Dundee Advanced Interventions Service

Intensive OCD Service – Operational Framework

Host NHS Board: NHS Tayside

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Section A: Scope of the Framework

This document provides an overview of the structure and processes of the National Intensive OCD Service provided by the Advanced Interventions Service as part of the SLA with National Services Division of NHS Scotland.

A1. Aims and Objectives

A1.a) Service Aims

1. To provide specialist assessment of a small number of patients in Scotland with chronic, severe, and treatment-refractory Obsessive-Compulsive Disorder (OCD).
2. To provide intensive/inpatient Exposure and Response Prevention (ERP) to a small number of OCD patients for whom treatment facilities do not exist elsewhere in Scotland.
3. To ensure that patients with OCD who may be considering neurosurgical treatment have been demonstrated to fail to respond to all available treatments.
4. To provide specialist advice on the management of severe OCD and related disorders to secondary- and tertiary-care mental health services in NHS Scotland.

A1.b) Service Objectives

1. To deliver intensive treatment programmes, consisting of ≥ 50 hours of expert, therapist-guided ERP to between 4-6 patients to Scottish patients each year. Such treatment will include inpatient treatment, and may involve home-based treatment.
2. The service will provide pathways of care for patients with the most severe, chronic, and treatment-refractory OCD. Such pathways may include: behavioural treatment; expert psychopharmacology; and neurosurgical treatment.
3. To provide consultancy to and where appropriate and within service capacity, training for clinical teams treating complex and severe cases of OCD.

A2. Hours of operation

The service will operate under normal conditions between 9am and 5pm Monday to Friday. In some cases (where travel is necessary to assess patients outwith Dundee) members of the service will make visits that require travel outwith these hours. Such assessments will be made on a case-by-case basis, and after discussion with referrers, patients, and carers.

In addition, there may be occasions where it is appropriate and clinically-indicated for treatment to be delivered outwith these hours. Such instances will be considered on the basis of clinical need and staff availability.

At the current time, the service is unable to provide routine treatment at weekends but exceptions may be made where the care plan requires it. Treatment at weekends will be provided after discussion with the patient, carers, and ward staff. It can only be provided on a limited basis and the effects on the delivery of treatment during the week will be appraised before providing such treatment.

A3. Service Location

A3.a) Location of service

The service is located at Ninewells Hospital & Medical School, Dundee. Inpatient provision is provided in Ward 1, Carseview Centre, Medipark, Dundee.

A3.b) Assessment location

It is expected that the majority of assessments will be undertaken at Ninewells Hospital in Dundee. Where patients are currently an inpatient, or are unable to travel, the service will aim to conduct the assessment in the patient's home, hospital, or other mutually-convenient location.

A4. Access to services

A4.a) Patient's home location

The service is open to all patients in Scotland, subject to the inclusion and exclusion criteria below. Referrals will be accepted from consultant psychiatrists in Scotland, or other senior psychiatrists as long as there is a named consultant who will remain responsible for the ongoing care of the patient.

Assessment and treatment (once accepted for treatment) is cost-neutral for Scottish patients.[1] Patients from the rest of the UK and Eire will need to have funding in place in order to be assessed (and treated).

[1] The service is funded from money that is top-sliced from NHS Boards' funding.

A4.b) Referral process

Referrals should be made to one of the consultants in the service, or to the Advanced Interventions Service in general. The address of the service is:

Advanced Interventions Service
Area 7, Level 6
South Block
Ninewells Hospital and Medical School
Dundee
DD1 9SY
Tel: +44 (0)1382 496233

Referrals will be discussed at the weekly team meeting and where sufficient information is available, allocation will take place. The referrer and the patient will be notified of the proposed date and invited to attend for assessment.

In some cases, there may be insufficient information to proceed to acceptance and allocation. In such situations, one of the clinicians in the team will discuss the patient with the referrer and make arrangements to receive additional information.

A4.c) Entry to service

Entry to the service will be subject to confirmation of assessment to the patient. At that point, they will not necessarily have an agreed admission date since further treatment and care planning may still be needed.

The decision to provide intensive treatment will be made by multidisciplinary team following collective discussion.

The status of any given patient referred to the service will be one of the following:

1. Allocation pending;
2. Awaiting assessment;
3. Assessed – intensive treatment not offered (advice and treatment recommendations provided);
4. Assessed – admission for Stage 1 treatment offered;
5. Awaiting admission date;
6. Admitted and currently receiving treatment;
7. Discharged – with follow-up;

8. Discharged – no longer active.

A4.d) Exit from service

Exit from the intensive treatment component of treatment will be the discharge date from the inpatient ward. Following discharge, a number of outcomes may occur:

1. There may be additional treatment provided in conjunction with the patient's local team in the patient's own home. These will be agreed on a case-by-case basis;
2. There may be planned 'troubleshooting' contacts with local services. In some circumstances, these may be in person but it is expected that most post-discharge contact will be conducted by telephone. This will be an opportunity to troubleshoot problems and support local services further;
3. The patient may be discharged fully from formal follow-up arrangements, but the service may agree to receive ongoing ratings of the patient's symptoms and functioning in order to inform future discussions with local services.

In most cases, it is expected that the patient will move through each of these treatment phases as part of the agreed care plan. More details are provided below in 'Section C: below.

A4.e) Waiting list

The service will not operate a waiting list. However, there are limited resources available to provide intensive and inpatient treatment, and it is recognised that there may be more than one patient requiring treatment at any given time.

In most cases, priority will be decided on the basis of where the patient is on the care pathway. For example, someone who was referred first but still required additional treatment steps will be deemed to be lower priority for admission to intensive treatment than someone who has undergone all necessary treatment trials.

In most cases, all patients are unwell and will have had disabling symptoms for some considerable time. Consequently, it is unlikely that symptom severity *per se* will be a significant factor in deciding the timing of intensive treatment.

Where a patient is waiting for treatment, the service will continue to liaise with local services, and will continue to make arrangements for treatment and follow-up. In some cases, the service may be able to provide support and/or supervision for complex treatment plans.

Section B: Criteria for Service Provision

B1. Stepped care model for OCD

The stepped-care model for treatment of OCD, as describe by NICE (2005), is shown below in Figure 1. Please note that Body Dysmorphic Disorder (BDD) is not part of the commissioned service; see section B4.b) below for further details.

The specialist service provided by the AIS and commissioned by National Services Division of NHS Scotland will provide assessment and treatment at steps 5 and 6, and treatment at step 6. Assessment outwith these levels may be conducted in some cases after detailed discussion with the patient, carers, and referrer.

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

Figure 1 | Stepped care model of treatment for OCD (National Institute for Health and Clinical Excellence, 2005)

B2. Criteria for referral to the AIS

The following criteria are intended to act as a guide to referral, rather than an absolute determination of who will be accepted for assessment. All referrals are accepted on a case-by-case basis and clinicians are advised to contact the service if there are any uncertainties regarding suitability.

B2.a) Comments on criteria compared to other specialist services

Our criteria are broadly consistent with other specialist services in the UK with some differences; the main one being the burden of symptoms measured on the Y-BOCS. As there may be a range of factors that affect someone's functioning and need for treatment (for example, comorbid conditions) the following should be seen as indicative rather than absolute.

B2.b) Inclusion criteria

1. Diagnosis of Obsessive-Compulsive Disorder made according to ICD-10 (World Health Organisation, 1992), DSM-IV (American Psychiatric Association, 1994), or DSM-5 (American Psychiatric Association, 2013);
    a. Comorbid diagnoses of Obsessive-Compulsive Personality Disorder (OCPD) or Asperger's Syndrome are not absolute contraindications, but they should not be the primary diagnosis and full criteria for OCD should be met. The severity of symptoms should be significant enough to indicate that personality disorder is insufficient to account for the impairments in functioning.
    b. Similarly, comorbid anxiety disorders (*e.g.* Generalized Anxiety Disorder, Agoraphobia) and depression are common in OCD. These are not a contraindication to referral, but it is expected that efforts have been made to determine that OCD is the primary source of the anxiety symptoms. Such efforts are likely to involve targeted treatment of the other conditions.
2. Symptoms of OCD have persisted for ≥ 2 years without improvement and despite treatment;
3. Severity of OCD, measured using the clinician-rated Y-BOCS, should be ≥ 24 (severe), although in most cases it is likely to be higher;
4. Global Assessment of Functioning (GAF) should be ≤ 50. This means that symptoms are severe and result in "*serious impairment in social, occupational or school functioning*";
5. The patient has had ≥ 2 trials of serotonin re-uptake inhibitors at maximum (or maximum-tolerated) dose – one of which should ideally be Clomipramine. Each trial should have been for ≥ 12 weeks;

6. The patient has had at least one trial of antipsychotic augmentation with one of the following: Risperidone, Aripiprazole, or Quetiapine. The augmentation trial should be ≥ 6 weeks in duration, and ideally 8-12 weeks;
7. The patient has had ≥ 20 hours of Exposure and Response Prevention, delivered by a therapist with experience in the treatment of OCD. Therapy should have been home-based where symptoms relate to the home environment. Documentation of treatment should be sufficient to appraise the content, delivery, and outcome of such treatment.

B2.c) Exclusion criteria

The service is unable to provide extensive support and/or supervision to patients that do not meet the above inclusion criteria. There is a clear understanding in commissioning arrangements that treatment at steps 1 to 4 in the NICE guidelines will be provided by NHS Boards.

In addition, the provision of 20 hours of exposure and response prevention, delivered in the patient's home, should be available within secondary care MH services as stipulated by the Psychological Therapies Matrix (NHS Scotland, 2008).

Where additional treatment steps are indicated, the service may be able to advise on further management, but it cannot supervise or deliver behavioural treatments for patients that are unable to access such treatment in their local area. In some cases, it may be able to advise referrers and/or patients and carers on accessing such treatment.

B3. Criteria for intensive/inpatient treatment service

The following criteria will be used for assessing suitability to entry into the intensive/inpatient service. The criteria are not absolute, and will be used as a guide when considering individuals for intensive treatment.

B3.a) Inclusion Criteria

1. Diagnosis of Obsessive-Compulsive Disorder made according to ICD-10 (World Health Organisation, 1992), DSM-IV (American Psychiatric Association, 1994), or DSM-5 (American Psychiatric Association, 2013);
    a. Comorbid diagnoses of Obsessive-Compulsive Personality Disorder (OCPD) or Asperger's Syndrome are not absolute contraindications, but they should not be the primary diagnosis and full criteria for OCD should be met. The severity of symptoms should be significant enough to indicate that personality disorder is insufficient to account for the impairments in functioning.
    b. Similarly, comorbid anxiety disorders (*e.g.* Generalized Anxiety Disorder, Agoraphobia) and depression are common in OCD. These are not a contraindication to admission, but it is expected that efforts have been made to determine that OCD is the primary source of the anxiety symptoms. Such efforts are likely to involve targeted treatment of the other conditions.
2. Symptoms of OCD have persisted for ≥ 2 years without improvement and despite treatment. In the majority of cases, total duration of illness is expected to be in excess of 5 years;
3. Severity of OCD, measured using the clinician-rated Y-BOCS, is likely to be ≥ 28 (severe). In most cases, it is expected that symptoms will be in the 'extreme' range (≥ 32);
4. Global Assessment of Functioning (GAF) should be ≤ 40. This means that symptoms are severe and result in "*...major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood*". It is unlikely, for example, that patients are able to work or function adequately in any major area and they will be dependent on family, carers, or services.
8. The patient has had ≥ 3 trials of serotonin re-uptake inhibitors at maximum (or maximum-tolerated) dose – one of which should be Clomipramine. Each trial should have been for ≥ 12 weeks;
5. The patient has had at least two trials of antipsychotic augmentation with one or more of the following: Risperidone, Aripiprazole, or Quetiapine.[2] The augmentation trial should be ≥ 6 weeks

[2] Augmentation trials should be sequential. There is no evidence that combined use of antipsychotics is beneficial.

in duration, and ideally 8-12 weeks. Augmentation of Clomipramine with an antipsychotic drug (wherever tolerated) should have been completed.

6. The patient has had at least one unsuccessful trial of Exposure and Response Prevention, being ≥ 20 hours in duration. This should have been delivered by a therapist with experience in the treatment of OCD. Therapy should have been home-based where symptoms relate to the home environment. Documentation of treatment should be sufficient to appraise the content, delivery, and outcome of such treatment.

B3.b) Exclusion Criteria

1. Demonstrated lack of willingness to engage in behavioural therapy, or evidence of intolerability to levels of anxiety associated with ERP.
2. Insufficient insight to understand the model and rationale for treatment.
3. Concurrent substance misuse disorder which requires any intervention other than continuation of maintenance treatment.
4. Concurrent major depressive illness that is severe enough to impair ability to engage in ERP or carries a significant risk of self-harm and/or suicide.
5. Concurrent personality disorder (*e.g.* borderline personality disorder) which is severe enough to affect treatment.
6. Body Dysmorphic Disorder (BDD) where BDD is the primary symptom domain and which is not associated with significant OCD. See section B4.b) below for more details.
7. Autism Spectrum Disorder (*e.g.* Asperger's syndrome) where symptoms are considered to be more appropriately attributable to the ASD, rather than OCD. See section B4.c) below for more details.

B4. Guidance on specific conditions

B4.a) Hoarding disorder

Hoarding disorder is related to OCD but there are sufficient differences (particularly with regards to response to behavioural treatment) to consider Hoarding Disorder to be a separate condition; indeed, DSM-5 categorises it as being separate from OCD (American Psychiatric Association, 2013).

Where the patient is suffering from a primary diagnosis of Hoarding Disorder, suitability for intensive treatment will be assessed on a case-by-case basis. The evidence for intensive inpatient treatment for hoarding is limited and any treatment needs to be delivered in the patient's home. Therefore, it is likely that patients with Hoarding Disorder have little to be gained from inpatient treatment and it is not within the remit of the service to provide it.

Given the significant disability that this disorder can cause, the AIS considers it important to work with local services to deliver treatment within the capacity of the service. The AIS will maintain a dialogue with National Services Division regarding this, and it will continue to monitor referrals for Hoarding Disorder over time.

B4.b) Body Dysmorphic Disorder (BDD)

Symptoms of Body Dysmorphia can occur within OCD. However, some patients have symptoms that are of sufficient severity and independence from other OCD symptoms to indicate a diagnosis of Body Dysmorphic Disorder.

Whilst BDD is related to OCD, treatment and response to treatment is different. The Advanced Interventions Service is not commissioned to provide treatment for BDD.

Where BDD is the primary problem, the service will offer to assess the patient, confirm diagnosis, and make recommendations regarding further treatment. Where treatment cannot be provided in Scotland, consideration will be given to onward referral to specialist services in London. Such treatment is outwith the funded value of the service.

B4.c) Asperger's syndrome

There is a significant and often complex overlap of symptoms between OCD and Asperger's syndrome, and in many cases the two conditions can look similar. Whilst the AIS is not commissioned to provide intensive treatment for Asperger's syndrome, we believe that we may have a role in assessing complex cases and advising on further management. Referrals will be considered on a case-by-case basis.

B4.d) Schizophrenia and other psychotic disorders

Obsessive-Compulsive symptoms arising from schizophrenia, or developing in the context of antipsychotic treatment for psychosis (*e.g.* Clozapine) are not considered to automatically fall within the remit of the service. However, the complexities of treating such conditions may mean that discussion of the case with the referring team is appropriate.

In some cases, OCD and schizophrenia may co-exist and treatment can be challenging. Where obsessive-compulsive symptoms are present, and are phenomenologically distinct from active psychosis (*i.e.* the content of obsessions is unrelated to the content of delusions, and insight into O-C symptoms is preserved), specialist assessment regarding future management may be appropriate. We would invite discussions about possible referrals in the first instance.

B4.e) Eating Disorders

Eating disorders can be comorbid with OCD, and the morbid preoccupations with food and excessive food-related behaviours can often 'mimic' OCD.

Before considering a referral to the AIS, we would expect that OCD is confirmed as the primary diagnosis. We also have the expectation that attempts will have been made to treat the eating disorder and this may include referral to specialist eating disorders services. In addition, the likelihood of successful intensive treatment for OCD being successful is low when the patient is significantly underweight.

Where the eating disorder is problematic (but not life-threatening) and is a complicating factor in the treatment of OCD, we would be happy to discuss the situation with referrers, as assessment and joint-management of such cases may be helpful.

Section C: Service Description

C1. Overview

Intensive treatment in the Advanced Interventions Service is conceptualised as a series of steps – in many cases, it is not appropriate to progress further until current treatment goals are met.

Whilst some patients may have previously undergone inpatient treatment, treatment in Dundee is likely to be more intensive than elsewhere.

C2. Duration of treatment

Intensive treatment programmes will be tailored to the individual. In most cases, intensive treatment will aim to deliver in excess of 50 hours of therapist-guided exposure therapy (excluding self-directed sessions by the patient). For most people, this will take between 3-5 weeks (not including pre-treatment).

C3. Intervention

C3.a) Exposure and Response Prevention (ERP)

Typically, patients will receive 3 hours of therapist-guided ERP per day, for five days each week. The target 'dose' will be ≥ 15 hours of ERP per week. Patients will be expected to engage with homework tasks, *i.e.* the patient will have additional self-directed exposure tasks to complete outside of the therapist-guided treatment sessions.

C3.b) Family work / work with carers

It is recognised that OCD does not occur in isolation, and families and carers are invariably affected by the illness. Their engagement and involvement is a vital part of treatment and the AIS is committed to working with them as part of the intensive treatment programme. Importantly, the involvement of family appears to be related to assessments of service quality and satisfaction (Mavrogiorgou, Siebers, Juckel, *et al*, 2013).

The assessment process will involve families and carers, and the discharge planning process will necessarily involve those with close contact with the patient. We recognise that attempting to reduce symptoms without wider environmental change is less effective.

C3.c) Other activities

Although the AIS is not staffed to deliver social and occupational activities, there is an expectation that these will be provided by NHS Tayside within the Carseview Centre. The team will work closely with inpatient staff to ensure that the environment is as therapeutic as possible.

C4. Location of treatment

Treatment will be delivered in the environment where symptoms are most problematic and where treatment will be most effective. In most cases, this will mean an inpatient stay but home-based treatment will be planned in the majority of cases.

The most appropriate location to deliver treatment will be reviewed as therapy progresses, and there will be flexibility to maximise treatment. As a general rule, intensive treatment will consist of the combination of inpatient and home-based treatment. For example, some patients may receive 30 hours of inpatient ERP with 20 hours of home-based treatment. In other cases, 40 hours of inpatient ERP may be combined with 10 hours of home-based treatment.

C5. Detailed description of treatment intervention

C5.a) Phase 1: Assessment and pre-treatment

The first 2 weeks of the inpatient stay will typically consist of assessment, formulation, treatment-planning, and orientation to the model. Structured assessments of symptom ratings will be conducted, and the effects of the illness on the patient and their family will be explored in detail.

At the end of Phase 1, progress will be reviewed in conjunction with the patient and a decision to proceed to further treatment will be made. In some cases, the inpatient environment is not the most suitable environment and/or the model is simply not suitable for the patient. In these cases, further inpatient treatment will not be offered as it is unlikely to be beneficial. However, the service will explore options for delivering home-based treatment for the patient and supervision for local services for a short period to ensure a smooth and supported transition back home.

C5.b) Phase 2: Intensive inpatient treatment

This phase of treatment will consist of at least three hours per day of therapist-guided exposure and response prevention; being delivered as an inpatient. For most individuals, this will consist of 30-40 hours of exposure.

During this treatment phase, planning for discharge and home-based treatment will take place. This will be supported by close liaison with the patient's local team and in almost all cases one or more team members will be invited to be involved in the treatment.

C5.c) Phase 3: Home-based treatment

Following intensive inpatient treatment the service will aim to deliver a phase of home-based treatment, in conjunction with local services. The frequency and intensity of this treatment will be determined on a case-by-case basis but typically it will comprise of an additional five days of treatment. This may be delivered as a five-day block or it may be spread out over a longer period of time.

C5.d) Phase 4: Long-term follow-up

Whilst the service may not have active contact with the patient, we believe that it is important to ensure that the long-term outcomes of treatment can be determined. Consequently, patients will be asked to complete ongoing rating scales of symptoms and functioning and these will be used inform discussions with the patient's local team.

This period of follow-up will last for 12 months and progress will be reviewed after this time.

C6. Post-discharge follow-up

C6.a) Ongoing treatment

After discharge, it is not expected that the AIS will continue to deliver active treatment with the patient. The AIS will negotiate an understanding that local services will be able to deliver an additional 20 hours of therapist-guided ERP in the most appropriate environment (*e.g.* home). Further, the AIS expect that local services will commit to providing at least 12-months of active follow-up for the patient.[3]

C6.b) Follow-up

The AIS will work closely with local services during Phase 3 of treatment (home-based therapy). After discharge from treatment, the primary follow-up points will be as follows:

1. Two-weeks after discharge: AIS will aim to conduct a two-week telephone review with local services in order to ensure that the transition has gone smoothly and to provide final troubleshooting support.
2. Six months after discharge: The AIS will conduct a telephone case-review with local services to review progress and to inform further decision-making. Further pharmacological and/or psychological treatment recommendations may be made.

[3] Although the patient may make treatment gains following intensive treatment, the likelihood of complete remission remains low and patients are likely to require ongoing support from MH services.

3. Twelve months after discharge: One-year after completing intensive treatment, the AIS will liaise with local services in order to review treatment and symptom burden (based on rating scales completed to date).

C6.c) Support for local services

To some extent, this is outlined above. The AIS will endeavour to provide telephone support for therapists who are continuing to provide ongoing treatment for patients that have been treated as part of the intensive treatment programme. This support is likely to take the form of 'troubleshooting' problems that are arising and refocusing of treatment.

It is unable to provide formal supervision for therapists as provision for this should be available within each NHS Board.

Section D: Service Delivery

D1. Links and interfaces

D1.a) Local services

Within this framework, 'local' refers to services local to the patient.

D1.b) Other specialist services

The service will seek, initiate, and maintain links with other similar specialist services in the UK and beyond. Benchmarking against other services, and sharing of treatment models will be an important component of our quality improvement programme.

D2. Patient disengagement

It is recognised that not all patients are able to adhere to an intensive programme of ERP. Where a patient indicates a wish to discontinue treatment, the team will endeavour to work with the patient to address the difficulties that are arising. This may require modifications to the intensity and/or content of the programme.

Where all reasonable adjustments have been tried and have been ineffective, the team will liaise with the patient, carers, and local services in order to ensure that discharge is safe, and supported.

Ultimately, such programmes require consenting individuals who are willing and able to work within an intensive behavioural treatment programme. Such programmes cannot be delivered within the framework of compulsory treatment, and consequently it is expected that patients will be free to withdraw from the programme.

D3. Training and Development

All staff working in the service are experienced clinicians. However, the intensity and complexity of delivering such treatment will necessitate high levels of therapeutic expertise. The service will maintain a development programme for staff, and will continue to seek opportunities to develop staff to the maximum.

The service will have an active programme of continuing professional development, and each member of the team will have a personal development plan which includes specific learning objectives relating to the intensive OCD treatment service.

Where these objectives cannot be met within the existing financial envelope, the service will explore all available options to ensure that staff can ensure their training is optimal.

D4. Evaluation and audit

D4.a) Outcome reporting

The service will report activity and outcomes as part of its annual reporting process. Annual reports will be submitted to NSD, and these will also be made available on our website.

D4.b) Audit

All staff have a role in contributing to audit, research, and service improvement. Outcome data will be collected continuously and outcomes for individual patients will be subject to regular review and discussion.

The personal development plans for each member of staff will include specific objectives relating to audit and/or research relating to OCD treatment.

Section E: Outcome measurement

E1. Standard assessment tools

The following section lists some of the rating scales used to measure symptom burden and social functioning. Outcomes will be described in our annual report. The 'core' assessments are listed below in section E2. Others will be used on a discretional basis.

E1.a) Diagnostic tools

1. Diagnosis will be established/confirmed prior to admission using the Mini-International Neuropsychiatric Inventory (Sheehan, Lecrubier, Sheehan, *et al*, 1998).
2. Personality will be assessed using semi-structured interviews in conjunction with informant histories (where consent has been obtained).

E1.b) Symptom ratings

1. Yale-Brown Obsessive-Compulsive Scale (YBOCS; Goodman, Price, Rasmussen, et al, 1989).
2. PADUA Inventory – Revised (Burns, Keortge, Formea, et al, 1996).
3. Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960).
4. Montgomery-Åsperg Depression Rating Scale (MADRS; Montgomery & Åsberg, 1979).
5. Inventory of Depressive Symptomatology (IDS; Rush, Gullion, Basco, et al, 1996).

E1.c) Social functioning and quality-of-life measures

1. MOS Short Form Health Survey (SF-36; Ware & Sherbourne, 1992).
2. WHODAS (Üstün, Kostanjsek, Chatterji, *et al*, 2010).
3. EQ-5D (The EuroQol Group, 1990).
4. Global Assessment of Functioning (GAF; Jones, Thornicroft, Coffey, *et al*, 1995).

E1.d) Other rating scales

1. Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983).
2. Inventory of Interpersonal Problems (IIP-64; Horowitz, Rosenberg, Baer, et al, 1988).
3. Family Accommodation Scale (FAS; Calvocoressi, Mazure, Kasl, *et al*, 1999).
4. Modified Thought-Action Fusion Scale (MTAFS; Rassin, Merckelbach, Muris, *et al*, 2001).
5. OCD Family Functioning Scale (OFF; Stewart, Hu, Hezel, *et al*, 2011).

6. Brown Assessment of Beliefs Scale (BABS; Eisen, Phillips, Baer, *et al*, 1998).

E2. Assessment timetable

Please note that ratings listed at time points are in addition to other ratings being completed prospectively. For example, at six months, it is expected that the patient will still be completing a monthly Y-BOCS.

Time	**Rating Scales to be completed (Patient)**	**Rating Scales to be completed (Clinician)**
Phase 1 (admission)	Y-BOCS (self-report) PADUA IDS EQ-5D SF-36 WHODAS BSI IIP-64 MTAFS FFS OFF	Y-BOCS HRSD; MADRS (where applicable) BABS GAF
Phase 2 (Weekly, during treatment)	Y-BOCS (self-report) IDS	-
Phase 2 (discharge)	Y-BOCS (self-report) PADUA IDS EQ-5D SF-36 WHODAS BSI IIP-64 MTAFS FFS OFF	Y-BOCS HRSD; MADRS (where applicable) BABS GAF
Phase 4 (monthly)	Y-BOCS (self-report)	-
Phase 4 (six-monthly)	FFS OFF	

Section F: References

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: American Psychiatric Press.

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