C09/S(HSS)/a

2013/14 NHS STANDARD CONTRACT FOR SEVERE OBSESSIVE COMPULSIVE DISORDER AND BODY DYSMORPHIC DISORDER SERVICE (ADULTS AND ADOLESCENTS)

PARTICULARS, SCHEDULE 2 – THE SERVICES, A - SERVICE SPECIFICATION

Service Specification No.	C09/S(HSS)/a
Service	Severe obsessive compulsive disorder and body dysmorphic disorder service (Adults and Adolescents)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Evidence base

It has been estimated that approximately 1% of the European population suffers from clinically relevant Obsessive Compulsive Disorder (OCD) (Wittchen and Jacobi, 2005). Assuming the population of England and Wales to be approximately 48 million adults, then 480,000 individuals may require treatment for OCD. However, modern psychological and pharmacological treatments have revolutionised outcomes for the majority of these patients (Mohammed, Fineberg and Drummond, 2000). Approximately 75% of patients will improve following graduated exposure (review by Drummond and Fineberg, 2007) and 60% will respond to serotonin re-uptake inhibiting drugs (SRIs) (Fineberg and Gale, 2005). If it were assumed that all patients received SRIs in their primary care practice, it might be expected that the condition of around 288,000 patients would improve and 192,000 would still require treatment. If these 192,000 patients were then referred to their local community mental health team (CMHT) and received appropriate treatment using graduated exposure, then approximately 48,000 patients throughout the UK may be expected not to respond to treatment locally and require more specialised treatment.

These 48,000 patients may need to be treated in a variety of ways. Augmentation of the SRI drugs with dopamine blocking or other treatments has been recommended (Fineberg et al., 2006) and may be effective in up to 50% patients (Bloch et al., 2006). This would leave 24,000 patients still needing further treatment. In the NICE guidelines these patients are at Level 5 in the continuum of severity and treatment

requirement. Many will require intensive home-based psychological treatment

delivered by regional specialist services. Taking these results it may be expected that 62% of patients would improve by at least a 30% reduction in symptoms with treatment at Level 5. This leaves 11,520 potential patients to be treated at Level 6. However, it is known that currently only a small percentage of sufferers present for treatment and many prefer to manage for many years before accepting treatment (Hollander and Wong, 1998).

2. Scope

2.1 Aims and objectives of service

The national Obsessive-Compulsive Disorder & Body Dysmorphic Disorder service (OCD/BDD) is commissioned to provide highly specialised assessment and treatment for patients experiencing severe OCD or BDD through out-patient, home-based, residential unit or in-patient services on behalf of NHS England for the population of England. The national OCD/BDD service delivers highly specialised interventions in conjunction with local mental health services and is available to people of all ages on the basis of need.

The aim of the service is to improve the mental health state of both adolescents and adults suffering with the most profound OCD/BDD at Level 6 of the NICE guidelines, who have failed all previous treatments (including home-based treatments), by delivering tailored enhanced treatment packages in a safe environment, specifically by:

- improving mental health and well being;
- reducing the burden of the disorder;
- minimising the risks posed by patients to themselves and to others;
- improving quality of life;
- promoting social inclusion and return to employment;
- enabling patients to function in daily life to the best of their ability.

The services aim to provide an effective and cost-effective comprehensive treatment package for the most severely disabled patients with OCD/BDD by working in collaboration with local services. Services are available for children, adolescents and adults and include:

- out-patient treatment;
- intensive out-patient and home-based treatment, including intensive liaison with local CMHTs and telephone monitoring;
- residential unit treatment; and
- in-patient treatment (for patients requiring 24 hour nursing care).

The service objectives are to:

- provide an exemplary and comprehensive service for all eligible people referred with severe treatment refractory OCD/BDD;

- provide expert diagnosis of severe refractory OCD/BDD utilising the most up-to-date validated assessment/diagnostic tools and knowledge;
- provide expert management of peoples with confirmed diagnosis of severe refractory OCD/BDD through the use of the most up-to-date clinical protocols for prescribing, therapeutic interventions and symptom management;
- effectively monitor patients to ensure optimal daily function and social inclusion;
- operate a rolling programme of clinical audit to test current practice and inform the evolution of care and therapeutic intervention for the range of mental health conditions;
- provide therapeutic support and care with a patient and family centred focus to maximise the patient experience of care within the nationally designated providers;
- act as the leading clinical services and a source of expert advice for the diagnosis and management of secure treatment refractory OCD/BDD in adolescent and adults within NHS;
- support local mental health and social care providers to manage adolescent and adults with serve treatment refractory OCD/BDD whenever it is clinically appropriate and safe to do so;
- provide high quality information for patients, families and carers in appropriate and accessible formats and mediums;
- develop the experience, knowledge and skills of the multi-disciplinary team (MDT) to ensure high quality sustainable provision.

2.2 Service description/care pathway

The NICE guideline for OCD recommends using a stepped care model underpinned by the principle that patients receive the least burdensome effective treatment necessary for their recovery. Within stepped care, the progression of patients from step 1 interventions through to higher step interventions is based on a mixture of increased need and past experience of treatment. It is an expected requirement that patients have had access to lower level treatments prior to receiving treatment from higher treatment steps.

The service will be delivered by a MDT:

- At step 6, highly specialist high intensity interventions will be delivered by professionals competent in the delivery of cognitive behavioural therapy (CBT) and other evidence-based treatments.
- The team will be supported by the local mental health service, such as intensive treatment services and by input from local General Practitioners.

Step 6 interventions include:

- individual CBT (15-30 sessions over 6 month period);
- therapy sessions should be supplemented by guided self help;
- associated medication advice and support for patients receiving augmentation and SRIs.

The providers are responsible for case management and communication with the

patient's CMHT, consultant psychiatrists, psychologists, managers or care-co-ordinators and GPs when required, including referral to alternative specialist services.

All patients will initially be offered a specialist assessment / screening, which will focus on the presenting problem, a risk assessment and referral on to other agencies, if appropriate. This will include the following elements:

- Prior to the start of treatment all patients should receive a comprehensive 'patient centred' assessment that clearly identifies the full range and impact of their mental health problems and any linked employment, social and physical health issues.
- Assessment of risk (suicide, harm to others, etc) should be assessed at initial contact and as appropriate thereafter.
- All patients must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the condition being treated. Key measures should be given at regular intervals in treatment to inform effective care planning and case management.
- The service should aim for pre- and post-treatment outcomes for all patients.
- The service should aim to meet the access standards for referral to decision to treat, and first treatment.

Once accepted the patient will be directed to the appropriate centre in the national service depending on their need and previous treatment history.

Following initial assessment patients will be offered enhanced specialist treatment in one national centre, including the following:

- All patients must be offered an evidence-based treatment appropriate to their condition, as indicated in current NICE guidelines. Where several evidence-based treatments are recommended patients should be offered choice.
- The evidence-based treatment should be given at the minimum dose that is necessary to achieve full and sustained recovery.
- Responsibility for prescribing medication should normally reside with either the patient's local CMHT or with the psychiatrists in the specialist OCD service. The members of the specialist team will ensure that patients have the relevant information to make an informed decision about medication. High risk patients (i.e. those displaying suicidal ideations, severe self neglect, severe injurious behaviour, psychotic symptomatology) identified through clinical judgement and/or objective risk outcome tools should be urgently discussed with the local mental health service. In such cases, these patients would usually need to be treated in an in-patient facility by the specialist OCD/BDD team, but this cannot be provided in an acute psychiatric emergency. Transfer to a specialised facility will be arranged appropriately with the local team. All patients and refers will be able to access the service they need easily, without reasonable delay.
- Patients should be given a choice about where they wish to be seen, and should also be offered flexibility in terms of appointment times and the manner in which contacts are made.

- Appropriate information about the national service should be developed, distributed and updated regularly by providers.

Days/hours of operation

It is expected that the out-patient/community service will be available during core office hours 9am-5pm, 52 weeks a year. The in-patient OCD/BDD service operates 356 days per year.

Discharge planning:

Clear discharge processes must be developed to ensure that all relevant partners are included in the process and excellent communication is in place. This will incorporate principles of the stepped care process and ensure that risk is managed and appropriate relapse prevention plans are developed and articulated. Discharge plans must be developed with service users and carers (where appropriate) and other professionals involved are fully aware of this plan.

The national service will discharge a patient following successful treatment back to the local mental health team with the appropriate advice to sustain the improvement in the patients' mental health. For patients who have not been responsive to treatment, a centre will either undertake a cross-centre referral within the national service to a follow up treatment, either psychological therapies or medication review. Any onward referral is only to be undertaken with the consent of the patient.

Patients who disengage from the national service can always be referred back to the national service by their local CMHT when they feel ready for treatment.

2.3 Population covered

This national service covers all patients in England with reciprocal arrangements existing for Europe. Separate contract arrangements are to be developed for Scotland, Wales and Northern Ireland whereby each referral is examined on an individual basis.

2.4 Any acceptance and exclusion criteria

Referral criteria, sources and routes

Clinical eligibility will be defined on the basis of a clinical assessment process by trained clinicians from the designated centres. There are specific criteria that must be met for a patient to be eligible for this NHS England commissioned services.

Adults eligible for NHS England service must:

- have a Yale Brown Obsessive Compulsive (or modified for BDD) score >30/40;

(or >36/48 on YBOCS modified for BDD);

- have failed to respond to two previous trials of serotonin reuptake inhibiting drugs at British National Formulary recommended doses for a minimum of three months each(or be unable to take this by virtue of their disorder or side-effects);
- have failed to respond to augmentation of above with one trial of either a dopamine-blocking agents; a mood stabiliser; supranormal SRI doses or addition of clomipramine (or be unable to take this by virtue of their disorder or side-effects); this criterion is not necessary for people with BDD); and have failed to respond to two previous trials of CBT includinng exposure and response prevention.

Patient choice will be respected and taken into account when interpreting the criteria (CBT as well as pharmacological).

Children and adolescents eligible for NHS England commissioned service must:

- have a children's Yale Brown Obsessive Compulsive(or BDD) Score >30/40;
- have received a previous trial of a serotonin reuptake inhibiting drug at BNF recommended doses for a minimum of three months (or be unable to take this by virtue of their disorder); and
- have received a previous trial of CBT with exposure and response prevention.

All referrals will be reviewed by the lead clinicians to ensure referrals are directed to the most appropriate service. Whilst the majority of patients will be treated as out-patients in the community, there is the ability to treat in different types of in-patient settings.

NB: It is a requirement that patients continue to receive monitoring and support (and if necessary therapy) through their local community mental health teams (or CAMHS for patients under 18 years of age), including having an identified named local care coordinator before, during and after completion of their treatment and follow up.

Response time & detail and prioritisation

All non-urgent referrals, received in writing by the national service, will be assessed by the provider within four weeks of the date of receiving the written letter of referral.

NB: Urgent/emergency referrals, due to self neglect or risk of suicide, should be referred to non-specialist in-patient services locally and be referred to the national service once the crisis has been resolved.

OCD/BDD occurs across the age spectrum and in all races, cultures, religions and sexual preferences. Despite this, there has in the past been a tendency for most patients accessing specialist services for OCD to be predominantly white British.

Previous studies looking at OCD in patients from a variety of different ethnic, cultural and religious backgrounds have failed to identify higher preponderance in any particular group (e.g. RAPHAEL,F.J., RANI,S., BALE,R. and DRUMMOND,L.M.

(1996) Religion, ethnicity and obsessive-compulsive disorder. International Journal of Social Psychiatry, 42, 38-44).

All units are required to complete an equitable access assessment and take steps to improve access for all communities and remove barriers to treatment.

2.5 Interdependencies with other services

The centres designated to provide the national OCD/BDD service need to develop a close relationship with the patient's local primary care services, specialist mental health services, schools and the third sector as required, and other social services support as appropriate.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

The nationally designated OCD/BDD service providers must be fully integrated into their trust's corporate and clinical governance arrangements.

The service will hold a monthly referral meeting to manage the national caseload for treatment refractory OCD/BDD and review referrals. The key tasks of the national referral group meeting will be to:

- review bed state, including empty beds in all the units, predicted discharges and current planned admissions;
- receive referral letters and consider new referrals for in-patient admission to any of the units against the agreed admission criteria;
- seek further information, if necessary, to clarify the likely suitability of each case for admission;
- discuss the clinical assessment as an expert peer review group and support the decision-making process as to the further clinical management pathway, taking into account the priorities presented by the group of patients currently being assessed and patients currently in the units at the time;
- write to / telephone referrers regarding the care pathway deemed suitable for each case;
- allocate each referral to one of the individual units for assessment against the agreed admission criteria OR inform the referrer that the referral does not meet the criteria.

Each unit will provide a representative to the national referral group meeting. This will normally be the lead clinician for the unit, but could also be another member of the MDT.

Supervision and management - Providing management and case supervision, clinical governance and evaluation:

- Treatment should be provided by clinicians with appropriate training in the relevant interventions i.e. psychological therapies should be accredited cognitive behavioural therapists with the British Association for Behavioural and Cognitive Psychotherapies.
- Therapists must have regular (weekly) clinical supervision from a clinician who is fully trained in the relevant intervention.
- Therapists should be organised in teams with an overall management structure that ensures the team provides the full range of evidence-based psychological interventions in order to maximise recovery rates.

See also NHS England service standards for Obsessive-Compulsive Disorder and Body Dysmorphic Disorder (OCD/BDD)

4. Key Service Outcomes

Outcome measures.

The national service will routinely collect clinical outcome data prior to treatment starting, through treatment (pre and end of treatment) and following treatment, and provide reports at the annual national clinical audit meeting.

The Yale Brown Obsessive Compulsive Scale (Y-BOCS) is recognised as the gold standard in outcome assessment for OCD, with strong psychometric properties (Taylor, 1998), and is also well-suited for use in evaluating treatment outcome (Fisher & Wells, 2005). The YBOCS modified for BDD is a 12 item clinician rated measure from 0-48.

Improvements in individual patients Y-BOCS scores are only clinically relevant and meaningful when reviewed against the initial severity of the patients:

- moderate to severe – reduction of 50% are classified as meaningful improvements;
- severe to profound – overall a 30% reduction in symptoms is seen as a reasonable aim;
- reduction of less than five points on the YBOCS is a definite "failure to respond".

5. Location of Provider Premises

Location(s) of service delivery

The service is delivered across England by five designated centres based in the South East of England, providing outreach across all regions in England.

- South West London and St Georges Mental Health NHS Trust
    - adult home based treatment including intensive home-based treatment and out-patient services including use of telephone treatment;

    - adult in-patient service (24 hour nursing unit).
- South London and Maudsley NHS Foundation Trust
    - Anxiety Disorders Residential Unit
- South London and Maudsley NHS Foundation Trust
    - Centre for Anxiety Disorders and Trauma (adult out-patient and home based service)
    - Adolescent OCD / BDD out-patient service
- Hertfordshire Partnership NHS Foundation Trust
- Adult out-patient and in-patient service specialising in psychopharmacology in conjunction with CBT
- The Priory Hospital North London. (a) Adult in-patient unit for OCD patients requiring treatment under the MHA or are unsuitable for Springfield Hospital; or for BDD patients that requires 24 hour nursing care. (b) Adolescent Unit for OCD and BDD (24 hour nursing care)

Sub-contractors

Independent advocacy services are to be provided through sub-contractual arrangements. They will be required to complete regular activity reports on service provision to centres and through the service review meetings, highlighting feedback and emerging themes that need to be actioned.

Each centre is responsible for establishing the sub-contract arrangement to provide a sufficient level of advocacy and Innovative Mental Health Practices (IMHPs) services for young people to access when under their care.

6. References

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