

**Quality
Standards**

Obsessive–Compulsive Disorder

Care in All Settings



Ontario Health
Quality

About This Quality Standard

The following quality standard addresses **care for people with obsessive–compulsive disorder**.

It applies to care for people in all settings but focuses on primary and community care. This quality standard focuses on care for adults (age 18 years and older), but it includes content that is relevant for children and adolescents (under age 18 years). It does not address care for some disorders that are related to obsessive–compulsive disorder (e.g., body dysmorphic disorder, hoarding disorder, excoriation disorder, or trichotillomania), because these are separate disorders that require different treatment.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards are developed by the Quality business unit at Ontario Health, in collaboration with health care professionals, patients, and caregivers across Ontario.

For more information, contact qualitystandards@hqontario.ca.

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the [Patient Declaration of Values for Ontario](#). This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

Health care professionals should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. It is important for care to be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis peoples. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guideline sources developed by groups that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

This quality standard is underpinned by the principle of recovery, as described in the Mental Health Strategy for Canada. People with obsessive-compulsive disorder can lead meaningful lives. People with obsessive-compulsive disorder have a right to services provided in an environment that promotes hope, empowerment, self-determination, and optimism, and that are embedded in the values and practices associated with recovery-oriented care.¹ The concept of recovery refers to "living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses".² As described in the Mental

Health Strategy for Canada, “recovery—a process in which people living with mental health problems and mental illnesses are actively engaged in their own journey of well-being—is possible for everyone. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments”.¹

Mental wellness is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as individuals have: purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.³ These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The First Nations Mental Wellness Continuum Framework provides an approach that “respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing”.³

Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for people with obsessive-compulsive disorder.

Quality Statement 1: Identification

People with suspected OCD are identified early using recognized screening questions and validated severity-rating scales.

Quality Statement 2: Comprehensive Assessment

People with suspected OCD, or who have had a positive screening result for OCD, receive a timely comprehensive assessment to determine whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

Quality Statement 3: Support for Family

People with OCD are encouraged to involve their family during their assessment and treatment, considering individual needs and preferences. Family members are connected to available resources and supports and provided with psychoeducation that includes how to avoid accommodation behaviours.

Quality Statement 4: Stepped-Care Approach for OCD

People with OCD receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first, based on symptom severity, level of functional impairment, and individual needs and preferences.

Quality Statement 5: Self-Help

People with OCD are informed about and supported in accessing self-help resources, such as self-help books, Internet-based educational resources, and support groups, considering their individual needs and preferences and in alignment with a stepped-care approach.

Quality Statement 6: Cognitive Behavioural Therapy for OCD

People with OCD have timely access to cognitive behavioural therapy with exposure and response prevention, considering their individual needs and preferences and in alignment with a stepped-care approach. Cognitive behavioural therapy with exposure and response prevention is delivered by a health care professional with expertise in OCD.

Quality Statement 7: OCD-Specific Pharmacological Treatment

People with moderate to severe OCD, or people who are not responding to psychological treatment, are offered a selective serotonin reuptake inhibitor (SSRI) at an OCD-specific dose and duration, considering their individual needs and preferences and in alignment with a stepped-care approach.

Quality Statement 8: Monitoring

People with OCD have their response to treatment (effectiveness and tolerability) monitored regularly over the course of treatment using validated tools in conjunction with an assessment of their clinical presentation.

Quality Statement 9: Support During Initial Treatment Response

People with OCD are informed about what to expect and supported during their initial treatment response. When initial treatment is not working, people with OCD are reassessed. They are offered other treatment options, considering their individual needs and preferences and in alignment with a stepped-care approach.

Quality Statement 10: Intensive Treatment

When psychological or pharmacological treatment is not working, or in cases of severe OCD, people are referred for intensive treatment, in alignment with a stepped-care approach.

Quality Statement 11: Relapse Prevention

People with OCD who are receiving treatment are provided with information and education about how to prevent relapse and manage symptoms if they re-emerge.

Quality Statement 12: Transitions in Care

People with OCD are given appropriate care throughout their lifespan and experience seamless transitions between services and health care professionals, including between care settings and from child and adolescent services to adult services.

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Scope of This Quality Standard

This quality standard addresses care for people living with obsessive–compulsive disorder (OCD). It applies to care for people in all settings but focuses on primary and community care. This quality standard focuses on care for adults (age 18 years and older), but it includes content that is relevant for children and adolescents (under age 18 years).

Few clinical practice guidelines were available to support the development of a comprehensive quality standard for children and adolescents. In this standard, guidance is provided where relevant clinical practice guideline recommendations and content for children and adolescents were available.

This quality standard uses the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) categorization of OCD as the presence of obsessions, compulsions, or both⁴:

- Obsessions are “recurrent and persistent thoughts, urges, or impulses that are experienced as ... intrusive and unwanted, and that in most individuals cause marked anxiety or distress. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action”
- Compulsions are “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. The behaviours or mental acts are aimed at preventing or reducing anxiety or stress or preventing some dreaded event or situation”

This quality standard does not include OCD-related disorders, such as body dysmorphic disorder, hoarding disorder, excoriation disorder, or trichotillomania. Disorders related to OCD were excluded from the scope because of limitations in the relevant clinical practice guidelines. This quality standard also does not address trauma- and stressor-related disorders (including post-traumatic stress disorder).

For information about anxiety disorders, please see *Anxiety Disorders: Care in All Settings*, which was developed concurrently with this quality standard.

Why This Quality Standard Is Needed

Obsessive–compulsive disorder is characterized by the presence of obsessions (recurrent, persistent, intrusive thoughts, urges, or images) and/or compulsions (repetitive behaviours). It is estimated that 1.6 to 2.3% of adults (1 in 50) have had OCD at some time in their life (lifetime prevalence).^{5–8} Based on a Statistics Canada population-

based health survey, the prevalence of diagnosed OCD in Canada is 0.93%, or 1 in 100 people aged 15 or older.⁹ Among children, OCD is more common in boys; but among adults, men and women are equally affected.¹⁰

The disabling symptoms of OCD contribute to a poorer quality of life, not only for people with OCD, but also for their families.^{5,11} The debilitating symptoms and considerable functional impairment associated with OCD lead to a higher risk of suicidal ideation and suicide attempts.¹² About one-quarter of people with OCD have attempted suicide.^{5,11}

Obsessive–compulsive disorder also contributes to the considerable economic burden that mental health and addictions have on society. In 2015, Canada's estimated public and private mental health expenditure was \$15.8 billion.¹³

In 2018, 12.3% of adults and 21.6% of children and youth in Ontario with OCD had their first contact for OCD in the emergency department (ED), which means that they had not accessed mental health or addictions services from a physician in the 2 years prior (NACRS, DAD, OMHRS, and OHIP Claims Database, provided by ICES, 2019*). In 2018, 460 adults and 299 children and youth visited the ED for OCD (NACRS, provided by ICES, 2019*). Further, for people who visited the ED for OCD, the rate of unscheduled ED revisits within 30 days for mental health and addictions was 22.4% (NACRS, provided by ICES, 2019*). Emergency department revisits were more common in females than in males (27.2% versus 16.8%; NACRS, provided by ICES, 2019*).

In 2017, there were 343 hospitalizations for OCD, with the number ranging from 1–5 to 59 across regions in Ontario (DAD, OMHRS, provided by ICES, 2019*). For people in Ontario with a hospital admission for OCD, the rate of unscheduled hospital readmissions within 30 days for mental health and addictions was 10.9%. There was variation in the hospital readmission rate across regions in Ontario, with the highest rate at 20.1% in the Mississauga Halton local health integration network (LHIN) compared with 0% in the Erie St. Clair, South East, and South West LHINs. These findings may reflect people getting care from providers who are not physicians, people unable to access mental health and addictions services delivered by physicians, and potential missed opportunities for mental health services in primary and community care.¹⁴

Several equity factors—including gender, income, comorbidity, Indigenous identity, and geography—may affect specific populations with OCD. The lowest neighbourhood income quintile had the highest proportion of people who reported a diagnosis of OCD or an anxiety disorder (Canadian Community Health Survey, Mental Health, 2012). As well, more people in rural areas reported a diagnosis of OCD or an anxiety disorder than people in urban areas (7.5% versus 4.8%, respectively; Canadian Community Health Survey, Mental Health, 2012).

* DAD, Discharge Abstract Database; NACRS, National Ambulatory Care Reporting System; ICES, Institute for Clinical Evaluative Sciences; OHIP, Ontario Health Insurance Plan; OMHRS, Ontario Mental Health Reporting System.

There are substantial gaps in the health care system when it comes to treating people with OCD. Health care professionals do not always recognize the different ways OCD can present or know what the appropriate treatments are; this represents a knowledge gap and opportunity for education.¹⁵⁻¹⁸ Many primary care physicians see patients with mental health and addictions needs, but few report feeling well prepared to care for them.¹³ Further, people with OCD can be embarrassed about their obsessions and compulsions or can be unaware of where to find help; either can result in them not seeking professional help.^{15,16,19} In a literature review examining the factors associated with non-treatment or delayed treatment seeking, the research studies found that people with OCD delay seeking treatment for many years, ranging from 3 to 17 years.¹⁹

These factors all contribute to delays in diagnosis and treatment. Although effective treatments exist, on average 52.8% of people aged 15 years and older globally who require care for OCD do not receive treatment.²⁰ In adults, the mean time from first experiencing minor symptoms to the onset of OCD is 6 years, and an additional 11 years passes before they receive treatment.²¹ There are many opportunities to improve OCD care in Ontario so that people have timely access to appropriate, evidence-based treatment.

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For Patients

This quality standard consists of quality statements. These describe what high-quality care looks like for people with OCD.

Within each quality statement, we've included information on what these statements mean for you, as a patient.

In addition, you may want to download this accompanying [patient guide](#) on OCD, to help you and your family have informed conversations with your health care providers. Inside, you will find questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people with OCD.

They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions (Appendix 2) to help you assess the quality of care you are delivering, and identify gaps in care and areas for improvement. While it is not mandatory to use or collect data when using a quality standard to improve care, measurement is key to quality improvement.

There are also a number of resources online to help you, including:

- Our [patient guide](#) on OCD, which you can share with patients and families to help them have conversations with you and their other health care providers. Please make the patient guide available where you provide care
- Our [measurement resources](#), which include our data tables to help you identify gaps in care and inform your resource planning and improvement efforts; our measurement guide of technical specifications for the indicators in this standard; and our “case for improvement” slide deck to help you to share why this standard was created and the data behind it
- Our [Getting Started Guide](#), which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- [Quorum](#), an online community dedicated to improving the quality of care across Ontario. This is a place where health care providers can share information, inform, and support each other, and it includes tools and resources to help you implement the quality statements within each standard
- [Quality Improvement Plans](#), which can help your organization outline how it will improve the quality of care provided to your patients, residents, or clients in the coming year

While you implement this quality standard, there may be times you find it challenging to provide the care outlined due to system-level barriers. Appendix 1 provides our recommendations to provincial partners to help remove these barriers so you can provide high-quality care. In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

How to Measure Overall Success

The Anxiety Disorders and Obsessive–Compulsive Disorder Quality Standards Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with OCD. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

See Appendix 2 for additional details on how to measure these indicators and our [measurement guide](#) for more information and support.

Indicators That Can Be Measured Using Provincial Data

- Percentage of people with an unscheduled ED visit for OCD for whom the ED was the first point of contact for mental health and addictions care
- Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for OCD
- Percentage of inpatient readmissions related to mental health and addictions within 30 days of discharge following a hospital admission for OCD

The above indicators may capture care for only a subset of people with OCD. See the section below on local measurement for additional indicators that may be used to assess quality of care.

Indicators That Can Be Measured Using Only Local Data

- Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who receive a comprehensive assessment that determines whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment
- Percentage of people with OCD for whom cognitive behavioural therapy (CBT) with exposure and response prevention was determined to be appropriate and who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD
- Percentage of people with OCD who report an improvement in their quality of life
- Percentage of people with OCD who “strongly agree” with the following question: “The services I have received have helped me deal more effectively with my life’s challenges”[‡]
- Percentage of people with OCD who complete CBT with exposure and response prevention and have reliable recovery[‡]
- Percentage of people with OCD who complete CBT with exposure and response prevention and have reliable improvement[‡]
- Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, and who receive a selective serotonin reuptake inhibitor (SSRI) at an OCD-specific dose and duration

[‡] This question is from the Ontario Perception of Care Tool (OPOC) for Mental Health and Addictions (question 30) developed at the Centre for Addiction and Mental Health (CAMH). This question closely aligns with the overall quality standard and can be useful in determining patient experience. This question is part of a larger survey made available through CAMH that can be accessed upon completion of a Memorandum of Understanding and License Agreement with CAMH. Please see the [OPOC Community of Practice](#) for more information.

[‡] As measured by a validated severity-rating scale for OCD before treatment is initiated and after treatment is completed. Please see quality statement 1 for more information about the scales.

Quality Statements to Improve Care: The Details

1

Identification

People with suspected OCD are identified early using recognized screening questions and validated severity-rating scales.

Sources: American Academy of Child and Adolescent Psychiatry, 2012²⁶ | American Psychiatric Association, 2007²⁷ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definitions

People with suspected OCD: People who present with symptoms typical of OCD, such as contamination concerns, intrusive thoughts, excessive washing or checking behaviours, or other repetitive rituals or compulsive behaviours.

Identified early: Identification of possible OCD should occur as early as possible (early after symptoms emerge, and early in life). People identified for possible OCD require further evaluation or referral to a health care professional who can conduct a more comprehensive assessment (see quality statement 2). Use of recognized screening questions and validated severity-rating scales for OCD is not recommended for all patients; these tools are intended for people who present with symptoms typical of OCD or to rule out OCD before making a diagnosis.

Recognized screening questions: The following are examples of recognized screening questions.

- MACSCREEN⁵:
 - Are you bothered by repeated and unwanted thoughts of any of the following types: thoughts of hurting someone else, sexual thoughts, excessive concern about contamination/germs/disease, preoccupation with doubts ("what if" questions) or an inability to make decisions, mental rituals (e.g., counting, praying, repeating), or other unwanted intrusive thoughts?
 - If you answered "yes" to any of the above: do you have trouble resisting these thoughts, images, or impulses when they come into your mind?
 - Do you feel driven to perform certain actions or habits over and over again, or in a certain way, or until it feels just right? Such as: washing, cleaning, checking (e.g., doors, locks,

1

Identification

appliances), ordering/arranging, repeating (e.g., counting, touching, praying), hoarding/collecting/saving

- If you answered "yes" to any of the above: do you have trouble resisting the urge to do these things?
- From the National Institute for Health and Care Excellence guideline²²:
 - Do you wash or clean a lot?
 - Do you check things a lot?
 - Is there any thought that keeps bothering you that you would like to get rid of but cannot?
 - Do your daily activities take a long time to finish?
 - Are you concerned about putting things in a special order, or are you very upset by mess?
 - Do these problems trouble you?
- Diagnostic Assessment Research Tool (DART) Questionnaire²³ self-reported screening questions:
 - Currently, do you have frequent, repetitive thoughts, urges, or images that are unwanted or intrusive and cause you significant anxiety or distress (e.g., doubts about whether you've done things properly, thoughts about being dirty or contaminated, or unwanted disturbing images or thoughts)?
 - Currently, do you engage in any repetitive behaviours (e.g., checking, cleaning) or mental rituals (e.g., repeating phrases) that you can't resist doing and that are in response to upsetting thoughts or because of rules that you must follow?

Validated severity-rating scales: Many validated severity-rating scales are available to measure the severity of symptoms in OCD, including the following examples (child and adolescent versions are available):

- Yale-Brown Obsessive Compulsive Scale (Y-BOCS and CY-BOCS)²⁴
- Obsessive-Compulsive Inventory Revised (OCI-R and OCI-CV)²⁵

1

Identification

Rationale

The mean age of onset for OCD is approximately 20 years of age, but symptoms can occur in children younger than age 10 years, with few new cases in the early 30s.⁵ Rates of treatment-seeking are estimated to be only about 14% to 56% in people with OCD, which suggests that OCD is underrecognized and undertreated. Many health care professionals may not be fully informed about how to identify, diagnose, and treat OCD. As well, people may not recognize their symptoms as OCD, or they may feel embarrassed about their obsessions and compulsions and so delay or avoid seeking help.^{15,16}

By itself, identification does not diagnose OCD, but it does help to provide preliminary documentation of symptoms and quantify severity in a time-limited setting, and indicates who may need further assessment (see quality statement 2).²⁹

Timely diagnostic clarity helps people access appropriate treatment sooner. People who have considerable symptoms or associated distress and impairment but who do not meet the criteria for diagnostic assessment should have their symptoms monitored by a health care professional.

It is important to consider the applicability of validated tools for assessment of specific populations; factors to consider include age and developmental stage, language, cultural relevance, and cognitive ability.

For children and adolescents, screening questions should include developmentally appropriate language²⁶ and be based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*.⁴ In addition to the young person's self-report, obtaining information from parents and other sources (e.g., teachers) can help describe the impact of OCD on family and on school functioning.²²

1

Identification

What This Quality Statement Means

For People With Suspected OCD

Your health care professional should ask you questions about your symptoms to find out whether you might have OCD. These questions aren't used on their own to diagnose OCD, but they are an important first step.

For Clinicians

Use recognized screening questions and validated severity-rating scales to identify people who might have OCD and would benefit from further comprehensive assessment and appropriate treatment.

For Health Services Planners

Ensure that systems, processes, and resources are in place in all health settings for clinicians to identify people and appropriately identify people who may have OCD.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with suspected OCD who are identified using recognized screening questions and validated severity-rating scales
- Number of days from when someone with suspected OCD initially presents to a health care professional to when they are identified using recognized screening questions and validated severity-rating scales

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

2

Comprehensive Assessment

People with suspected OCD, or who have had a positive screening result for OCD, receive a timely comprehensive assessment to determine whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

Sources: American Academy of Child and Adolescent Psychiatry, 2012²⁶ | American Psychiatric Association, 2007²⁷ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definitions

People who have had a positive screening result for OCD: People identified for further comprehensive assessment to determine if they have OCD. People are identified using recognized screening questions and a validated severity-rating scale (see quality statement 1).

Timely comprehensive assessment: The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee agreed that, ideally, comprehensive assessment should occur within 4 to 8 weeks of the first point of contact, and be based on the criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*.⁴ The assessment determines whether the person has OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment. Assessments are communicated in accessible language for the patient.

This time frame for assessment was developed by advisory committee consensus with the aim of being aspirational and practical. Communicating a diagnosis is a legal act that can be conducted by specific regulated professions. Other health care professionals can still conduct a comprehensive assessment using validated tools to help people with suspected OCD be triaged to the most appropriate care. Health care professionals should let people know their qualifications when they conduct the assessment.

2

Comprehensive Assessment

Severity of symptoms: Assessed using a validated severity-rating scale (based on the list provided in the Definitions section of quality statement 1).

Comorbid conditions: People with OCD may also have other physical or psychiatric conditions that affect their symptoms and response to treatment. It is important to assess for comorbid conditions and the risk of self-harm or suicide. Other conditions to assess for include depression, anxiety disorders, alcohol or substance use disorder, attention-deficit/hyperactivity disorder,³⁰ body dysmorphic disorder, or an eating disorder.²²

Associated functional impairment: May include a person's level of distress and impairment, any physical symptoms, or effects on their quality of life. The following are examples of validated tools to assess functional impairment: Illness Intrusiveness Rating Scale, the World Health Organization Disability Assessment Schedule (WHODAS), or the Work and Social Adjustment Scale (WSAS).

Rationale

Obsessive–compulsive disorder is characterized by obsessions (unwanted thoughts, images, or urges) and compulsions (repetitive behaviours or mental acts). It is generally underdiagnosed and undertreated, so identification and diagnosis based on a comprehensive assessment are key steps to helping people access appropriate treatment. Symptoms can be challenging to assess, because they can manifest internally, and rely on recognition and report on the part of the person with suspected OCD.²⁹

Based on the criteria from *DSM-5*,⁴ a diagnosis of OCD requires the presence of obsessions and/or compulsions. In *DSM-5*, OCD has been moved from “anxiety disorders” to a new diagnostic category called “obsessive–compulsive and related disorders.”⁵

For children and adolescents, developmentally appropriate language should be used and collateral information from parents and other sources (e.g., teachers) should be considered. Symptoms of OCD may change over time, be prominent in one setting and not in another, or be kept secret from others.²⁶ Refer to *DSM-5* for diagnostic criteria specific to children.⁵

2

Comprehensive Assessment

Treatment should not be delayed while awaiting a diagnosis. For example, psychoeducation, self-help, and other lower-intensity treatments may be offered right away.

What This Quality Statement Means

For People With Suspected OCD

You should be offered an assessment to determine whether you have OCD. Your health care professional should also talk with you about how bad and frequent your symptoms are, whether you have any other conditions, and whether your OCD is making it hard for you to manage your life at home, school, or work.

For Clinicians

Use the *DSM-5* diagnostic criteria and a validated severity-rating scale to accurately diagnose people with suspected OCD. A comprehensive assessment includes determining whether the person has OCD and the severity of symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

For Health Services Planners

Ensure that systems, processes, and resources are in place in all health settings for clinicians to conduct comprehensive assessments and accurately diagnose people with OCD.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who receive a comprehensive assessment
- Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who have a comprehensive assessment initiated within 8 weeks of the first point of contact
- Number of days from when someone with suspected OCD or someone who had a positive screening result for OCD has their first point of contact to when a comprehensive assessment is initiated

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

3

Support for Family

People with OCD are encouraged to involve their family during their assessment and treatment, considering individual needs and preferences. Family members are connected to available resources and supports and provided with psychoeducation that includes how to avoid accommodation behaviours.

Sources: American Psychiatric Association, 2007²⁷ | National Institute for Health and Care Excellence, 2005²²

Definitions

Family: The people closest to a person in terms of knowledge, care, and affection; they may include biological family, family through marriage, or family of choice and friends. The person with OCD defines their family and who will be involved in their care.

Accommodation behaviours: Also known as “family accommodation” or “symptom accommodation,” family and surrounding people change their behaviour in an effort to soothe the worries of the person with OCD. These behaviours may include providing frequent reassurance, modifying daily routines, facilitating avoidance of anxiety-provoking situations, or taking part in rituals or compulsions to reduce the person's obsessional distress. A reduction in accommodation behaviours is associated with improved health outcomes. Using a validated tool to assess the accommodation behaviours can be helpful.

Rationale

Obsessive–compulsive disorder often affects surrounding people and relationships, especially a person's family. Wherever appropriate and possible, health care professionals should promote a collaborative and reflective approach when working with people with OCD and their family.²² For adults, family involvement is based on the person's preferences, values, and needs, acknowledging that not everyone may want to involve their family in their care.

3

Support for Family

In the treatment and care of people with OCD, family members should be given comprehensive information (both verbal and written) about the disorder, its likely causes, its course, and its treatment.²² Psychoeducation is needed for families and caregivers, because a reduction in accommodation behaviours has been associated with improved OCD symptom severity and treatment outcomes.^{30,31}

For children and adolescents, it is especially important to consider the needs of family and caregivers and to develop a collaborative approach with family and caregivers.²² Actively engaging with families and caregivers in planning treatment and maintaining optimism contribute to establishing a strong therapeutic relationship with the young person and their family and caregivers.²²

What This Quality Statement Means

For People With OCD

Consider involving your family in your care (it can help, but the choice is up to you). If your family is involved, they should also be offered education, information, and support. This includes information about accommodation and reassurance.

For Clinicians

Ensure that families receive psychoeducation about OCD, including information about the detrimental impact of accommodation behaviours. Families should be included in care and treatment planning, according to the wishes of the person with OCD.

For Health Services Planners

Ensure that systems, processes, and resources are in place so that families can be involved in the care of people with OCD.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with OCD who choose to have their family involved in their care and whose family is connected to available resources and supports and provided with psychoeducation by a health care professional
- Percentage of children and adolescents with OCD whose family is connected to available resources and supports and provided with psychoeducation by a health care professional
- Percentage of people with OCD whose family is involved in their care and whose family reports feeling supported and informed about OCD
- Percentage of people with OCD whose family is involved in their assessment and treatment and whose family reports a reduction in accommodation behaviours

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

4

Stepped-Care Approach for OCD

People with OCD receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first, based on symptom severity, level of functional impairment, and individual needs and preferences.

Source: National Institute for Health and Care Excellence, 2005²²

Definition

Stepped-care approach: Involves choosing the least intensive, most effective treatment first. In this approach, care is guided by the level of symptom severity, the comprehensive assessment, the person's response to treatment (effectiveness and tolerability), and their needs and preferences.

The stepped-care approach does not necessarily involve a linear progression. Although every person suspected to have OCD should complete step 1 (identification and assessment), a person with OCD can move to a higher step without completing the previous step:

- Step 1, for all people with known or suspected OCD: identification and assessment, education about OCD and treatment options, and ongoing monitoring of symptoms
- Step 2, for people diagnosed with mild to moderate OCD that has not improved after education and ongoing monitoring of symptoms: self-help, psychoeducation, involvement of family, and low-intensity psychological treatment or pharmacological treatment with a selective serotonin reuptake inhibitor (SSRI)

4

Stepped-Care Approach for OCD

- Step 3, for people with moderate to severe OCD, an inadequate response to the interventions in step 2, or marked functional impairment: higher-intensity psychological treatment (CBT with exposure and response prevention) and/or pharmacological treatments, or combined treatments
- Step 4, for people with severe OCD, an inadequate response to interventions in steps 2 or 3, or marked functional impairment: more intensive treatment (psychological [CBT with exposure and response prevention] and/or pharmacological interventions); consider augmentation strategies; and interprofessional care. Consultation with or referral to a health care professional with specialized expertise in OCD
- Step 5, for people with severe OCD, an inadequate response to interventions in steps 2, 3, or 4, or very marked functional impairment: initiate consultation with or referral to intensive treatment services for OCD; consider inpatient care

Rationale

A stepped-care approach helps guide health care professionals and people with OCD in selecting the most appropriate treatment option when they are developing a treatment plan. Treatment is based on the results of a comprehensive assessment, the severity of the person's disorder, and consideration of the person's needs and preferences.

4

Stepped-Care Approach for OCD

What This Quality Statement Means

For People With OCD

Your treatment plan should be based on a stepped-care approach. Your health care professional should offer you the most appropriate treatment option first. If your symptoms don't improve, you should be offered the next most appropriate treatment option.

For Clinicians

Use a stepped-care approach, offering the least intensive, most effective treatment option first, to help guide the development of a treatment plan for people with OCD. Collaborate with people to determine the most effective interventions based on the severity of their disorder and their individual needs and preferences.

For Health Services Planners

For people with OCD, ensure that systems, processes, and resources are organized so that the least intensive, most effective interventions are available based on their needs.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD who have a treatment plan that follows a stepped-care approach
- Percentage of people with OCD who have followed a stepped-care approach to treatment and have shown improvement in symptoms

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

5

Self-Help

People with OCD are informed about and supported in accessing self-help resources, such as self-help books, Internet-based educational resources, and support groups, considering their individual needs and preferences and in alignment with a stepped-care approach.

Sources: American Psychiatric Association, 2007²⁷ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definitions

Self-help resources: Include written or electronic materials of a suitable reading level and language that are based on the principles of cognitive behavioural therapy. Self-help materials can:

- Be self-directed (unguided), such as reading books or using workbooks (known as bibliotherapy) or an Internet resource
- Involve a small amount of intervention (guided), with support from a trained health care professional

Self-help approaches are aimed at empowering the person to gather information about OCD and develop management strategies. Self-help approaches complement regular visits with a health care professional.

5

Self-Help

Support groups: Peer- or professional-led support groups offer educational, practical, or emotional support to help people with OCD and their family or friends. Support groups can be conducted in person, online, or by telephone. They may be peer-led or moderated by health care professionals.

Rationale

Most people know little about the nature, biology, course, and treatment of OCD; all people with OCD should be given information about OCD and access to educational materials.^{26,32} Through self-help strategies, people can learn about OCD and ways to cope effectively. Psychoeducation (education and information for those seeking mental health services) and access to self-help resources can remove some of the stigma related to OCD and assist people in making informed decisions about their treatment.²⁷

Peer support is also important. The empathetic relationship between people who have a lived experience in common can provide emotional and social support, encouragement, and mentorship. Peer support can foster hope, and it can help people develop a sense of self-efficacy and a stronger ability to cope.^{34,35}

Families can also benefit from psychoeducation and being involved in the self-help process. This is especially relevant for children and adolescents, where guided self-help may be considered in conjunction with support and information for families and caregivers.

5

Self-Help

What This Quality Statement Means

For People With OCD

You should be offered education and information about OCD. You should also be connected with self-help resources, including books, Internet resources, and support groups so that you can learn more about OCD and its treatment.

For Clinicians

Offer people with OCD education and information about OCD. Connect people with recommended self-help resources, including books, Internet resources, and support groups.

For Health Services Planners

Ensure that systems, processes, and resources are in place for people with OCD to have access to evidence-based self-help resources.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD for whom self-help was determined to be appropriate and who report feeling supported in accessing self-help resources based on their individual needs and preferences

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

6

Cognitive Behavioural Therapy for OCD

People with OCD have timely access to cognitive behavioural therapy with exposure and response prevention, considering their individual needs and preferences and in alignment with a stepped-care approach. Cognitive behavioural therapy with exposure and response prevention is delivered by a health care professional with expertise in OCD.

Sources: American Academy of Child and Adolescent Psychiatry, 2012²⁶ | American Psychiatric Association, 2007²⁷ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definition

Timely access to cognitive behavioural therapy: The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee agreed that, ideally, cognitive behavioural therapy (CBT) should begin within 4 to 6 weeks of comprehensive assessment.

Cognitive behavioural therapy with exposure and response prevention: Cognitive behavioural therapy is not a single approach; it is a process that addresses the factors that caused and maintain the person's OCD.⁵ In OCD, CBT includes behavioural techniques such as exposure and response prevention and cognitive techniques. With exposure and response prevention, people with OCD are taught, in a gradual and structured environment, to confront the situations and objects they fear (exposure) and to refrain from performing their compulsions (response prevention). Exposures may include live and imagined encounters. The goal is for the person with OCD to learn how to weaken the connection between their feared stimuli and their compulsive behaviour, in the end responding differently to their triggers.²⁷

Cognitive behavioural therapy may be delivered in different formats (i.e., in individual or group sessions, in person, via videoconference, or guided via the Internet). Sessions may vary in length

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Cognitive Behavioural Therapy for OCD

from less than an hour to 2 hours.²⁷ According to expert consensus, an adequate trial of CBT for OCD for most people consists of 13 to 20 weekly sessions.²⁷

Health care professionals with expertise in OCD have training in delivering CBT specific to OCD. For example, the Canadian Association of Cognitive and Behavioural Therapies offers formal national certification for cognitive behavioural therapists who meet training and supervision eligibility criteria in Canada. Training for OCD is offered by the International OCD Foundation.

Rationale

Psychological treatments play an important role in the management of OCD. When delivered by a trained health care professional, CBT with exposure and response prevention is an effective treatment for OCD. Psychological and pharmacological approaches are similarly effective for the short-term, and some evidence supports psychological approaches in the long-term, so it is important to discuss the potential benefits and risks of any treatment before starting.²⁷ Treatment responses to psychological interventions are not immediate; a prolonged course of treatment is usually needed to achieve an initial response.²⁷ Motivational interviewing may also help people with OCD overcome reluctance to engage in treatment.

For children and adolescents, psychological treatment should be based on validated psychological treatment protocols, take into account the developmental age of the person with OCD, and engage with family members.^{5,21}

What This Quality Statement Means

For People With OCD

You should be offered cognitive behavioural therapy with exposure and response prevention as a treatment for your OCD, considering your needs and preferences. You should be offered this therapy promptly, from someone who has expertise in treating OCD.

For Clinicians

Offer CBT with exposure and response prevention to people with OCD. They should receive CBT from a health care professional who has expertise in OCD within 4 to 6 weeks of their comprehensive assessment.

For Health Services Planners

Ensure that systems, processes, and resources are in place for people with OCD to have timely access to CBT with exposure and response prevention.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD for whom CBT with exposure and response prevention was determined to be appropriate and who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD
- Percentage of people with OCD who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD that begins within 6 weeks of the comprehensive assessment
- Local availability of CBT programs delivered by trained and certified health care professionals

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

OCD-Specific Pharmacological Treatment

People with moderate to severe OCD, or people who are not responding to psychological treatment, are offered a selective serotonin reuptake inhibitor (SSRI) at an OCD-specific dose and duration, considering their individual needs and preferences and in alignment with a stepped-care approach.

Sources: American Academy of Child and Adolescent Psychiatry, 2012²⁶ | American Psychiatric Association, 2007²⁷ | Anxiety Disorders Association of Canada, 2014⁵ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²² | World Federation of Societies of Biological Psychiatry, 2012³⁵

Definitions

Moderate to severe OCD: The classification of moderate to severe OCD is based on the results of a comprehensive assessment and a validated severity-rating scale (see quality statement 1).

OCD-specific dose and duration: Is typically higher than what is prescribed for other indications. Clinicians should refer to clinical practice guidelines for further guidance on OCD-specific medication dosage recommendations.⁵

An OCD-specific trial duration typically lasts 10 to 12 weeks, with monitoring for effectiveness and tolerability. People with initial treatment periods that last beyond 12 weeks may need reassessment for effectiveness (factoring in possible delay in onset of therapeutic response). For people who respond positively to a medication trial, treatment should continue for at least 12 months.

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OCD-Specific Pharmacological Treatment

Selective serotonin reuptake inhibitor: A medication commonly referred to as an “antidepressant” in the treatment of major depression, but also prescribed to treat other disorders, including OCD, anxiety disorders, chronic pain, and posttraumatic stress disorder. Examples of SSRIs include escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline. The dose of an SSRI to treat OCD is usually higher than for other diagnoses. It is also common for it to take longer to alleviate the symptoms of OCD than for other diagnoses.

For children, adolescents, and young adults, careful monitoring is required when an SSRI is prescribed, especially at the beginning of treatment,^{21,25} because of its association with increased risk of suicidal thinking and self-harm in a minority of people under age 30 years.²² It is also recommended that children and adolescents with OCD take medication in combination with CBT with exposure and response prevention.²²

Rationale

Treatment should be appropriate to the severity of the person's illness, their preferences, and their response. For people with mild or moderate OCD, psychological treatments should always be offered first. If psychological treatment is not a feasible option, pharmacological treatment should be offered. Health care professionals and people with OCD should have discussions about potential benefits and risks, side effects, and adverse effects before starting treatment.

When initial psychological treatment is unsatisfactory, health care professionals need to explore the factors in a person's life that may affect why a treatment is not working well (see quality statement 8), such as comorbid health conditions, adherence to treatment, the presence of psychosocial stressors, cultural considerations, or family dynamics.²⁷ For children and adolescents, additional factors may include the impact of learning disorders, psychosocial and environmental risk factors (e.g., family discord), or mental health problems among family members.²² Additional interventions may need to be considered to address these factors.

Although SSRIs are typically used to treat OCD, health care professionals should remain familiar with the evidence base for other medication classes (e.g., tricyclic antidepressants such as clomipramine) and adjunctive therapies for those who do not respond to SSRIs. Clinicians should

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OCD-Specific Pharmacological Treatment

refer to clinical practice guidelines for further guidance on pharmacological management of OCD.⁵

What This Quality Statement Means

For People With OCD

If you have moderate to severe OCD, or if your symptoms are not getting better with psychological treatment (cognitive behavioural therapy with exposure and response prevention), you should be offered a type of medication called a selective serotonin reuptake inhibitor (SSRI). You should take it at a dose and for a length of time that are specific for OCD.

For Clinicians

For people who have moderate to severe OCD or who are not responding to psychological treatment, offer an SSRI at an evidence-based, OCD-specific dosage and duration.

For Health Services Planners

Ensure that systems, processes, and resources are in place for people with OCD to receive evidence-based pharmacotherapy when psychological interventions are ineffective.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, who receive an SSRI at an OCD-specific dose and duration
- Percentage of people with OCD who are offered an SSRI and who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

8

Monitoring

People with OCD have their response to treatment (effectiveness and tolerability) monitored regularly over the course of treatment using validated tools in conjunction with an assessment of their clinical presentation.

Sources: British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definitions

Effectiveness and tolerability: Effectiveness is indicated by an improvement in symptoms. Tolerability is the acceptability of the treatment, including side effects.⁵ Goals for effectiveness and tolerability are individualized based on the person's needs and preferences.⁵ Regular monitoring is also an opportunity for health care professionals to assess other outcomes, such as effects on any long-term/comorbid conditions, quality of life, and impact on school or employment.³⁷ Other factors that should be monitored include side effects, adverse effects, adherence to treatment, and suicidal ideation.

Monitored regularly: Monitoring by the treating clinician involves the use of validated tools and clinical judgment in conjunction with an assessment of the person's clinical presentation. Monitoring response to treatment also includes assessing the person's level of engagement with the treatment choice (e.g., participation in therapy, adherence to medication).

- For psychotherapy: Monitoring occurs session by session, and the person's treatment response is recorded at each session
- For medication: Monitoring and documentation of treatment response usually occur weekly or bi-weekly when the medication is initiated and when the dosage is adjusted, and at least monthly until the person's condition is stabilized. People with OCD and their health care professional should expect to see some improvement by 6 to 8 weeks, with full response closer to 10 to 12 weeks

8

Monitoring

- Long-term follow-up: when a person of any age with OCD is in remission (few or no substantial symptoms), they should be monitored regularly for 12 months by a health care professional.²² Regular follow-up should occur as needed, at a frequency mutually agreed upon by the health care professional and the person with OCD

Rationale

Regular monitoring of a person's response to treatment ensures that effectiveness can be assessed and treatment can be adjusted if needed.³⁷ Monitoring treatment response is critical to optimizing care and should be part of every treatment plan.

For children, adolescents, and young adults, careful monitoring is important when prescribing an SSRI, because it is associated with an increased risk of suicidal thinking and self-harm in a minority of people under age 30.²²

8

Monitoring

What This Quality Statement Means

For People With OCD

After you start treatment for OCD, your health care professional should follow up with you to check how you are responding to the treatment. For psychotherapy, they should check in with you about how the treatment is working at every session. For medication, they should check how the treatment is working every week or two when the medication is started and if the dosage changes, and at least every month until your condition is stable.

For Clinicians

Monitor the effectiveness and tolerability of treatment for people with OCD. Regular monitoring should take place at each session for psychotherapy and at least monthly for pharmacotherapy until the person's condition is stabilized. When prescribing SSRIs, carefully monitor people under the age of 30 years for risk of suicidal thinking and self-harm.

For Health Services Planners

Ensure that systems, processes, and resources are in place so that people receiving treatment for OCD are regularly monitored for their response to treatment.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD who are receiving psychotherapy and who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician
- Percentage of people with OCD who are receiving pharmacotherapy and whose condition is not yet stabilized who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician
- Percentage of people with OCD who are in remission and who receive follow-up by a health care professional at least once within 12 months

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Support During Initial Treatment Response

People with OCD are informed about what to expect and supported during their initial treatment response. When initial treatment is not working, people with OCD are reassessed. They are offered other treatment options, considering their individual needs and preferences and in alignment with a stepped-care approach.

Sources: American Academy of Child and Adolescent Psychiatry, 2012²⁶ | American Psychiatric Association, 2007²⁷ | Anxiety Disorders Association of Canada, 2014⁵ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definition

Reassessed: When initial treatment is unsatisfactory, health care professionals should explore the possible impact of interference from comorbid health conditions, adherence to treatment, the presence of psychosocial stressors, the level of family accommodation behaviours, and the ability to tolerate an adequate trial of psychotherapy or the maximum recommended medication dosages.²⁷ For children and adolescents, additional factors may include the impact of learning disorders, psychosocial and environmental risk factors (e.g., family discord), or the presence of mental health problems among family members. Additional interventions may need to be considered to address these factors.

Rationale

Often, initial psychological or pharmacological treatments do not relieve all OCD symptoms. For instance, at least 40% of people do not respond to the first medication they try; it is necessary to inform people with OCD of this fact and normalize their expectations of initial treatments.^{5,27} In the case of medications, many people may feel no positive effects for the first few weeks but improve greatly over time. It is important that people with OCD participate in an adequate trial of psychotherapy or receive the complete OCD-specific medication dose and duration during their initial treatment to experience the full benefits of the treatment and determine its effectiveness and tolerability.

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Support During Initial Treatment Response

When initial treatments are unsatisfactory despite a full and OCD-specific trial, people with OCD should be reassessed before being offered other treatments. The goal of reassessment is to identify any other factors that may be influencing their treatment response and help determine the next appropriate treatment option.

What This Quality Statement Means

For People With OCD

Your health care professional will talk with you about how long it may take to see a treatment response. If your treatment is not working, your health care professional should ask you questions to reassess your OCD and your situation. You should then be offered another treatment option, considering your needs and preferences and in alignment with a stepped-care approach.

For Clinicians

Inform people with OCD about what to expect, and provide support. Ensure that people with OCD who are not responding to initial treatment receive a comprehensive reassessment. Based on the stepped-care approach, offer the next-step treatment, which may include increasing intensity, switching modalities, combining treatment, or consulting a health care professional with specialized expertise in OCD.

For Health Services Planners

Ensure that systems, processes, and resources are in place so that people with OCD who are not responding to initial treatment are reassessed and offered other treatment options based on a stepped-care approach.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD who are not responding to initial treatment and who are reassessed by a health care professional before being offered other treatment options
- Percentage of people with OCD who are not responding to initial treatment and are reassessed who have a treatment plan that follows a stepped-care approach
- Percentage of people with OCD who have followed a stepped-care approach to treatment who have shown improvement in symptoms

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Intensive Treatment

When psychological or pharmacological treatment is not working, or in cases of severe OCD, people are referred for intensive treatment, in alignment with a stepped-care approach.

Sources: American Psychiatric Association, 2007²⁷ | National Institute for Health and Care Excellence, 2005²²

Definition

Intensive treatment: Treatments specific to OCD that involve individualized care from an interprofessional team with additional specialized expertise in OCD. Intensive treatments may include more intensive CBT with exposure and response prevention, alternative psychotherapies, trialling another recommended pharmacotherapy, or adjunctive pharmacotherapy. There are somatic treatments with emerging research that may be considered in some circumstances; please refer to clinical practice guidelines for information about the evidence supporting them (e.g., repetitive transcranial magnetic stimulation, deep brain stimulation, capsulotomy, or cingulotomy).⁵ Intensive treatment for OCD may involve a residential program or inpatient services.

Rationale

People who have tried conventional psychological and pharmacological treatments without success and who continue to have disabling symptoms that interfere with their ability to function may require more intensive treatment. More intensive treatment involves specialized expertise for OCD-specific treatment. This type of care may require referral to specialty services and may involve a residential program or inpatient services. This aligns with the stepped-care approach, seeking the least intensive, most effective treatment first.

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Intensive Treatment

What This Quality Statement Means

For People With OCD

If your OCD is severe or psychological or pharmacological treatments are not working for you, your health care team should refer you for specialized intensive treatment.

For Clinicians

Ensure that people with severe OCD or people who are not responding to conventional psychological or pharmacological treatments are referred to receive specialized intensive treatment.

For Health Services Planners

Ensure that systems, processes, and resources are in place so that people with severe OCD or who are not responding to conventional treatment can access specialized intensive treatment.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with severe OCD, or those who are not responding to psychological or pharmacological treatment, who are referred for intensive treatment

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Relapse Prevention

People with OCD who are receiving treatment are provided with information and education about how to prevent relapse and manage symptoms if they re-emerge.

Sources: American Psychiatric Association, 2007²⁷ | British Association for Psychopharmacology, 2014²⁷ | National Institute for Health and Care Excellence, 2005²²

Definition

How to prevent relapse: Relapse is when symptoms worsen and return to the level that the person experienced before treatment. If a person has few or no substantial symptoms, they are described as being “in remission.”

To prevent going back to previous ways of thinking and behaving, people with OCD need to prepare strategies for managing symptoms if they return. Information and education about maintaining recovery and preventing relapse should include:

- Understanding the nature of OCD
- Knowing what happens when treatment ends
- Knowing how to address symptoms
- Planning for long-term follow-up
- Knowing how to access mental health services when needed

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Relapse Prevention

Rationale

Obsessive–compulsive disorder has a fluctuating or episodic course. Even with effective treatment, people with OCD face the possibility that symptoms will re-emerge (relapse). It is important to acknowledge that while hope and recovery are possible, some of the experiences of OCD can recur (such as intrusive, upsetting thoughts), and that it is important to anticipate how to deal with them.

Helping people with OCD manage their risk of relapse is an essential part of treatment. For example, for psychotherapy, the patient and health care team may want to include booster sessions (follow-up sessions after the main course of psychotherapy). For pharmacotherapy, they may emphasize the importance of a full medication trial to reduce the likelihood of relapse.

Supportive care and maintenance strategies to prevent relapse may include knowing one's own triggers and red flags, practising skills, lifestyle behaviours, self-care, and knowing how to get help from health care professionals when needed.³⁸ This preparation puts a focus on people's strengths, autonomy, and personal capability. It also empowers people to be involved in their care, affirming their autonomy and self-determination.

For children and adolescents, when considering withdrawal of medication, patients, families, and caregivers should be educated about relapse prevention and/or withdrawal symptoms.²² Psychological treatment should continue throughout the period of drug discontinuation to reduce the risk of relapse.²²

What This Quality Statement Means

For People With OCD

Your health care team should give you information and education about how to prevent and manage relapse. They should talk with you about:

- The nature of OCD
- What to expect when you're in recovery and no longer in treatment
- When to be concerned and what to do
- When to follow up with your health care team
- What strategies to use to manage your symptoms
- How to access mental health services if you need more support

For Clinicians

Offer people with OCD information and education about how to prevent a relapse and how to manage symptoms when they return. These discussions should include the nature of OCD, what to expect when treatment ends, the appropriate interval for follow-up with the health care team, strategies to use to manage symptoms, and how they can access mental health services if they need more support.

For Health Services Planners

Ensure that systems, processes, and resources are in place so that people with OCD can receive information and education about relapse prevention, learn how to manage symptoms if they re-emerge, and access timely mental health services when they need it.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD who are receiving treatment and who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge
- Percentage of people whose OCD symptoms have been in remission and who relapse within 1 year

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Transitions in Care

People with OCD are given appropriate care throughout their lifespan and experience seamless transitions between services and health care professionals, including between care settings and from child and adolescent services to adult services.

Sources: American Psychiatric Association, 2007²⁷ | National Institute for Health and Care Excellence, 2005²²

Definition

Seamless transition: Consists of a set of actions designed to ensure the safe and effective coordination and continuity of care when people experience a change in health status, health care professional, service, or location (within, between, or across settings). For example, transitions in care can take place when a person moves from hospital to home or from primary care to community care (setting), but also when moving from child and adolescent care to adult care (service). For more information on transitions, please see the *Transitions Between Hospital and Home* quality standard.

Rationale

Obsessive-compulsive disorder has effects throughout a person's life, so appropriate care should be provided across the person's lifespan, including coordinated care between services aimed at specific ages (i.e., child/adolescent to adult, pregnancy/postpartum/perinatal, and older adults).²² Obsessive-compulsive disorder can be a chronic condition, and it often affects some of the most intimate aspects of a person's life. Health care professionals should ensure continuity of care and minimize the need for multiple assessments by different health care professionals.²²

Seamless transitions require a coordinated approach among knowledgeable and skilled health care professionals who are familiar with the person's clinical status, goals of care, plan of treatment,

care plan, and health-information needs. Timely and effective communication is essential to prevent problems that may occur if services and supports are not well integrated. Seamless transitions include appropriate monitoring and follow-up, and they contribute to quality care and prevention of relapse. It is important to coordinate the person's care with health care professionals who are treating co-occurring medical conditions, and other clinicians and social agencies such as schools and vocational rehabilitation programs.²⁷

What This Quality Statement Means

For People With OCD

When you change health care professional or type of service (for example, if you return home from being in hospital), your care team should work with you to ensure a smooth transition. The care you receive should be appropriate to your age. This includes making sure that you and any new team members have the right information, and that you receive the services you need.

For Clinicians

Ensure that people moving between health care professionals and services experience coordinated and seamless transitions. This includes providing age-appropriate care across the lifespan and facilitating communication between settings and other related processes.

For Health Services Planners

Ensure that systems, processes, and resources are in place to facilitate communication and information-sharing between health care professionals and services for safe and effective transitions.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of people with OCD who transition between services or health care professionals and who experience a seamless transition
- Percentage of people with OCD who transition from child and adolescent services to adult services and who experience a seamless transition

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Emerging Practice Statement: Mindfulness-Based Therapy

What is an Emerging Practice Statement?

An emerging practice statement describes an area for quality improvement that has been prioritized by the advisory committee but for which there is insufficient or inconsistent evidence in the guidelines used in the development of the quality statements. An emerging practice statement acknowledges that there is a need for evidence-based guidance to be developed in an area, but the evidence base in this area is still emerging.

Rationale

We cannot provide guidance at this time on the use of mindfulness-based therapy for the treatment of OCD because there is a lack of recommendations about this therapy in the clinical practice guidelines we used to develop the OCD quality statements (because it is an emerging area of research). While there is a limited body of literature showing that mindfulness-based interventions have potential as a complementary or augmentation treatment for OCD, further evidence supporting its effectiveness to treat OCD is needed before a quality statement can be made.

Appendices

Appendix 1. Recommendations for Adoption: How the Health Care System Can Support Implementation

While clinicians and organizations work hard to implement this quality standard, we recommend actions be taken within the system to support those on the front lines to deliver high-quality care.

The following system-level barriers that affect implementation of this quality standard have been identified:

- There is room for improvement related to capacity and expertise among health care providers to assess, treat, and/or manage OCD; people with OCD can experience misdiagnosis and/or fail to receive the treatment they need
- There is a lack of clarity among providers about which standardized identification or assessment tools to use and how
- Identification and assessment are not always being carried out in a culturally appropriate way; this may be due to a lack of identification/assessment tools for specific populations (e.g., newcomer, Indigenous, and Francophone populations)
- People with OCD are not being triaged or treated using the stepped-care approach because of inconsistent provider knowledge and skills related to this approach and varying access to services (including CBT and specialized expertise in OCD) across the province
- There is inconsistency in the qualifications of providers of cognitive behavioural therapy (CBT) and in their knowledge and skills related to providing CBT for OCD
- Patients re-entering the system after relapse face barriers to receiving additional care; they often have to repeat the referral process and wait for services they had been discharged from (poor continuity of care)
- There are very limited options for intensive treatment for people with OCD in Ontario
- The availability of OCD support groups for people with OCD and their families/caregivers in Ontario is variable and limited
- Financial barriers, such as the lack of extended health insurance coverage for programs and services, make it challenging for people with OCD to properly manage their condition

- People who do not have access to private insurance can experience difficulties affording prescription medications and/or treatment, such as CBT

These barriers emerged following our review of the available evidence; a scan of existing programs; extensive consultation with the Anxiety Disorders and Obsessive–Compulsive Disorder Quality Standards Advisory Committee, stakeholders, and organizations; and from input received when a draft of this quality standard was posted for public feedback.

Specific adoption strategies should not reinforce current states of inequity and inequality faced by specific populations, such as language barriers, lack of access, and unique care needs, but should contribute to improvement or highlight areas of opportunity.

The Ontario Structured Psychotherapy Program

The Ontario Structured Psychotherapy Program was funded in 2017/18 as part of a 3-year pilot project to test the provision of evidence-based forms of CBT for anxiety and depression. The program is being initially rolled out with intake through four hospitals: the Centre for Addiction and Mental Health, the Royal Ottawa Healthcare Group, Ontario Shores Centre for Mental Health Sciences, and Waypoint Centre for Mental Health Care. Through these four “hubs,” group and individual psychotherapy is being delivered in multiple satellite sites, including primary care teams, community mental health and addictions agencies, social service agencies, and postsecondary campuses. To support high-quality service delivery, the program developed a consistent approach to training and supervision. Based on early positive results, consideration for further program expansion will be made.

Recommendations for Adoption

The following are recommendations to bridge system-level gaps and address some of the barriers highlighted above.

Action may be required by Ontario Health, the Ministry of Health, or other health system partners to facilitate the adoption of this quality standard in everyday practice.

Recommendation 1

Consider further expansion of the Ontario Structured Psychotherapy Program to increase access for people of all ages across Ontario. The program aims to enable seamless entry and transition into mental health and addictions services, including services for OCD. Expansion should be informed by the experiences and lessons of the four hospitals participating in the initial rollout.

Actor: Ministry of Health and Ontario Health

Time frame for implementation: immediate (initiate within 1–2 years)

Recommendation II

To facilitate culturally appropriate identification and assessment, ensure the availability of validated tools that have been translated and/or adapted for use with all population groups.

Actor: Ministry of Health and Ontario Health

Time frame for implementation: immediate (initiate within 1–2 years)

Recommendation III

Conduct a scan of existing OCD support groups for patients and families in Ontario. Ensure that the scan is made publicly available to inform service planning and delivery that is appropriate to need.

Actors: Addictions and Mental Health Ontario and the Canadian Mental Health Association, Ontario

Support: Ontario Health Teams

Time frame for implementation: medium term (initiate within 2–4 years)

Recommendation IV

Conduct a needs assessment and capacity planning to understand the demand for and availability of intensive treatment services for people with OCD for whom psychological or pharmacological treatment is not working (or in cases of severe OCD). Ensure that resource availability is commensurate with need and improve awareness of intensive treatment options for people with OCD.

Actor: Ministry of Health

Time frame for implementation: medium term (initiate within 2–4 years)

Recommendation V

Develop a standardized process for data collection and reporting for the mental health and addictions sector that is consistent with recommendations⁵ made in other mental health and addictions quality standards. Ensure that this strategy includes new ways of leveraging existing data and information collected to support care.

Actor: Ministry of Health and Ontario Health

Time frame for implementation: medium term (initiate within 2–4 years)

⁵ These recommendations include implementing a common provincial performance scorecard for services across the lifespan, using a unique client identifier, and expanding the collection of sociodemographic information, including metrics related to this quality standard.

Appendix 2. Measurement to Support Improvement

The Anxiety Disorders and Obsessive-Compulsive Disorder Quality Standards Advisory Committee identified some overarching goals for this quality standard. These goals were mapped to indicators that can be used to monitor the progress being made to improve care for people with OCD. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Collecting and using data associated with this quality standard is optional. However, data will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts.

We realize this standard includes a lengthy list of indicators. We've given you this list so you don't have to create your own quality improvement indicators. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

To assess equitable delivery of care, you can stratify locally measured indicators by patient socioeconomic and demographic characteristics, such as age, education, gender, income, language, and sex.

Our [measurement guide](#) provides more information and concrete steps on how to incorporate measurement into your planning and quality improvement work.

How to Measure Overall Success

Indicators That Can Be Measured Using Provincial Data

Percentage of people with an unscheduled emergency department (ED) visit for OCD for whom the ED was the first point of contact for mental health and addictions care

- Denominator: total number of people with an unscheduled ED visit for OCD
- Numerator: number of people in the denominator who did not have a health care visit for mental health and addictions care in the previous 2 years

- Data sources: National Ambulatory Care Reporting System (NACRS), Discharge Abstract Database (DAD), Ontario Health Insurance Plan (OHIP) Claims Database, Ontario Mental Health Reporting System (OMHRS)

Percentage of repeat unscheduled ED visits related to mental health and addictions within 30 days following an unscheduled ED visit for OCD

- Denominator: total number of unscheduled ED visits for OCD
- Numerator: number of ED visits in the denominator followed within 30 days after leaving the hospital by a repeat unscheduled ED visit related to mental health and addictions
- Data source: NACRS

Percentage of inpatient readmissions related to mental health and addictions within 30 days of discharge following a hospital admission for OCD

- Denominator: total number of hospital admissions for OCD
- Numerator: number of hospital admissions in the denominator followed within 30 days of discharge by an inpatient readmission related to mental health and addictions
- Data sources: DAD, OMHRS

Indicators That Can Be Measured Using Only Local Data

Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who receive a comprehensive assessment that determines whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment

- Denominator: total number of people with suspected OCD, or who have had a positive screening result for OCD
- Numerator: number of people in the denominator who receive a comprehensive assessment that determines whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment

- Data source: local data collection
- Note: Please see quality statement 2 for more details

Percentage of people with OCD for whom cognitive behavioural therapy (CBT) with exposure and response prevention was determined to be appropriate and who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD

- Denominator: total number of people with OCD for whom CBT with exposure and response prevention was determined to be appropriate
- Numerator: number of people in the denominator who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD
- Data source: local data collection
- Note: Appropriateness of CBT with exposure and response prevention is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach. Please see quality statement 6 for more details on CBT for OCD

Percentage of people with OCD who report an improvement in their quality of life

- Denominator: total number of people with OCD
- Numerator: number of people in the denominator who report an improvement in their quality of life
- Data source: local data collection

Percentage of people with OCD who “strongly agree” with the following question: “The services I have received have helped me deal more effectively with my life’s challenges.”

- Denominator: total number of people with OCD who answer the following question, “The services I have received have helped me deal more effectively with my life’s challenges.”
- Numerator: number of people in the denominator who “strongly agree”

- Data source: local data collection
- Notes:
 - This question is from the Ontario Perception of Care Tool (OPOC) for Mental Health and Addictions (question 30) developed at the Centre for Addiction and Mental Health (CAMH). This question closely aligns with the overall quality standard and can be useful in determining patient experience. This question is part of a larger survey made available through CAMH that can be accessed upon completion of a Memorandum of Understanding and License Agreement with CAMH. Please see the [OPOC Community of Practice](#) for more information.
 - This indicator is also an area of focus for the Excellence through Quality Improvement Project (EQIP). To find out more, visit [CMHA](#) or [AMHO](#)

Percentage of people with OCD who complete CBT with exposure and response prevention and have reliable recovery

- Denominator: total number of people with OCD who complete CBT with exposure and response prevention
- Numerator: number of people in the denominator who have reliable recovery
- Data source: local data collection
- Notes:
 - Reliable recovery occurs when a client's score on a validated severity-rating scale for OCD³⁹:
 - Is above a clinical cut-off before treatment is initiated and is below the clinical cut-off after treatment is completed (reduction in symptoms); and
 - Changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion
 - Please see quality statement 1 for more information about the scales, and the measurement guide for more information on how to calculate reliable recovery

Percentage of people with OCD who complete CBT with exposure and response prevention and have reliable improvement

- Denominator: total number of people with OCD who complete CBT with exposure and response prevention

- Numerator: number of people in the denominator who have reliable improvement
- Data source: local data collection
- Notes:
 - Reliable improvement occurs when a client's score on a validated severity-rating scale for OCD changes (improves) by a set number of points (that is statistically significant) between treatment initiation and treatment completion³⁹
 - Please see quality statement 1 for more information about the scales, and the measurement guide for more information on how to calculate reliable improvement

Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, and who receive a selective serotonin reuptake inhibitor (SSRI) at an OCD-specific dose and duration

- Denominator: total number of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate
- Numerator: number of people in the denominator who receive an SSRI at an OCD-specific dose and duration
- Data source: local data collection
- Note: Appropriateness of pharmacological treatment is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach

How to Measure Improvement for Specific Statements

Quality Statement 1: Identification and Appropriate Screening

Percentage of people with suspected OCD who are identified using recognized screening questions and validated severity-rating scales

- Denominator: total number of people with suspected OCD

- Numerator: number of people in the denominator who are identified using recognized screening questions and validated severity-rating scales
- Data source: local data collection

Number of days from when someone with suspected OCD initially presents to a health care professional to when they are identified using recognized screening questions and validated severity-rating scales

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when someone with suspected OCD initially presents to a health care professional to when they are identified using recognized screening questions and validated severity-rating scales
- Data source: local data collection

Quality Statement 2: Comprehensive Assessment

Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who receive a comprehensive assessment

- Denominator: total number of people with suspected OCD or who have had a positive screening result for OCD
- Numerator: number of people in the denominator who receive a comprehensive assessment
- Data source: local data collection
- Note: Please see quality statement 1 for the definition of people with suspected OCD. This indicator is also included in the section "How to Measure Success"

Percentage of people with suspected OCD, or who have had a positive screening result for OCD, who have a comprehensive assessment initiated within 8 weeks of the first point of contact

- Denominator: total number of people with suspected OCD, or who have had a positive screening result for OCD, who have a comprehensive assessment initiated
- Numerator: number of people in the denominator who have this comprehensive assessment initiated within 8 weeks of the first point of contact
- Data source: local data collection

- Note: Please see quality statement 1 for the definition of people with suspected OCD

Number of days from when someone with suspected OCD or someone who had a positive screening result for OCD has their first point of contact to when a comprehensive assessment is initiated

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when someone with suspected OCD or someone who had a positive screening result for OCD has their first point of contact to when a comprehensive assessment is initiated
- Data source: local data collection

Quality Statement 3: Support for Family

Percentage of adults with OCD who choose to have their family involved in their care and whose family is connected to available resources and supports and provided with psychoeducation by a health care professional

- Denominator: total number of adults with OCD who choose to have their family involved in their care
- Numerator: number of people in the denominator whose family is connected to available resources and supports and provided with psychoeducation (including how to avoid accommodation behaviours) by a health care professional
- Data source: local data collection

Percentage of children and adolescents with OCD whose family is connected to available resources and supports and provided with psychoeducation by a health care professional

- Denominator: total number of children and adolescents with OCD
- Numerator: number of people in the denominator whose family is connected to available resources and supports, and provided with psychoeducation (including how to avoid accommodation behaviours) by a health care professional
- Data source: local data collection

Percentage of people with OCD whose family is involved in their care and whose family reports feeling supported and informed about OCD

- Denominator: total number of people with OCD whose family is involved in their care
- Numerator: number of people in the denominator whose family reports feeling supported and informed about OCD
- Data source: local data collection

Percentage of people with OCD whose family is involved in their assessment and treatment and whose family reports a reduction in accommodation behaviours

- Denominator: total number of people with OCD whose family is involved in their assessment and treatment
- Numerator: number of people in the denominator whose family reports a reduction in accommodation behaviours
- Data source: local data collection
- Note: consider using a validated tool to assess the accommodation behaviours

Quality Statement 4: Stepped-Care Approach for OCD

Percentage of people with OCD who have a treatment plan that follows a stepped-care approach

- Denominator: total number of people with OCD who have a treatment plan
- Numerator: number of people in the denominator whose treatment plan follows a stepped-care approach
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Percentage of people with OCD who have followed a stepped-care approach to treatment and have shown improvement in symptoms

- Denominator: total number of people with OCD who have followed a stepped-care approach to treatment
- Numerator: number of people in the denominator who have shown improvement in symptoms
- Data source: local data collection
- Notes:
 - A validated severity-rating scale can be used to evaluate improvement in symptoms. Please see quality statement 1 for validated severity-rating scales
 - This indicator is also included in quality statement 9

Quality Statement 5: Self-Help

Percentage of people with OCD for whom self-help was determined to be appropriate and who report feeling supported in accessing self-help resources based on their individual needs and preferences

- Denominator: total number of people with OCD for whom self-help was determined to be appropriate
- Numerator: number of people in the denominator who report feeling supported in accessing self-help resources based on their individual needs and preferences
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection (e.g., through a patient survey)
- Note: Appropriateness of self-help is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach

Quality Statement 6: Cognitive Behavioural Therapy for OCD

Percentage of people with OCD for whom CBT with exposure and response prevention was determined to be appropriate and who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD

- Denominator: total number of people with OCD for whom CBT with exposure and response prevention was determined to be appropriate
- Numerator: number of people in the denominator who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD
- Data source: local data collection
- Note: Appropriateness of CBT with exposure and response prevention is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach. This indicator is also included in the section "How to Measure Success"

Percentage of people with OCD who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD that begins within 6 weeks of the comprehensive assessment

- Denominator: total number of people with OCD who receive CBT with exposure and response prevention delivered by a health care professional with expertise in OCD
- Numerator: number of people in the denominator whose CBT with exposure and response prevention begins within 6 weeks of the comprehensive assessment
- Data source: local data collection

Local availability of CBT programs delivered by trained and certified health care professionals

- Data source: local data collection

Quality Statement 7: OCD-Specific Pharmacological Treatment

Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate, who receive an SSRI at an OCD-specific dose and duration

- Denominator: total number of people with moderate to severe OCD, or people who are not responding to psychological treatment for whom pharmacological treatment was determined to be appropriate
- Numerator: number of people in the denominator who receive an SSRI at an OCD-specific dose and duration
- Data source: local data collection
- Notes:
 - Appropriateness of pharmacological treatment is based on a stepped-care approach. Please see quality statement 4 for more information about the stepped-care approach. This indicator is also included in the section "How to Measure Success"
 - See clinical practice guidelines for further guidance on OCD-specific dosage recommendations

Percentage of people with OCD who are offered an SSRI and who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects

- Denominator: total number of people with OCD who are offered an SSRI
- Numerator: number of people in the denominator who feel involved in discussions about their medication(s), including potential benefits and risks, side effects, and adverse effects
- Data source: local data collection

Quality Statement 8: Monitoring

Percentage of people with OCD who are receiving psychotherapy and who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician

- Denominator: total number of people with OCD who are receiving psychotherapy
- Numerator: number of people in the denominator who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation at each treatment session by the treating clinician
- Data source: local data collection
- Note: Please see quality statement 1 for validated severity-rating scales

Percentage of people with OCD who are receiving pharmacotherapy and whose condition is not yet stabilized who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician

- Denominator: total number of people with OCD who are receiving pharmacotherapy and whose condition is not yet stabilized
- Numerator: number of people in the denominator who have their response to treatment (effectiveness and tolerability) monitored using validated tools in conjunction with an assessment of their clinical presentation on a monthly basis by the treating clinician
- Data source: local data collection
- Note: Please see quality statement 1 for validated severity-rating scales

Percentage of people with OCD who are in remission and who receive follow-up by a health care professional at least once within 12 months

- Denominator: total number of people with OCD who are in remission (few or no substantial symptoms)
- Numerator: number of people in the denominator who receive follow-up by a health care professional at least once within 12 months
- Data source: local data collection

Quality Statement 9: Support for Initial Treatment Response

Percentage of people with OCD who are not responding to initial treatment and who are reassessed by a health care professional before being offered other treatment options

- Denominator: total number of people with OCD who are not responding to initial treatment
- Numerator: number of people in the denominator who are reassessed by a health care professional before being offered other treatment options
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Percentage of people with OCD who are not responding to initial treatment and are reassessed who have a treatment plan that follows a stepped-care approach

- Denominator: total number of people with OCD who are not responding to initial treatment and are reassessed
- Numerator: number of people in the denominator who have a treatment plan that follows a stepped-care approach
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Percentage of people with OCD who have followed a stepped-care approach to treatment who have shown improvement in symptoms

- Denominator: total number of people with OCD who have followed a stepped-care approach to treatment
- Numerator: number of people in the denominator who have shown improvement in symptoms
- Data source: local data collection
- Notes:
 - A validated severity-rating scale can be used to evaluate improvement in symptoms. Please see quality statement 1 for validated severity-rating scales
 - This indicator is also included in quality statement 4

Quality Statement 10: Intensive Treatment

Percentage of people with severe OCD, or those who are not responding to psychological or pharmacological treatment, who are referred for intensive treatment

- Denominator: total number of people with severe OCD or those who are not responding to psychological or pharmacological treatment
- Numerator: number of people in the denominator who are referred for intensive treatment
- Data source: local data collection

Quality Statement 11: Relapse Prevention

Percentage of people with OCD who are receiving treatment and who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge

- Denominator: total number of people with OCD who are receiving treatment
- Numerator: number of people in the denominator who feel confident in how to prevent relapse and how to manage symptoms if they re-emerge
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Percentage of people whose OCD symptoms have been in remission and who relapse within 1 year

- Denominator: total number of people whose OCD symptoms have been in remission (few or no substantial symptoms following treatment)
- Numerator: number of people in the denominator who relapse within 1 year
- Data source: local data collection

Quality Statement 12: Transitions in Care

Percentage of people with OCD who transition between services or health care professionals and who experience a seamless transition

- Denominator: total number of people with OCD who transition between services or health care professionals
- Numerator: number of people in the denominator who experience a seamless transition
- Potential stratification: by type of transition
- Data source: local data collection

Percentage of people with OCD who transition from child and adolescent services to adult services and who experience a seamless transition

- Denominator: total number of people with OCD who transition from child and adolescent services to adult services
- Numerator: number of people in the denominator who experience a seamless transition
- Data source: local data collection

Appendix 3. Glossary

Caregiver: An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with OCD. Other terms commonly used to describe this role include "care partner," "informal caregiver," "family caregiver," "carer," and "primary caregiver."

Culturally appropriate: An approach that incorporates cultural or faith traditions, values, and beliefs; uses the person's preferred language; adapts culture-specific advice; and incorporates the person's wishes to involve family and/or community members.⁴⁰

Family: The people closest to a person in terms of knowledge, care, and affection; may include biological family, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.

Health care professionals: Regulated professionals, such as social workers, psychotherapists, nurses, nurse practitioners, physicians, psychologists, occupational therapists, and pharmacists.

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