brighton and Hove, with the hope that this could be expanded to include other ATSS in the trust. It is also hoped that the OCD Clinic could be extended to other services in the trust. The clinic offers ERP at all levels of severity of OCD including a psychoeducation workshop, self-help ERP, an ERP therapy group, individual ERP therapy sessions and an intensive ERP intervention. ERP can be complemented with cognitive therapy strategies where this is indicated.

Guidance in the menu is informed by the OCD Clinic.

1. **Adults, Children and Young People not in SPFT services who are experiencing sub-threshold or mild OCD**

For all those with subthreshold or mild symptoms of OCD and who not want to be referred to a mental health services such as IAPT, they should be offered all of the following:

OCD self-help resources based on **Exposure and Response Prevention (ERP)**.

**Resources for adults:**

- The Books on Prescription service recommend a number of self-help books for OCD ([http://reading-well.org.uk/books/books-on-](http://reading-well.org.uk/books/books-on-))
The Prescriber Leaflet can be found here: https://tra-resources.s3.amazonaws.com/uploads/entries/document/842/Reading_Well_Books_on_Prescription_digital_user_leaflet.pdf. Once completed, the reader can present the form at their local library to borrow the selected book(s).

- OCD resources on the AnxietyBC website: www.anxietybc.com/adults/obsessive-compulsive-disorder

- The ERP Self-Help workbook:

Resources for children, young people and their parents or carers:


Contact information for Support Organisations

- OCD-UK
  Web: www.ocduk.org
  Tel: 0845 120 3778 or 0345 120 3778
  Email: support@ocduk.org

- OCD Action:
  Web: www.ocdaction.org.uk
  Tel: 0845 390 6232
  Email: support@ocdaction.org.uk

2. Mild to Moderate OCD

The following is based on what is currently offered to adults receiving care in the OCD Clinic in IAPT services in Brighton and Hove and in East Sussex. We recommend that the following should be offered to all those experiencing OCD, including adults experiencing mild or moderate OCD under the care of an ATS where joint working with IAPT can be arranged and to children and young people receiving care in the trust.
Adults, young people and children who present with OCD should be offered in the first instance:

- **Psychoeducation about OCD and about ERP for OCD.** In the OCD Clinic, this is provided in the form of a two-session OCD Information Workshop, inviting the person with OCD and proactively encouraging friends and family members to attend. This can be offered to groups of people as a workshop if there is sufficient demand, or as a 1:1 session if this is more appropriate. The workshop provides clear information about OCD, a cognitive behavioural formulation of OCD and information about ERP. The emphasis at this stage is that there is no expectation to change or to implement any strategies. This is in order to engage people with OCD who may be anxious about engaging in therapy. A protocol and resources for the workshop are available on request through the OCD Clinic (SPNT.OCDClinic@nhs.net).

- **3-8 sessions of guided self-help ERP** (with or without cognitive therapy elements) guided by a trained practitioner. The practitioner supports the person to guide themselves through using ERP self-help materials. The practitioner offering guided self-help ERP should have received ERP training and should receive regular supervision from a CBT therapist or from a psychological therapist with appropriate ERP training. It can aid recovery to involve friends or family members to support the person in their use of self-help ERP materials and to ensure that people in the person’s support network have a good understanding of OCD and the rationale for ERP. This advice applies across the lifespan, but it is likely to be particularly important to involve parents when offering guided self-help ERP to children and young people. Please note that guided self-help may not be appropriate where OCD is complex or severe, a decision regarding this should be made taking the best interests of the person into account. In this case, psychoeducation about OCD and CBT for OCD (e.g. through the OCD Information Workshop) should usually still be offered as the first step, followed by formal ERP therapy. A practitioner guide to guiding ERP self-help and self-help resources are available on request through the OCD Clinic (SPNT.OCDClinic@nhs.net).

### 3. Treatment-Resistant or Severe OCD

Where OCD symptoms remain following guided self-help ERP (e.g. the OCI or Child OCI Distress score is 40+ at the end of guided self-help), or where OCD is considered too severe for complex for guided self-help, people should be offered with a view to supporting the person to recover from OCD where possible (clinical recovery is operationalised as when OCI distress scores falling below 40, but bear in mind the limitations with this measure described earlier):
• Formal ERP therapy (with the addition of cognitive therapy elements if deemed clinically beneficial). This should be offered by a practitioner psychologist or CBT therapist who has received training in ERP and who has access to ERP supervision. **ERP training and supervision should be based on an inhibitory learning theory (ILT) approach**, the contemporary theory of exposure-based therapies which has important clinical implications for how ERP is delivered. As above, involving friends and family members to support the ERP approach and to ensure good understanding of OCD and the rationale for ERP is recommended. This is particularly the case when offering ERP to children and young people. For more information on ILT and ERP please contact the OCD Clinic (SPNT.OCDClinic@nhs.net).

• ERP therapy may be offered using the OCD Clinic Group+ approach which combines a 10-session therapy group with additional 1:1 sessions to maximise the possibility of recovery. The group is being adapted for young people for piloting in the Brighton and Hove Wellbeing Service from September 2018. A copy of the OCD Clinic Group+ protocol for adults and the piloted version for young people is available on request through the OCD Clinic (SPNT.OCDClinic@nhs.net).

• ERP therapy may be offered as up to 16 sessions of 1:1 therapy, with the addition of cognitive therapy for OCD where appropriate. The OCD Clinic Group+ protocol can be used as a guide for 1:1 therapy sessions.

• Involvement of friends or family members. A protocol and resources for separate a two-session Friends and Families Workshop or single 1:1 session for families and friends to support ERP can be obtained from the OCD Clinic (SPNT.OCDClinic@nhs.net).

If a service-user does not show symptom improvement following the above, and if OCD remains severe and has a significant impact on the person’s quality of life, a CBT therapist or practitioner psychologist with ERP training and supervision could offer:

• Intensive ERP consisting of up to 3 sessions of ERP (with/without cognitive therapy) a week and in a variety of settings familiar to the person (e.g. at home, in shops). This could be achieved by offering regular therapy sessions with a CBT Therapist/Psychologist alongside 1-2 ERP support sessions each week with a support worker or assistant. The OCD Clinic operate this model in Brighton and Hove ATS and can provide a protocol and resources (SPNT.OCDClinic@nhs.net).

• Where OCD is sufficiently severe that the person is at significant risk of harm to themselves or others, and an inpatient admission is appropriate, intensive ERP (with/without cognitive therapy) could be offered on the inpatient ward in SPFT if deemed clinically appropriate. This should consist of at least daily
supported ERP, supervised by a CBT Therapists or Practitioner Psychologist with appropriate ERP training.

4. Supporting Recovery

Following therapy completion and to maintain recovery children, young people and adults could be signposted to local OCD peer support groups run by OCD Action and OCD UK and/or to the Recovery / Wellbeing / Discovery College. Before referring it should be clarified that the groups support and encourage an ERP approach to supporting recovery.

6. Co-occurring Difficulties

Principles for working with people experiencing co-occurring conditions

1. **Co-occurrence of mental health conditions is the norm**, rather than the exception, so determining which interventions to offer from which menu in the face of co-occurring difficulties is a key decision for clinician and service user.

2. Screening and detection of the full range of current difficulties is challenging and may require use of screening tools and other specialist assessment.

3. These decisions are best made according to:
   a. **Evidence**: In regards to what works best with the particular constellation of difficulties occurring together
   b. **Formulation**: An understanding of what is driving what (including attention to the full range of potential presenting problems and to risk)
   c. **Goals**: Service-user goals for treatment
   d. **Impact**: The possibility for the biggest impact on quality of life

4. Menus of care and interventions should be chosen on the basis of these four factors, which will vary for each individual at different points in time.

5. There may be a primary condition, which is currently the main source of difficulty and possibly contributing to other difficulties. This is often a target for treatment. **It should not be assumed however, that the primary condition is the person’s chosen target for treatment**: they may have completely different goals or more immediate needs.

6. **It should not be assumed that the presence of a so-called “personality disorder”, emotional intensity difficulties, history of psychosis or other complex**
or enduring difficulties will reduce the effectiveness of treatment for other mental health conditions, although some adaptations may be necessary.

7. For psychological interventions:
   a. The strongest evidence base concerns tackling one specific target condition at a time, whilst taking account of interference from other conditions. The primary condition will often be the target condition, but this is not always the case.
   b. In the presence of extensive co-occurring difficulties, ‘transdiagnostic’ psychological interventions that tackle underlying common processes might be considered; although the evidence for transdiagnostic psychological interventions is weaker than that for treatment of single target conditions. An alternative approach is to focus on each presenting problem in turn with the same therapist, e.g. offering ERP for OCD as a focused intervention followed by CBT for social anxiety, and so on.

8. Resolving a target condition effectively may lead to partial or complete resolution of other conditions (e.g. becoming free of panic disorder may lead to recovery from depression).

9. Treatment for a target condition in the context of co-occurring difficulties may need to be adapted and this adaptation should be based on specific research evidence for those treatments (e.g. longer treatment period or additional treatment focusing on other difficulties). For example, children, young people and adults on the autistic spectrum may have OCD. There is good evidence that ERP is effective for OCD in the context of autistic spectrum conditions and this should be offered. Adding cognitive therapy to ERP may not be helpful in this context and a pure ERP approach would usually be the most suitable option.

10. Menus of care and interventions should describe any specific NICE guidance on sequencing of treatment, yet allow for individually tailored treatment plans based on formulation. Where depression co-occurs with OCD, NICE recommend that the OCD is treated first, as depression is often secondary to OCD. However, decisions on what to treat first should be based on clinical judgement and on what it most important to the service user.

11. Another common co-occurring difficulty is with substance misuse problems where co-operation with partner agencies may be required to define the menu of care and interventions.
12. With co-occurring difficulties care planning is particularly important in connecting care so that everyone involved is working to a co-ordinated plan based on a shared understanding of the difficulties.

7. Outcome Monitoring

- The distress subscale of the OCI (Appendix 3), Child OCI (Appendix 4) or the children and young people’s version of the Yale-Brown Obsessive Compulsive Scale (CY-BOCS) (Appendix 5) should be used to monitor outcomes for interventions for OCD. The selected measure should be completed at the start of an intervention and again at the end of the intervention, making sure to clarify that items on the OCI or Child OCI are rated on the basis of distress caused, not on the basis of frequency. Clinical recovery is shown when a person’s score falls from above the clinical cut-off (40+) to below 40 and interventions should focus on bringing people into the clinical recovery range. In IAPT, recovery is also contingent on the person’s PHQ-9 score being in the non-clinical range at the end of treatment (<10). However, please bear in mind that the OCI has poor accuracy in identifying the presence of OCD and so the cut-off score of 40 should only be used to inform an assessment with a clinician experienced in working with people with OCD.

- In addition to using standardised measures, service user progress towards goals and subjective feedback should be used to evaluate benefits of interventions for OCD.

8. Implementation

- The maCAG are keen to work with CDSs to support implementation of this menu. Please contact the maCAG to discuss how the CAG can best support your CDS with implementation (macag@sussexpartnership.nhs.uk).
Appendix 1: OCD Clinic Screening Leaflet

The pdf document below provides a useful guide for clinicians when deciding whether or not OCD is a significant problem for the person. To open the document please double click on the icon below.

[OCD Clinic Screening Leaflet v4](OCD Clinic Screening Leaflet v4.pdf)
Appendix 2: DSM 5 Criteria for OCD

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviours or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviours or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behaviour, as
in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behaviour, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Taken from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright 2013). American Psychiatric Association.
Appendix 3: Obsessive Compulsive Inventory (OCI) Adult Version

The following statements refer to experiences which many people have in their everyday lives. Please **CIRCLE** the number that best describes **HOW MUCH** that experience has **DISTRESSED** or **BOTHERED** YOU DURING THE PAST MONTH.

Over the past month I have been **DISTRESSED** of **BOTHERED** by:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>A lot</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpleasant thoughts come into my mind against my will and I cannot get rid of them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I think contact with bodily secretions (perspiration, saliva, blood, urine etc.) may contaminate my clothes or somehow harm me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I ask people to repeat things to me several times, even though I understood them the first time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I wash and clean obsessively</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I have to review mentally past events, conversations and actions to make sure that I didn’t do something wrong.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have saved up so many things that they get in the way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I check things more often than necessary</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I avoid using public toilets because I am afraid of disease or contamination.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I repeatedly check doors, windows, drawers etc.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I repeatedly check gas and water taps and light switches after turning them off.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I collect things I don’t need.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I have thoughts of having hurt someone without knowing it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13 I have thoughts that I might want to harm myself or others.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I get upset if objects are not arranged properly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I feel obliged to follow a particular order in dressing, undressing and washing myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I feel compelled to count while I am doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I am afraid of impulsively doing embarrassing or harmful things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I need to pray to cancel bad thoughts or harmful things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I keep on checking forms or other things I have written.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. I am excessively concerned about cleanliness.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I find it difficult to touch an object when I know it has been touched by strangers or certain people.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. I need things to be arranged in a particular order.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. I get behind in my work because I repeat things over and over again.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25. I feel I have to repeat certain numbers.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. After doing something carefully, I still have the impression I have not finished it.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>27. I find it difficult to touch garbage or dirty things.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28. I find it difficult to control my own thoughts.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. I have to do things over and over again until if feels right.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30. I am upset by unpleasant thoughts that come into my mind against my will.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Before going to sleep I have to do certain things in a certain way.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. I go back to places to make sure that I have not harmed anyone.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. I frequently get nasty thoughts and have difficulty in getting rid of them.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I avoid throwing things away because I am afraid I might need them later.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. I get upset if others change the way I have arranged my things.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. After I have done things, I have persistent doubts about whether I really did them.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. I sometimes have to wash or clean myself simply because I feel contaminated.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>39. I feel that there are good numbers and bad numbers.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 I repeatedly check anything which might cause fire.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Even when I do something very carefully I feel that it is not quite right.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. I wash my hands more often or longer than necessary.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring

Please note, it is important that the person completing the OCI understands that they are rating each item for how much they have been distressed or bothered by the item in the past month.

A total score can be calculated by adding ratings for each item together. A total score of 40 or more can indicate that OCD is a clinically significant problem for the person. However, the OCI is not a diagnostic instrument. This means that the rate of false positives is reasonably high (where someone has a score of 40 or more but does not have clinically significant OCD). The rate of false negatives is also reasonably high (where some has a score of less than 40 but does have clinically significant OCD). This means that the OCI can contribute to the assessment process, but an OCI score should not be taken as a sole indicator of OCD.
Appendix 4: Obsessive Compulsive Inventory (OCI) Children and Young People Version

The pdf document below is a version of the OCI adapted for children and young people. To open the document please double click on the icon below.

OCI (Child and Young Person version).pdf
Appendix 5: Children’s Yale-Brown Obsessive Compulsive Scale (CY-BOCS)

The pdf document below is a version of the clinician administered Yale-Brown Obsessive Compulsive Scale adapted for children and young people. To open the document please double click on the icon below.
Appendix 6: Obsessive Beliefs Questionnaire Short Form (OBQ-SF)

Below are some different attitudes or beliefs that people sometimes hold. Read each statement carefully and decide how much you agree or disagree with it. For each statement, choose the number matching the answer that best describes how you think. Because people are different, there are no right or wrong answers. To decide whether a given statement is typical of your way of looking at things, simply keep in mind what you are like most of the time. Use the following scale:

1. Disagree very much
2. Disagree moderately
3. Disagree a little
4. Neither agree nor disagree
5. Agree a little
6. Agree moderately
7. Agree very much

1. If I’m not absolutely sure, I’m bound to make a mistake.
   
   1  2  3  4  5  6  7

2. To be a worthwhile person, I must be perfect at everything I do.
   
   1  2  3  4  5  6  7

3. Even if harm is very unlikely, I should try to prevent it at any cost.
   
   1  2  3  4  5  6  7

4. For me, having bad urges is as bad as actually carrying them out.
   
   1  2  3  4  5  6  7

5. If I don’t act when I foresee danger, then I am to blame for consequences.
   
   1  2  3  4  5  6  7
6. In all kinds of daily situations, failing to prevent harm is just as bad as deliberately causing it.
   1 2 3 4 5 6 7

7. For me, not preventing harm is as bad as causing harm.
   1 2 3 4 5 6 7

8. I should be upset if I make a mistake.
   1 2 3 4 5 6 7

9. For me, things are not right if they are not perfect.
   1 2 3 4 5 6 7

10. Having nasty thoughts means I’m a terrible person.
    1 2 3 4 5 6 7

11. If I do not take extra precautions, I am more likely than others to have or cause a serious disaster.
    1 2 3 4 5 6 7

12. I am more likely than other people to accidentally cause harm to myself or to others.
    1 2 3 4 5 6 7

13. Having bad thoughts means I am weird or abnormal.
    1 2 3 4 5 6 7

14. Even when I am careful, I often think bad things will happen
    1 2 3 4 5 6 7

15. Having intrusive thoughts means I’m out of control.
    1 2 3 4 5 6 7

16. Harmful events will happen unless I’m careful.
    1 2 3 4 5 6 7
17. I must keep working until it’s done exactly right.
   1 2 3 4 5 6 7
18. To me, failing to prevent disaster is as bad as causing it.
   1 2 3 4 5 6 7
19. Having a bad thought is morally no different than doing a bad deed.
   1 2 3 4 5 6 7
20. No matter what I do, it won’t be good enough.
   1 2 3 4 5 6 7

Scoring

The OBQ-SF is a helpful way of identifying the types of appraisals that are commonly associated with OCD. Scores for individual items should be totalled within the following four appraisal domains:

Overestimation of threat: 3, 11, 12, 14, 16

Inflated beliefs about personal responsibility for causing/preventing harm: 5, 6, 7, 18

Over-importance of thoughts: 4, 10, 13, 15, 19

Perfectionism: 1, 2, 8, 9, 17, 20
Appendix 7: Family Accommodation Scale (Self-Report)

A copy of the FAS is attached below, please double click on the icon below to open the document:

[PDF]
Family accommodations scale
Appendix 8: Useful Contacts and Resources

**OCD Action**

Information and support for people with OCD, and their friends, family & carers.

Tel: 0845 390 6232  
Web: [www.ocdaction.org.uk](http://www.ocdaction.org.uk)

**OCD-UK**

A service-user led charity for people with OCD. A source of independent advice and information and can help with local support group information.

Tel: 0845 120 3778  
Email: support@ocduk.org  
Web: [www.ocduk.org](http://www.ocduk.org)

**AnxietyBC OCD Resources**


**ERP Self-Help Workbooks**

Children: Dawn Huebner (2007) *What to do When your Brain Gets Stuck: A Kid’s guide to overcoming OCD.*


**Book on Prescription Service**

Public libraries participate in this scheme. A prescriber (e.g. GP) can write a prescription using the Prescriber Leaflet, a copy of which can be found here:


The person with the prescription can then present the form at their local library to borrow the book.

The current list of books available on prescription for OCD can be found here:
Autism Sussex:

Where there is a query about whether someone may be on the Autistic Spectrum, information and advice can be sought from the charity Autism Sussex (see, website [http://www.autismsussex.org.uk/](http://www.autismsussex.org.uk/) for further details).
The OCD Menu of Care and Interventions has been produced by the Mood and Anxiety Clinical Academic Group (maCAG) in Collaboration with the Children and Young People’s CAG

For further information please contact the maCAG:

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