

Standards of care for obsessive–compulsive disorder centres

José M. Menchón^{a,b,c}, Michael van Ameringen^d, Bernardo Dell’Osso^{e,f}, Damiaan Denys^{g,h,i,j}, Martijn Figees^g, Jon E. Grant^k, Eric Hollander^{l,m}, Donatella Marazzitiⁿ, Humberto Nicolini^{o,p}, Stefano Pallanti^{q,r}, Christian Ruck^s, Roseli Shavitt^t, Dan J. Stein^{u,v,w}, Erik Andersson^s, Rajshekhar Bipeta^x, Danielle C. Cath^y, Lynne Drummond^{z,A}, Jamie Feusner^{B,C}, Daniel A. Geller^{D,E}, Georgi Hranov^F, Christine Lochner^{w,G}, Hisato Matsunaga^H, Randy E. McCabe^{d,I}, Davis Mpavaenda^J, Takashi Nakamae^K, Richard O’Kearney^L, Massimo Pasquini^M, Ricardo Pérez Rivera^N, Michael Poyurovsky^O, Eva Real^{a,b}, Maria Conceição do Rosário^P, Noam Soreni^{d,Q}, Richard P. Swinson^d, Nienke Vulink^g, Joseph Zohar^R and Naomi Fineberg^J

^aPsychiatry Department, Bellvitge University Hospital_IDIBELL, Barcelona, Spain; ^bCarlos III Health Institute_CIBERSAM, Spain; ^cDepartment of Clinical Sciences, School of Medicine, University of Barcelona, Barcelona, Spain; ^dDepartment of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario, Canada; ^eDepartment of Psychiatry, University of Milan, Milan, Italy; ^fFondazione IRCCS Ca’ Granda Policlinico, Milan, Italy; ^gAcademic Medical Center, Department of Psychiatry, University of Amsterdam, Amsterdam, The Netherlands; ^hBrain and Cognition, Amsterdam, The Netherlands; ⁱNetherlands Institute for Neuroscience, Amsterdam, The Netherlands; ^jRoyal Netherlands Academy of Arts and Sciences, Amsterdam, The Netherlands; ^kDepartment of Psychiatry and Behavioral Neuroscience, University of Chicago, Chicago, IL, USA; ^lDepartment of Psychiatry and Behavioral Sciences, Albert Einstein College of Medicine, NY, USA; ^mMontefiore Medical Center, NY, USA; ⁿDipartimento di Medicina Clinica e Sperimentale, Sezione di Psichiatria, University of Pisa, Pisa, Italy; ^oNational Institute of Genomic Medicine, Mexico City, Mexico; ^pCarracci Medical Group, Mexico City, Mexico; ^qPsychiatry and Behavioral Sciences, UC Davis Health System, Sacramento, CA, USA; ^rIstituto di Neuroscienze, Florence, Italy; ^sDepartment of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden; ^tDepartment and Institute of Psychiatry, University of São Paulo School of Medicine, São Paulo, Brazil; ^uPsychiatry and Mental Health Department, University of Cape Town, Cape Town, South Africa; ^vGroote Schuur Hospital, Cape Town, South Africa; ^wMRC Unit on Anxiety and Stress Disorders, South Africa; ^xGandhi Medical College and Hospital, Hyderabad, India; ^yDepartment of Clinical Psychology, Utrecht University, Utrecht, The Netherlands; ^zSouth West London and St George’s Mental Health NHS Trust, London, United Kingdom; ^ASt George’s, University of London, London, United Kingdom; ^BSemel Institute for Neuroscience and Human Behavior, Los Angeles, CA, USA; ^CDavid Geffen School of Medicine at UCLA University of California, Los Angeles, CA, USA; ^DDepartment of Psychiatry, Massachusetts General Hospital, Boston, MA, USA; ^EHarvard Medical School, Boston, MA, USA; ^FMedical University, Sofia, Bulgaria; ^GDepartment of Psychiatry, Stellenbosch University, South Africa; ^HDepartment of Neuropsychiatry, Hyogo College of Medicine, Nishinomiya, Hyogo, Japan; ^IAnxiety Treatment and Research Center, St. Joseph’s Healthcare Hamilton, Hamilton, Canada; ^JHertfordshire Partnership University NHS Foundation Trust, Hertfordshire, United Kingdom; ^KDepartment of Psychiatry, Graduate School of Medical Science, Kyoto Prefectural University of Medicine, Kyoto, Japan; ^LThe Australian National University, Research School of Psychology, Canberra, Australia; ^MDepartment of Neurology and Psychiatry, Sapienza University of Rome, Rome, Italy; ^NBio-Behavioral Institute, Buenos Aires, Argentina; ^OTechnion, Israel Institute of Technology, Haifa, Israel; ^PChild and Adolescent Psychiatry Unit (UPIA), Department of Psychiatry, Federal University of São Paulo (UNIFESP), São Paulo, Brazil; ^QPediatric OCD Consultation Service, Anxiety Treatment and Research Center, St. Joseph’s HealthCare, Hamilton, Ontario, Canada; ^RTel Aviv University, Sackler School of Medicine, NY, USA

ABSTRACT

In recent years, many assessment and care units for obsessive–compulsive disorder (OCD) have been set up in order to detect, diagnose and to properly manage this complex disorder, but there is no consensus regarding the key functions that these units should perform. The International College of Obsessive–Compulsive Spectrum Disorders (ICOCS) together with the Obsessive Compulsive and Related Disorders Network (OCRN) of the European College of Neuropsychopharmacology (ECNP) and the Anxiety and Obsessive Compulsive Disorders Section of the World Psychiatric Association (WPA) has developed a standards of care programme for OCD centres. The goals of this collaborative initiative are promoting basic standards, improving the quality of clinical care and enhance the validity and reliability of research results provided by different facilities and countries.

ARTICLE HISTORY

Received 6 December 2015
Revised 19 March 2016
Accepted 11 May 2016



KEYWORDS

Accreditation standards; obsessive–compulsive disorder; OCD units; standards of care

Introduction

Obsessive–compulsive disorder (OCD) is a heterogeneous condition that may manifest in a variety of ways. Highly specialised staff are needed to detect and diagnose the disorder and to properly manage it. In recent years, many assessment and care units for OCD have been set up in order to address these specific issues, but there is no consensus regarding the key functions that these

units should perform. The International College of Obsessive–Compulsive Spectrum Disorders (ICOCS) together with the Obsessive Compulsive and Related Disorders Network (OCRN) of the European College of Neuropsychopharmacology (ECNP) and the Anxiety and Obsessive Compulsive Disorders Section of the World Psychiatric Association (WPA) has developed an standards of care programme for OCD centres, in order to promote basic standards, improve the quality of clinical care and deliver the best

CONTACT José Manuel Menchón  jmenchon@bellvitgehospital.cat  Psychiatry Department, Bellvitge University Hospital, Bellvitge Biomedical Research Institute (IDIBELL), Barcelona, Spain; Carlos III Health Institute, Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM), Spain; Department of Clinical Sciences, School of Medicine, University of Barcelona, Barcelona, Spain

© 2016 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group. This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

treatment for patients with OCD. This collaborative initiative also aims to enhance the validity and reliability of research results provided by different facilities and countries. This initiative is similar to those that have been implemented to establish standards of care for other mental health issues, such as diagnostic assessment and treatment of people with dementia (MSNAP 2012) or the administration of electroconvulsive therapy (ECTAS 2012).

Methods

Standards of care were selected through a highly consensual procedure that gathered a large number of opinions and points of view. This was done in an interactive and iterative way, enabling considerable feedback to be obtained from experienced therapists in the field of OCD. Consensus was not based only on the experts' opinions, but on widely used clinical practice guidelines in OCD, also. Examples of these guidelines have been developed by the following associations and institutions: the National Institute for Health and Care Excellence (NICE guideline 2005), the American Psychiatric Association (APA guideline 2013), the British Association for Psychopharmacology (Baldwin et al. 2014), American Academy of Child and Adolescent Psychiatry (AACAP guideline 2012), the World Federation of Societies of Biological Psychiatry (Bandelow et al. 2012) and the Cape Town Consensus Statement (Stein 2007). The process began with the call for applications to participate in the working groups (child and adult) in May 2013. Applications were received (from ICOCS members and non-members) and three groups were established: the Steering Committee (formed by 13 board members, not included in the working groups), the Child OCD Centres Working Group and the Adult OCD Centres Working Group. The working groups of the ICOCS Credentialing Task Force included leaders and highly experienced practitioners in OCD (including psychiatrists, psychologists and mental health nurses) from many different countries: Turkey, South Africa, United Kingdom, Sweden, United States of America, Israel, the Netherlands, Bulgaria, Canada, Japan, Argentina, Hungary, Brazil and Australia.

After a review of similar initiatives, a survey containing a comprehensive list of possible standards was sent to all members of the working groups. The objective was to decide which items should be included as standards. The working members had to rate the possible standards according to the following:

- (0): should not be included
- (1): the standard is not essential, but may be pertinent for an OCD unit
- (2): the standard may be important for an OCD unit
- (3): the standard is definitely necessary for an OCD unit

The standards were grouped into the following areas:

- I. Resources
- II. Procedures and assessment
- III. Management and follow-up
- IV. Quality indicators.

When all the responses had been received, a list with the selected standards was again sent to the members of the working groups, and two teleconferences were held shortly after (with the adult and child working groups). In this second stage, the groups were asked to distribute the standards on the following two different levels:

- a. Recommended standards, considered key elements for an OCD unit (i.e., those that an accredited centre would be expected to meet)

- b. Excellence standards (i.e., those that an excellent service should meet or criteria that, while not essential for an OCD unit, would bring higher quality to the unit).

Once this information had been received, a Reference Group also assessed the proposed standards. Thereafter, the proposal was sent to the Steering Committee, which produced an overview of all the feedback. The final proposal was presented at the ICOCS 9th Scientific Meeting, held in Berlin on 22 October 2014.

Results

Resources

Facilities

The unit provides suitable facilities in an environment that is appropriate to the needs of people with OCD. The service offers places and resources for staff to carry out their duties effectively.

Recommendable

1. To have private consultation rooms
2. Availability of a psychiatric inpatient ward or day treatment facilities (not necessarily specific for OCD, may be a general psychiatric inpatient ward) with specific knowledge of OCD treatment for severe patients or for specific OCD treatments.¹

Excellence

1. Consultation and counselling rooms large enough for family meetings
2. Group therapy room
3. Access to facilities for showering/bathing, for practising behavioural exercises
4. Computer and internet access for therapeutic exposure of patients
5. Access to kitchen facilities so as to practise preparing food

Child units

Availability of or integration with a paediatric general medical service (given the frequent comorbidity and, in particular, the potential role of a post-infectious autoimmune basis in OCD pathophysiology).

Human resources

Skilled and qualified staff are essential to ensure that patients obtain the appropriate treatment in accordance with state-of-the-art knowledge. The staff members involved in the assessment and treatment of patients work as a multidisciplinary team and discuss relevant clinical matters. Staff members are properly trained for their job and their continuing professional development is facilitated. The roles and responsibilities of team members are defined.

Recommendable

1. The unit has at least one staff psychiatrist with clinical experience and training in the following:
 - The diagnosis, background and treatment of OCD:
 - Psychopathology of obsessions and compulsions and the assessment of insight.
 - Main clinical dimensions/subtypes of OCD.
 - Diagnostic criteria for OCD.
 - The diagnosis, background and treatment of OCD spectrum and related disorders.

- At least one scale for the assessment of OCD, preferably the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman et al. 1989).
- At least one clinical practice guideline for OCD.
- Assessment of depression and anxiety
- The standard pharmacological management of OCD, including efficacy rates and side effects of the drugs used.
- Strategies of pharmacological treatment for resistant OCD.
- The principles of cognitive-behavioural therapy for OCD.
- Detecting obsessive/compulsive symptoms in patients who do not express them spontaneously.
- Conducting a clinical interview with a patient with OCD (obtaining the relevant information, directing the interview towards the relevant issues, managing lengthy and detailed answers).
- Accepting other treatments, which may include neurosurgery, in accordance with the current evidence base.
- Good communicative skills to interact with other professionals and families.
- Other training or knowledge that is not essential but valuable:
 - Knowledge of the principles and efficacy rates of deep brain stimulation and classical neurosurgery.
 - Assessment of tic disorder and autism spectrum disorders

Child units (specific for child units in addition to the above standards):

- Psychopathology of tic disorder and assessment of repetitive behaviours.
 - Psychopathology of autism spectrum disorders.
 - Psychopathology of childhood and adolescence (disruptive, impulse control and conduct disorders, attention-deficit hyperactivity disorder and eating disorders).
 - Confidence with taking medical history.
 - At least one scale for the assessment of OCD in children, preferably the Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) (Scahill et al. 1997).
 - At least one clinical practice guideline for OCD (suggested: AACAP or NICE).
 - Conducting a clinical interview with the family of a patient with OCD.
2. The unit has at least one professional with expertise in cognitive-behavioural therapy (or a registered cognitive-behavioural therapist). This professional may be a psychiatrist, a clinical psychologist, a nurse, a social worker, or a qualified and trained therapist. The professional should have clinical experience and training in the following:
- Psychopathology of obsessions and compulsions.
 - Main clinical dimensions/subtypes of OCD.
 - Distinction between obsession and delusion.
 - Diagnostic criteria of OCD.
 - OCD spectrum and related disorders.
 - At least one scale for the assessment of OCD.
 - Specific behavioural therapy techniques for OCD.
 - Conducting a clinical interview with a patient with OCD (obtaining the relevant information, directing the interview towards the relevant issues, managing lengthy and detailed answers).
 - Good communicative skills to interact with other professionals and families.

- Other training that is not essential but valuable:
 - The specific cognitive therapy strategies for OCD.
 - Group treatment for OCD patients.

Child units (specific for child units in addition to the above standards):

- At least one scale for the assessment of OCD (preferably CY-BOCS).
- Conducting a clinical interview with the family of a patient with OCD.
- Assessing family responses to and attitudes and beliefs about a child's OCD
- Managing family accommodation of symptoms
- Treating common comorbid difficulties (e.g. disruptive behaviours)

Excellence

1. A clinical psychologist or mental health professional who may deliver psychological therapies other than cognitive behavioural therapy (CBT).
2. A mental health nurse with clinical experience in OCD for inpatients.
3. Therapist with experience in family therapy.
4. Neurosurgeons trained in deep brain stimulation, if this treatment is offered by the unit.

Procedures and assessment

The OCD unit provides timely access to assessment and diagnosis. Direct interview is performed by clinically trained staff to gather relevant information and ensure an accurate OCD diagnosis. Assessment must be able to detect key aspects that may help in providing individualised treatment. The patient's family is also included in the assessment process (whenever possible), provided that their participation in treatment planning improves the likelihood of treatment compliance.

Recommendable

1. There is a protocol for the assessment of OCD (which conforms to recommended guidelines or practice standards).
2. The clinical assessment includes the following:
 - Detailed list of obsessive-compulsive symptoms.
 - Subtype or dimensions.
 - Degree of insight.
 - Risk of suicide.
 - Severity, assessed through a rating scale.
 - Degree of functional impairment.
 - Age at onset of the first symptoms and of the disorder.
 - Behavioural analysis.
 - Past or present history of tics or Tourette's syndrome.
 - Conditions associated with the onset and course of symptoms.
 - Assessment of depression.
 - Assessment of comorbidities.
 - Personality traits or disorders.
 - Differential diagnosis with respect to other disorders.
 - Checklist of life events.

Child units (specific for child units in addition to the above standards):

- History of paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).
- Assessment of comorbidities (particularly disruptive disorders, eating disorders, autism spectrum disorder).

3. Availability of imaging and laboratory tests should either be available on site, if the unit is located in a hospital or medical clinic setting, or be accessible through a convenient referral procedure established with a nearby laboratory.

- Neuroimaging techniques: These are not necessary for routine clinical assessment of OCD but used if needed to rule out other conditions. Main techniques used are magnetic resonance imaging (MRI), computed tomography (CT).
- Laboratory tests: These are not necessary for routine clinical assessment of OCD but used if needed to rule out other conditions.
- Electrocardiogram (ECG).

Child units (specific for child units):

- Neuroimaging techniques: Main technique used is MRI.
- Laboratory tests: Availability of immunological/infectious disease workup, if needed.
- ECG.

4. Family assessment. It includes the following:

- Family history of OCD, tics and other psychiatric disorders.
- Degree of support from relatives and assessment of awareness among family members of the patient's OCD.
- Degree of understanding of the disorder among relatives.
- Ability of relatives to participate in treatment and the need for their participation.
- Assessment of family accommodation.

Excellence

1. Assessment of:
 - History of PANDAS.
 - Relationship of OCD with life events.
 - Relationship of OCD with reproductive events.
 - Cognitive biases.
2. There are guidelines on the criteria for referring patients to the OCD unit and for referring patients from the unit to other mental health centres.
3. Neuropsychological assessment aimed at exploring basic neuropsychological disturbances that may appear in OCD (such as response inhibition, cognitive flexibility, problems with memory, attention and executive functions). In child units: particularly when a neurodevelopmental disorder is comorbid with OCD.

Management and follow-up

Management and follow-up is an interdisciplinary clinical process designed to enable individualised treatment planning and treatment delivery. The service has access to a range of evidence-based intervention, and it is able to offer appropriate support, advice and information to patients regarding the different treatment options. It is imperative to evaluate and update the individual's progress or lack of progress. The treatment plan is developed with the participation of the patient and/or his/her parent or legal guardian, as appropriate, and includes all the components of OCD treatment.

Recommendable

1. Details of previous treatments are recorded.
 - Age at first treatment
 - Previous drug treatments (doses, duration, efficacy and side effects)

- Previous psychological therapies (types and efficacy)
 - Response to previous treatments
2. The OCD unit is able to deliver the following treatments:

- Pharmacological treatment
- standard treatment with serotonin reuptake inhibitors (SRI)
- strategies for resistant OCD
- Individual cognitive-behavioural therapy (CBT)

Child units

- Family sessions
- Evidence-based treatment for common comorbid problems

3. The unit is able to carry out a follow-up of cases, if needed; this will not be necessary if there are referral sources in the community, along with good communication between the unit treatment providers and follow-up providers.

Child units

4. The unit has the capacity to provide psychological interventions across the age range of childhood and adolescence.

Excellence

1. Home visits and delivering CBT at home in specific cases
2. Ability to have sessions longer than 60 minutes
3. Group CBT for OCD symptoms
4. Family orientation
5. Psycho-education
6. Neurosurgery: Deep brain stimulation, classical surgery
7. The unit uses follow-up data to systematically analyse outcomes.
8. (N.B. access to the different treatments should not be biased by the cost of the treatment)

Quality indicators

These indicators suggest an active involvement of the unit in acquiring knowledge on OCD, as well as delivering it to society. Their presence can be considered as an indirect indicator of the unit's quality.

1. Staff members attend specific OCD meetings.
2. Staff members participate in OCD networks or associations.
3. Staff members participate in research on OCD through projects and studies published in specialist journals.
4. Staff members participate in educational activities, whether for professionals, relatives or the community.
5. There is a training programme on OCD.
6. The OCD unit has its own website.
7. The unit records clinical activity data (e.g., number of OCD patients seen per year, number of new cases per year, rates of response and remission, among others).
8. Develop links with other OCD units.

Conclusions

The aim of this ICOCS initiative was to provide practical standards for clinical care in OCD centres, being research issues addressed to a lesser extent. The authors believe that standardising care in OCD centres will indirectly improve the validity and reliability of research results (at least results would be easier to compare between different settings). One of the goals of setting up standards of care was that they could be used as accreditation standards for the institutions participating in the consensus. The full set of standards and criteria proposed in this report is aspirational and

it is unlikely that any service would meet all of them. It has been conceived as a dynamic process and it is open to new advances that may occur in the future. It is expected that the ICOCS will conduct periodic reviews of these standards.

Disclosure statement

N. Fineberg received financial support to attend scientific meetings from the International College of Obsessive-Compulsive Spectrum Disorders (ICOCS) and the European College of Neuropsychopharmacology (ECNP). N. Fineberg and E. Hollander are Associate Editors of International Journal of Psychiatry in Clinical Practice, and J. Zohar, J. E. Grant and S. Pallanti are part of the Editorial Advisory Board of the same journal.

Note

1. Although OCD patients are not usually treated as inpatients, in some cases, hospitalisation may be advisable because of the severity of the disorder or in order to provide specific OCD therapies such as intensive cognitive-behavioural therapy (CBT).

References

- AACAP guideline (the American Academy of Child and Adolescent Psychiatry). 2012. Practice parameter for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *J Am Acad Child Adolesc Psychiatry*. 51:98–113.
- APA guideline (the American Psychiatric Association). 2013. Guideline watch (March 2013): practice guideline for the treatment of patients with obsessive-compulsive disorder. Available from: <http://psychiatryonline.org/guidelines>.
- Baldwin DS, Anderson IM, Nutt DJ, Allgulander C, Bandelow B, den Boer JA, Christmas DM, Davies S, Fineberg N, Lidbetter N, et al. 2014. Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: a revision of the 2005 guidelines from the British association for psychopharmacology. *J Psychopharmacol*. 28:403–439.
- Bandelow B, Sher L, Bunevicius R, Hollander E, Kasper S, Zohar J, Möller HJ; WFSBP Task Force on Mental Disorders in Primary Care; WFSBP Task Force on Anxiety Disorders, OCD and PTSD. 2012. Guidelines for the pharmacological treatment of anxiety disorders, obsessive-compulsive disorder and posttraumatic stress disorder in primary care. *Int J Psychiatry Clin Pract*. 16:77–84.
- Cresswell J, Murphy G, Hodge S, editors. The ECT accreditation service (ECTAS). 2012. Standards for the administration of ECT.
- Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill C, Heninger GR, Charney DS. 1989. The Yale-Brown obsessive compulsive scale. I. Development, use, and reliability. *Arch Gen Psychiatry*. 46:1006–1011.
- Doncaster E, Hodge S, Orrell M, editors. Memory services national accreditation programme. (MSNAP). 2012. Standards for memory services.
- NICE guideline (The National Institute for Health and Care Excellence). 2005. Obsessive-compulsive disorder and body dysmorphic disorder: treatment. Available from: nice.org.uk/guidance/cg31.
- Scahill L, Riddle MA, McSwiggan-Hardin M, Ort SI, King RA, Goodman WK, Cicchetti D, Leckman JF. 1997. Children's Yale-Brown obsessive compulsive scale: reliability and validity. *J Am Acad Child Adolesc Psychiatry*. 36:844–852.
- Stein DJ. 2007. The Cape Town Consensus Statement on obsessive-compulsive disorder. *Int J Psychiatry Clin Pract*. 11:11–15.