PRIMARY CARE

Step 1			Comments	Additional actions
Fluoxetine ≥ 40mg/day ☐	OR	Sertraline ≥ 200mg/day ☐	Should be determined by patient choice.	Referral to primary care psychology, and offer self-help materials.
Escitalopram ≥ 20mg/ day ☐				
Step 2			**Comments**	**Additional actions**
Any one from Step 1 that has not been tried.			Should be determined by patient choice.	Referral to primary care psychology, and offer self-help materials.

Maximum no. of available trials in primary care	3
Expected no. of trials to be given in a primary care setting	2

What should happen next if there has been insufficient clinical response despite adequate trials?

1. Referral to CMHT for specialist assessment and advice.[1]

SECONDARY CARE

Step 3A (DISCRETIONARY)			Comments	Additional actions
Clomipramine ≥ 200mg/ day ☐			Can be considered at discretion of the patient and clinician. May be considered if the patient is reluctant to move onto antipsychotic augmentation.	Offer adjunctive CBT/ ERP (minimum 12 hours) ☐
Step 3B (AUGMENT WITH)			**Comments**	**Additional actions**
Risperidone ≥ 1.5 mg/ day ☐	OR	Aripiprazole ≥ 10mg/ day ☐	Choice should be determined by patient preference.	Offer adjunctive CBT/ ERP (minimum 12 hours) ☐
Step 4 (AUGMENT WITH)			**Comments**	**Additional actions**
Memantine ≥ 10mg/ day ☐	OR	Lamotrigine ≥ 150mg/ day ☐	Don't skip Step 3B. First line augmentation should be with atypical antipsychotics due to stronger evidence.	Offer adjunctive CBT/ ERP (minimum 12 hours) ☐

[1] Timing of referral should also be informed by severity, impairment, and other factors (*e.g.* risk, diagnostic uncertainty, comorbidity)

	Step 5		Comments	Additional actions
	Any one of steps 3 or 4 that have not been tried. For example, poor tolerability of one or more antipsychotics might prompt a trial of a different drug.			Offer adjunctive CBT/ ERP (minimum 12 hours) ☐
	Maximum no. of available trials in secondary care	5	Includes a trial of CBT/ ERP for OCD.	
	Expected no. of trials to be given in a secondary care setting	2		
	Running total no. of trials to have been completed (including primary care):	4		
	What should happen next if there has been insufficient clinical response despite adequate trials?	1. Referral to specialist OCD service for review and possible treatment.		

	Steps 6-7		Comments	Additional actions
SPECIALIST/ TERTIARY CARE	Any of: Inference-Based Therapy (IBT) ☐ Inpatient/ Intensive Exposure and Response Prevention (ERP) ☐ Plus any untried treatments listed above (depending on applicability and patient choice)		ERP has stronger evidence base. Should be based on tolerability of previous agents, patient preference, and timing of other interventions (*e.g.* inpatient treatment)	
	Maximum no. of available trials in specialist/ tertiary care	3	Including at least one trial of intensive treatment	
	Expected no. of trials to be given in a specialist service setting	2		
	Running total no. of trials to have been completed (including primary and secondary care):	6-8		
	Step 8		**Comments**	**Additional actions**
	Ablative neurosurgery		For suitable patients only.	

Appendix 1: Guidance for use of all medications

- Durations of treatment trials for OCD are longer than for other conditions. Typically, a trial of at least 10-12 weeks at maximum or maximum-tolerated dose is necessary to determine if a drug is likely to be beneficial. The total duration for a drug is likely to be longer than this, when allowing for dose titration.
- It is preferable to have a longer trial at a dose that is tolerated than a shorter trial at a poorly-tolerated dose. For example, 10 weeks of Risperidone 1mg is better than a two week trial of Risperidone 4mg.
- When initiating and/ or switching medications, patients usually need to be reviewed more frequently. Often, simply delaying the next dose increase can significantly improve tolerability and increase the patient's trust in the treatment approach.

Appendix 2: Guidance for use of all antidepressants

- Target doses for antidepressants in OCD are higher than target doses for depression. 'Typical' treatment doses for most SSRIs are inadequate for OCD.
- There is little compelling evidence to suggest that one medication is better than others. The goal is to find treatments that are tolerated, and which can be taken for long enough to assess benefit.
- Most serotonergic antidepressants can be cross-titrated and this is often preferable to minimise the risk of withdrawal/ discontinuation symptoms. Also, many patients find that even though their OCD symptoms might not respond to a drug, they will often get worse when you reduce the dose.

Appendix 3: Guidance for use of augmentation strategies

- The best evidence is for antipsychotic augmentation of serotonergic antidepressants. However, typical doses for OCD are lower than those used to treat schizophrenia and bipolar disorder. The principle of 'start low, go slow' is usually correct.
- The choice of antipsychotic should be influenced by patient preference, but informed by the expectation that if the first choice doesn't work (or isn't tolerated), the next step would be to try the second choice.
- Whilst there may be a preference to try treatments with apparent better tolerability (e.g. Memantine), the evidence base supports antipsychotic augmentation as the first-line augmentation approach.

Appendix 4: Guidance for optimal delivery of psychological therapy

- For patients with moderate to severe OCD, patients should be given a choice between medication and psychological/ behavioural therapy. Where symptoms are more severe and/ or chronic, it is likely that a combined approach will be required in order to achieve symptomatic improvement.
- It is often difficult for patients to be able to access high quality CBT/ ERP in most community mental health teams. The thresholds described reflect a pragmatic balance

between the need for patients to have tried evidence-based treatments and to not get caught up in receiving endless non-evidence-based interventions.

- Key principles for psychological therapy include:
    - The best evidence exists for CBT, ERP, and CBT/ ERP (it is usually combined).
    - Although other modalities may be available, they are less convincing treatments and many are supported by lesser-quality evidence of improvement in populations that do not resemble patients in CMHTs.
    - The balance between cognitive and behavioural is less important when considering referral to the AIS, and is often influenced by the formulation and patient preference. In most cases, some form of exposure is likely to be required.
    - It is usually easier to identify (and count) exposure sessions than cognitive sessions.
    - A trial of treatment of at least 12 sessions (each session typically lasting at least an hour) is necessary to determine if psychological therapy might be helpful. This equates to at least 12 hours of therapy. A good target is 16 hours of CBT/ ERP.
    - If psychological therapy is not appearing to help, it probably makes sense to 'bank' the sessions so far rather than explore other modalities. Consider referral to the AIS if other relevant treatment steps have been completed.
    - Whilst high levels of therapist expertise is desirable, it is not essential for a patient to have had a trial of treatment from an accredited therapist before being referred to the AIS.