

Quality Standards

Obsessive–Compulsive Disorder

Care in All Settings

February 2019

**Health Quality
Ontario**

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Summary

This 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). This quality standard 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).

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, patients, residents, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help patients, residents, 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

The statements in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

Quality standards also include an inventory of indicator definitions to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps in care and areas for improvement. These indicator definitions can be used to assess processes, structures, and outcomes. It is not mandatory to use or collect data when using a quality standard to improve care. The indicator definitions are provided to support quality improvement efforts; clinicians and organizations may choose indicators to measure based on local priorities and local data availability.

In addition, tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact qualitystandards@hqontario.ca.

About This Quality Standard

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).

This quality standard uses the categorization for OCD from the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*).¹ The 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 does not address trauma- and stressor-related disorders.

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

Terminology Used in This Quality Standard

In this quality standard, the term “family” refers to the people closest to a person in terms of knowledge, care, and affection, and 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.

The term “caregiver” refers to 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.”

In this quality standard, the term “health care professionals” refers to regulated professionals, such as nurses, nurse practitioners, pharmacists, physicians, physiotherapists, psychologists, occupational therapists, and social workers.

Why This Quality Standard Is Needed

Obsessive–compulsive disorder is characterized by the presence of obsessions (recurrent, persistent, intrusive thoughts) and/or compulsions (compulsive, repetitive behaviours). In Canada, it has an estimated lifetime prevalence in adults of 2.0%, or 1 in 40 people.² Among children, OCD is more common in boys, but among adults, men and women are equally affected.³

The disabling symptoms of OCD contribute to a poorer quality of life, not only for people with OCD, but also for their families.^{2,4} The debilitating symptoms and considerable functional impairment associated with OCD lead to a higher risk of suicidal ideation and suicide attempts.⁵ About one-quarter of people with OCD have attempted suicide.^{2,6}

Rates of hospitalizations and emergency department (ED) visits attributable to OCD vary across Ontario (Discharge Abstract Database and Ontario Mental Health Reporting System; Institute for Clinical Evaluative Sciences, 2016). In 2016, there was a 4.8-fold difference between the

regions with the highest and lowest rates of long-stay hospitalization (58 per 100,000 population in the North East Local Health Integration Network [LHIN] compared with 12 per 100,000 population in the Toronto Central and Champlain LHINs) and a 3.7-fold difference between the highest and lowest rates of ED visits (292 per 100,000 population in the North East LHIN compared with 78 per 100,000 population in the Mississauga-Halton and Champlain LHINs).

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 reporting a diagnosis of OCD or an anxiety disorder (Canadian Community Health Survey, Mental Health, 2012). As well, 7.5% of people in rural areas reported a diagnosis of OCD or an anxiety disorder, compared to 4.8% of people in urban areas (Canadian Community Health Survey, Mental Health, 2012). Access to health care services are also a factor: rates of unscheduled ED visits for OCD, in which the ED was the person's first point of contact for mental health and addictions care, were higher in rural areas than in urban areas (Discharge Abstract Database, National Ambulatory Care Reporting System, Ontario Mental Health Reporting System, Ontario Health Insurance Plan; Institute for Clinical Evaluative Sciences, 2016).

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.^{7,8} Further, people with OCD are often embarrassed about their obsessions and compulsions and do not seek professional help.^{9,10} These are all factors that contribute to delays in diagnosis and treatment. There is about a 10-year gap between symptom onset and seeking help, plus another 7 years before correct diagnosis and/or treatment.¹¹ There are many opportunities to improve OCD care in Ontario so that people have timely access to appropriate, evidence-based treatment.

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect, equity, person-centred care, and recovery as described in the Mental Health Strategy for Canada.¹²

People with OCD should receive services that are respectful of their rights and dignity and that promote informed decision-making and self-management. Each person is unique and has the right to determine their path toward mental health and well-being.

People with OCD should be provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, disability, and background (including self-identified cultural, linguistic, ethnic, and religious backgrounds). Equitable access to the health system also includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and needs to be considered throughout a person's health care journey. For example, services should be actively offered in French and other languages.

Person-centred care aims to promote the health and well-being of the whole person. It includes developing an individualized care plan that considers the individual's needs, preferences, attitudes, and experiences, and the outcomes of previous treatments. Person-centred care also includes families and caregivers, when appropriate, especially for children and adolescents.

The principle of a recovery-oriented practice focuses on supporting people in leading full and meaningful lives.¹³ People with OCD have a right to services provided in an environment that

promotes hope, empowerment, autonomy, and optimism, and that are embedded in the values and practices associated with recovery-oriented care. The concept of recovery refers to “living a satisfying, hopeful, and contributing life, even when there are ongoing limitations caused by mental health problems and illnesses.”^{12,13} 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.”¹² Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments.¹³

Health care professionals should be aware of the historical context of the lives of Indigenous peoples throughout Canada and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guidelines developed by non-Indigenous groups, which may not include culturally relevant care or acknowledge traditional Indigenous beliefs and practices. It is important that care be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis peoples in Ontario.

The First Nations Mental Wellness Continuum Framework, developed in partnership with First Nations peoples, presents a shared vision for the future of First Nations mental wellness programs and services. The framework’s overarching goal is to improve mental wellness outcomes for First Nations.¹⁴ “Mental wellness” is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as people find purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.¹⁴ These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The framework provides an approach that “respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing.”¹⁴

A high-quality health system is one that provides good access, experience, and outcomes for everyone in Ontario, no matter where they live, what they have, or who they are.

How Success Can Be Measured

The Anxiety Disorders and Obsessive–Compulsive Disorder Quality Standard Advisory Committee identified a small number of overarching goals for this quality standard. These have been mapped to indicators that providers may want to monitor to assess quality of care provincially and locally.

How Success Can Be Measured Provincially

In this section, we list indicators that can be used to monitor the overall success of the standard provincially, given currently available data. If additional data sources are developed, other indicators should be added.

- 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 people with a repeat unscheduled ED visit related to mental health and addictions within 30 days following an unscheduled ED visit for OCD
- Percentage of people with an inpatient readmission related to mental health and addictions within 30 days of discharge following an incident 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.

In addition to the overall measures of success, each quality statement within the standard is accompanied by one or more indicators. These indicators are intended to guide the measurement of quality improvement efforts related to the implementation of the statement.

How Success Can Be Measured Locally

Providers may want to monitor their own quality improvement efforts and assess the quality of care they provide to people with OCD. It may be possible to do this using their own clinical records, or they might need to collect additional data. We recommend the following indicators to measure the quality of care patients are receiving; these indicators cannot be measured provincially using currently available data sources:

- Percentage of people with suspected OCD, or who have screened positive 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 who receive cognitive behavioural therapy (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 treatment with CBT with exposure and response prevention and move to recovery (as measured by an OCD screening tool before treatment is initiated and after treatment is completed). (Note: please refer to Quality Statement 1 for more information about the screening tools)
- Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment, who receive a selective serotonin reuptake inhibitor (SSRI) at an OCD-specific dose and duration

To assess the equitable delivery of care, the statement-specific indicators and the overall indicators can be stratified by patient socioeconomic and demographic characteristics, such as income, education, language, age, sex, and gender.

*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: <https://www.eenetconnect.ca/g/provincial-opoc-cop/>

Quality Statements in Brief

Quality Statement 1: Identification and Screening

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

Quality Statement 2: Comprehensive Assessment

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

Quality Statement 3: 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.

Quality Statement 4: Support for Family and Caregivers

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

Quality Statement 5: 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. Cognitive behavioural therapy with exposure and response prevention is delivered by a health care professional with expertise in OCD.

Quality Statement 6: 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.

Quality Statement 7: 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 the person's clinical presentation.

Quality Statement 8: Support for Initial Treatment Response

When initial psychological or pharmacological 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 9: 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 10: Relapse Prevention

People with OCD who are receiving treatment are provided with information and education about relapse prevention.

Draft—do not cite. Report is a work in progress and could change following public consultation.

Quality Statement 11: Transitions in Care

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

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Quality Statement 1: Identification and Screening

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

Background

Obsessive–compulsive disorder has an estimated lifetime prevalence of 2.0% in adults.² 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.² 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.^{9,10}

Identification of possible OCD should occur as early as possible (early after the appearance of symptoms, and early in life). By themselves, identification and screening are not used to diagnose OCD, but they do help to provide preliminary documentation of symptoms and quantify severity in a time-limited setting (see Quality Statement 2).¹⁵ Timely diagnostic clarity also 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 also important to consider the language, cultural relevance, and applicability of validated tools for screening and assessment.

Sources: American Academy of Child and Adolescent Psychiatry, 2012¹⁶ | American Psychiatric Association, 2007¹⁷ | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

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.

Recognized screening questions

The following are examples of recognized screening questions:

- MACSCREEN²:
 - 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, 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 guideline¹⁹:
 - 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) Questionnaire²⁰ self-reported screening questions (tool to be validated):
 - 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

The following are examples of validated tools to measure the severity of symptoms in OCD (child and adolescent versions are available):

- Yale-Brown Obsessive Compulsive Scale (YBOCS and CY-BOCS)²¹
- Obsessive–Compulsive Inventory Revised (OCI-R and OCI-CV)²²

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 as a means of identifying people who might have OCD and might benefit from further comprehensive assessment and appropriate treatment.

For Health Services

Ensure that systems, processes, and resources are in place in all health settings for clinicians to identify and screen people with suspected OCD.

Quality Indicators

Process Indicators

Percentage of people with suspected OCD who are screened 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 screened 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 screened 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 screened using recognized screening questions and validated severity-rating scales
- Data source: local data collection

Quality Statement 2: Comprehensive Assessment

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

Background

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.¹⁵

Based on the criteria from *DSM-5*,¹ 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.”²

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

Sources: American Academy of Child and Adolescent Psychiatry, 2012¹⁶ | American Psychiatric Association, 2007¹⁷ | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Timely comprehensive assessment

The OCD Quality Standard Advisory Committee agreed that, ideally, comprehensive assessment should occur within 4 to 12 weeks of the first point of contact, based on the criteria from *DSM-5*.¹ The assessment determines whether they have OCD, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

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, which 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.

Severity of symptoms

The severity of OCD symptoms is 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 have other physical or psychiatric conditions that affect their symptoms and response to treatment. It is important to assess for comorbid conditions and risk of self-harm or suicide. Other conditions to assess for include depression, anxiety disorders, alcohol or

substance use disorder, attention-deficit/hyperactivity disorder,²³ body dysmorphic disorder, or an eating disorder.¹⁹

Associated functional impairment

Associated functional impairment may include a person's level of distress and impairment, any physical symptoms, or effects on their quality of life.

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 provider should also talk with you about how bad 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 scales to accurately diagnose people with 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

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

Process Indicators

Percentage of people with suspected OCD, or who have screened positive for OCD, who receive a comprehensive assessment that determines:

- **Whether they have OCD**
- **The severity of their symptoms**
- **Whether they have any comorbid conditions**
- **Whether they have any associated functional impairment**

- Denominator: total number of people with suspected OCD, or who have screened positive 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
 - Whether they have any associated functional impairment
- Data source: local data collection
- Note: Refer to Quality Statement 1 for the definition of people with suspected OCD

Percentage of people with suspected OCD, or who have screened positive for OCD, who receive a comprehensive assessment within 12 weeks of the first point of contact

- Denominator: total number of people with suspected OCD, or who have screened positive for OCD, who receive a comprehensive assessment
- Numerator: number of people in the denominator who receive this comprehensive assessment within 12 weeks of the first point of contact
- Data source: local data collection
- Note: Refer to Quality Statement 1 for the definition of people with suspected OCD

Structural Indicator

Local arrangements to provide health care professionals with training to perform comprehensive assessments for OCD

- Data source: local data collection

Quality Statement 3: 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.

Background

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.^{17,24} 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 treatments.¹⁷

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.^{25,26}

For children and adolescents, the involvement of family and caregivers is an important consideration. Guided self-help may be considered in conjunction with support and information for family and caregivers.¹⁹

Sources: American Psychiatric Association, 2007¹⁷ | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Self-help resources

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

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

Self-help approaches aim to empower the person to gather information about anxiety disorders, as well as develop management strategies.

Support groups

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

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 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 peer support groups.

For Health Services

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

Quality Indicators

Process Indicator

Percentage of people with OCD whose health care professional informs them about and supports them in accessing self-help resources based on their individual needs and preferences

- Denominator: total number of people with OCD
- Numerator: number of people in the denominator whose health care professional informs them about and supports them 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

Outcome Indicator

Percentage of people with OCD who report feeling informed and supported in accessing self-help resources

- Denominator: total number of people with OCD
- Numerator: number of people in the denominator who report feeling informed and supported in accessing self-help resources
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Quality Statement 4: Support for Family and Caregivers

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

Background

Obsessive–compulsive disorder often impacts surrounding people and relationships, especially a person’s family and caregivers. Wherever appropriate and possible, health care professionals should promote a collaborative and reflective approach when working with people with OCD and their family or caregivers.¹⁹ 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.

In the treatment and care of people with OCD, family members and caregivers should be given comprehensive information (both verbal and written) about the disorder, its likely causes, its course, and its treatment.¹⁹ Psychoeducation is needed for families and caregivers, because a reduction in accommodation behaviours has been associated with improved OCD symptom severity and treatment outcomes.^{27,28}

For children and adolescents, it is especially important to consider the needs of family and caregivers.

Sources: American Psychiatric Association, 2007¹⁷ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Accommodation behaviours

Accommodation behaviours (also known as family accommodation or symptom accommodation) are actions that family and caregivers take to help their loved one manage their OCD symptoms. These behaviours may include providing 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.

What This Quality Statement Means

For People With OCD

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

For Clinicians

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

For Health Services

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

Quality Indicators

Process Indicators

Percentage of people with OCD who choose to have their family/caregivers involved in their care and whose family/caregivers are connected to available resources and supports, and provided with psychoeducation by a health care professional

- Denominator: total number of people with OCD who choose to have their family/caregivers involved in their care
- Numerator: number of people in the denominator whose family/caregivers are connected to available resources and supports, and provided with psychoeducation (including the impact of accommodation behaviours) by a health care professional
- 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 choose to have their family/caregivers involved in their care and whose family/caregivers are involved during their assessment and treatment

- Denominator: total number of people with OCD who choose to have their family/caregivers involved in their care
- Numerator: number of people in the denominator whose family/caregivers are involved during their assessment and treatment
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Outcome Indicators

Percentage of people with OCD who choose to have their family/caregivers involved in their care and whose family/caregivers report feeling supported and informed about OCD

- Denominator: total number of people with OCD who choose to have their family/caregivers involved in their care
- Numerator: number of people in the denominator whose family/caregivers report feeling supported and informed about OCD
- Data source: local data collection

Percentage of people with OCD who choose to have their family/caregivers involved in their assessment and treatment and who report a reduction in accommodation behaviours by their family/caregivers

- Denominator: total number of people with OCD who choose to have their family/caregivers involved in their assessment and treatment
- Numerator: number of people in the denominator who report a reduction in accommodation behaviours by their family/caregivers
- Data source: local data collection

Quality Statement 5: 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. Cognitive behavioural therapy with exposure and response prevention is delivered by a health care professional with expertise in OCD.

Background

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; therefore, it is important to discuss the potential benefits and risks of any treatment before starting.¹⁸ Treatment responses to psychological interventions are not immediate, and a prolonged course of treatment is usually needed to achieve an initial treatment response.¹⁸ Motivational interviewing may also help people with OCD overcome resistance to treatment.

Sources: American Academy of Child and Adolescent Psychiatry, 2012¹⁶ | American Psychiatric Association, 2007¹⁷ | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Timely access to cognitive behavioural therapy

The OCD Quality Standard Advisory Committee agreed that, ideally, cognitive behavioural therapy 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; rather, it is a process that addresses the factors that caused and maintain the person's OCD.² In OCD, CBT relies on 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 confrontations. 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.¹⁷

Cognitive behavioural therapy may be delivered in different formats (i.e., individual or group sessions, in person, via videoconference, or guided via the Internet). Sessions may vary in length from less than an hour to 2 hours.¹⁷ According to expert consensus, an adequate trial for most people consists of 13 to 20 weekly sessions.¹⁷

Health care professionals with expertise in OCD have training in delivering CBT specific to OCD. 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.

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 with a health care professional who has expertise in treating OCD.

For Clinicians

Offer CBT with exposure and response prevention to people with OCD.

For Health Services

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

Process Indicators

Percentage of people with OCD 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
- 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

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

Structural Indicator

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

- Data source: local data collection

Quality Statement 6: 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.

Background

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.

Although SSRIs are considered first-line medication for 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 refer to clinical practice guidelines for further guidance on pharmacological management of OCD.²

For children and adolescents, careful monitoring is required when an SSRI is prescribed, because of its association with increased risk of suicidal thinking and self-harm in a minority of people under age 30 years.¹⁹ It is also recommended that children and adolescents with OCD take medication in combination with concurrent CBT with exposure and response prevention.¹⁹

Sources: American Academy of Child and Adolescent Psychiatry, 2012¹⁶ | American Psychiatric Association, 2007¹⁷ | Anxiety Disorders Association of Canada, 2014² | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹ | World Federation of Societies of Biological Psychiatry, 2012²⁹

Definitions Used Within This Quality Statement

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.

Selective serotonin reuptake inhibitor

Selective serotonin reuptake inhibitors are a medication commonly referred to as “antidepressants” in the treatment of major depression, but they are also prescribed to treat other disorders, including OCD, anxiety disorders, chronic pain, and post-traumatic stress disorder. Examples of SSRIs include escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline. The dose of an SSRI medication 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.

OCD-specific dose and duration

An OCD-specific dose 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.²

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.

What This Quality Statement Means

For People With OCD

If you have moderate to severe OCD, or if you are not getting better with cognitive behavioural therapy with ERP, you should be offered a type of medication called a selective serotonin reuptake inhibitor (SSRI). You should take it at a dose and for 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

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

Process Indicator

Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment, 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
- Numerator: number of people in the denominator who receive an SSRI at an OCD-specific dose and duration
- Data source: local data collection
- Note: Refer to clinical practice guidelines for further guidance on OCD-specific dosage recommendations

Outcome Indicator

Percentage of people with moderate to severe OCD, or people who are not responding to psychological treatment, who are offered an SSRI and who feel involved in discussions about their medication, including potential benefits and risks, side effects, and adverse effects

- Denominator: total number of people with moderate to severe OCD, or people who are not responding to psychological treatment and who are offered an SSRI
- Numerator: number of people in the denominator who feel involved in discussions about their medication, including potential benefits and risks, side effects, and adverse effects
- Data source: local data collection

Quality Statement 7: 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 the person's clinical presentation.

Background

Regular monitoring of a person's response to treatment ensures that effectiveness can be assessed, and treatment can be adjusted if needed.³⁰ 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, absenteeism at school or work, and ability to continue or return to employment.³⁰ Other factors that should be monitored include side effects, adverse effects, adherence to treatment, and suicidal ideation. Monitoring treatment response is critical to optimizing care and should be part of every treatment plan.

For children and adolescents, careful monitoring is important when prescribing an SSRI medication because it is associated with an increased risk of suicidal thinking and self-harm in a minority of people under the age 30 years.¹⁹

Sources: British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Effectiveness and tolerability

Effectiveness is indicated by an improvement in symptoms. Tolerability is the acceptability of the treatment, including side effects.² Goals for effectiveness and tolerability are individualized based on the person's needs and preferences.²

Monitored regularly

Monitoring response to treatment involves the use of validated tools in conjunction with an assessment of the person's clinical presentation and the use of clinical judgment. 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 occurs 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
- 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.¹⁹ The frequency of regular follow-up is as needed and is mutually agreed upon by the health care professional and the person with OCD

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 about

how the treatment is working at every session. For medications, 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.

For Health Services

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

Process Indicators

Percentage of people with OCD who are receiving psychotherapy and who have their response to treatment (effectiveness and tolerability) monitored using validated tools and recorded at each treatment session

- 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 and recorded at each treatment session
- Data source: local data collection
- Note: refer to 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 and recorded monthly

- 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 and recorded monthly
- Data source: local data collection
- Note: refer to Quality Statement 1 for validated severity-rating scales

Percentage of people with OCD who are in remission and who receive regular follow-up by a health care professional 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 regular follow-up by a health care professional within 12 months
- Data source: local data collection

Quality Statement 8: Support for Initial Treatment Response

When initial psychological or pharmacological 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.

Background

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.^{2,18} 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.

When initial treatments are unsatisfactory despite a full 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.

Sources: American Academy of Child and Adolescent Psychiatry, 2012¹⁶ | American Psychiatric Association, 2007¹⁷ | Anxiety Disorders Association of Canada, 2014² | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

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.¹⁷ 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.¹⁹ Additional interventions may need to be considered to address these factors.

Stepped-care approach

A stepped-care approach involves choosing the least intensive, most effective treatment first, considering a person's needs and preferences.¹⁹ Stratification within the stepped-care approach ensures that people receive appropriate treatment based on the severity of their condition. An initial assessment can be used to match people with the most appropriate initial treatment. The next step could involve increasing intensity of the treatment, switching modalities, other pharmacotherapy, combined treatment, or consultation with/referral to a health care professional with specialized expertise in OCD.

What This Quality Statement Means

For People With OCD

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.

For Clinicians

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

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

Process Indicators

Percentage of people with OCD who are not responding to initial psychological or pharmacological 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 psychological or pharmacological 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 psychological or pharmacological treatment and are reassessed who are offered other treatment options based on a stepped-care approach

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

Outcome Indicator

Percentage of people with OCD who have followed a stepped-care approach to treatment who have shown improvement in symptoms based on a validated severity-rating scale

- 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 based on a validated severity-rating scale
- Data source: local data collection
- Note: Refer to Quality Statement 1 for validated severity-rating scales

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Quality Statement 9: 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.

Background

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.

Sources: American Psychiatric Association, 2007¹⁷ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Intensive treatment

Intensive treatment refers to OCD-specific treatments that involve individualized care from an interprofessional team with 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).² Intensive treatment for OCD may involve a residential program or inpatient services.

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

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 Indicators

Process Indicator

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

Quality Statement 10: Relapse Prevention

People with OCD who are receiving treatment are provided with information and education about relapse prevention.

Background

Obsessive–compulsive disorder has a fluctuating or episodic course. Even with effective treatment, people with OCD face the possibility of 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, and knowing how to get help from health care professionals when needed.³¹ Preparing people for relapse prevention puts a focus on their 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, patient, families, and caregivers should be educated about relapse prevention and/or withdrawal symptoms.¹⁹ Psychological treatment should continue throughout the period of drug discontinuation to reduce the risk of relapse.¹⁹

Sources: American Psychiatric Association, 2007¹⁷ | British Association for Psychopharmacology, 2014¹⁸ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Relapse prevention

Relapse is a return to the level of symptoms 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 to prevent relapse. Information and education about relapse prevention should include:

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

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 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 relapse prevention. 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

Ensure that systems, processes, and resources are in place so that people with OCD can receive information and education about relapse prevention and can access timely mental health services when they need it.

Quality Indicators

Process Indicator

Percentage of people with OCD who are receiving treatment and are provided with information and education about relapse prevention by their health care professional

- Denominator: total number of people with OCD who are receiving treatment
- Numerator: number of people in the denominator who are provided with information and education about relapse prevention by their health care professional
- Data source: local data collection

Outcome Indicator

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
- Note: Consider defining the time period in which a person would need to experience few or no substantial symptoms to be considered in remission

Quality Statement 11: Transitions in Care

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

Background

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).¹⁹ 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.¹⁹

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.¹⁷

Sources: American Psychiatric Association, 2007¹⁷ | National Institute for Health and Care Excellence, 2005¹⁹

Definitions Used Within This Quality Statement

Seamless transition

A 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 (setting), but also when moving from child and adolescent care to adult care (service).

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

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

Process Indicators

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

Outcome Indicator

Percentage of people with OCD who transition between services or health care professionals and report that their health care professional or team knew about their medical history

- Denominator: total number of people with OCD who transition between services or health care professionals and answer the question “During your most recent visit, did this team or health care professional seem to know about your medical history?”
- Numerator: number of people in the denominator who answer “Yes”
- Data source: local data collection

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 guidelines we used to develop the OCD quality statements. 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.

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We focus on making health care more effective, efficient and affordable through a legislative mandate of:

- Reporting to the public, organizations, government and health care providers on how the health system is performing,
- Finding the best evidence of what works, and
- Translating this evidence into clinical standards; recommendations to health care professionals and funders; and tools that health care providers can easily put into practice to make improvements.

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