



Inpatient hospital admissions for people with obsessive-compulsive disorder (OCD). A position statement by the international college of obsessive-compulsive spectrum disorders^{☆, ☆☆}

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ABSTRACT

Background: The hospitalization of patients with obsessive-compulsive disorder (OCD) is less common in comparison to other mental disorders, and often a significant and distressing event.

Objectives: This paper presents a position statement, developed by the International College of Obsessive-Compulsive Spectrum Disorders, on the indications for hospital admission for people with OCD, the treatment that is offered within hospital, the complications that may occur in this setting, and principles for best practice.

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Methods: Current literature was critically reviewed and narratively synthesized by a group of international experts in the field of OCD.

Results: An inpatient hospital admission may be required for people with severe OCD who are unable to accept or tolerate pharmacological or psychological treatment as an outpatient or where there would be significant risks to the individual or those around them. Admissions have been associated with significant reductions in OCD severity. Inpatient treatment often involves psychoeducation of staff, patients and family members, pharmacotherapy, exposure and response prevention psychological work, addressing comorbidity as well as psychosocial issues such as family-relational issues, homelessness, grief or loss. Admissions can be distressing, and intensive inpatient-based therapy programs require the comprehensive assessment of risk.

Conclusions: The inpatient treatment of people with OCD is an important management option that needs to be well considered and managed. Admissions often require close monitoring of risks, additional support to staff who may be unfamiliar with OCD, addressing comorbidity, pharmacotherapy and exposure and response prevention therapy.

1. Introduction

Obsessive-compulsive disorder (OCD) is characterised by recurrent and intrusive thoughts, images or impulses (obsessions) and repetitive behaviours or mental acts (compulsions) [1]. OCD is a debilitating disorder which is both distressing for the individual and their families, but also associated with significant functional impairment and socioeconomic burden for societies [2]. First line treatments for OCD include selective-serotonin reuptake inhibitors (SSRIs) and exposure and response prevention therapy (ERP) [3–5]. Typically, ERP is administered on an individual or one on one basis as an outpatient, however group treatment programs have developed to more efficiently deliver ERP and to potentially lead to more rapid and more significant treatment responses [6–12]. Both inpatient and outpatient group treatment programs exist for OCD. Most inpatient programs are based on the principles of ERP. The Canadian Treatment Guidelines for OCD briefly mention that intensive OCD treatment can be delivered in inpatient or residential settings [13].

Thirty-two inpatient or residential treatment programs have been reported in the literature in the form of case reports and a meta-analysis was conducted by Veale et al. [14]. The meta-analysis [14] reports that such programs have been reported to have a robust effect size with significant reductions in Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) scores (mean reduction of 10.7 points). The meta-analysis also reports that improved treatment outcome was associated with being married or cohabitating, whereas poorer outcomes were associated with hoarding symptoms and comorbid alcohol use disorder.

The prevalence of OCD as a primary diagnosis in acute public inpatients ranges from 0.3 to 1.2 per 100,000 admissions in some settings [15,16]. Patients admitted to hospital with OCD often have significant comorbidity and long length of stays (See Table 1). This paper will explore the indications for inpatient admissions for OCD, the treatments that are provided in hospital, common complications or pitfalls and provide general principles to optimise inpatient admission outcomes.

2. Indications for admission

Admission to an inpatient facility for OCD is usually driven by a need for intensive, structured care, with continuous monitoring and multi-disciplinary treatment. Dedicated facilities for the treatment of OCD may not always be available, and in emergencies, placements in general psychiatric wards may be required. Reasons for inpatient care relate to extreme severity, non-compliance with medication or cognitive-behavioural therapy (CBT), heightened risks including self-neglect and suicidal risk or treatment-resistance.

Patients with OCD may exhibit extreme self-neglect, failing to manage basic activities of daily living (ADLs) such as ensuring bodily hygiene, using sanitary ware such as the toilet or menstrual protection and reducing food and fluid intake, leading to dangerously low body weight and impaired kidney function. This necessitates intensive

support, particularly when familial support is lacking, or caregiver burden has escalated to burnout. In some cases, patients who are neglecting their personal hygiene refuse to be touched and so nursing intervention to aid self-care and protect dignity and health becomes essential.

Non-adherence to pharmacotherapy (often due to contamination fears or misconceptions about medications exacerbated by frequent comorbid health anxiety) and psychological therapies can lead to hospital admission. Medication for OCD is indicated in the presence of comorbid severe depression. Combining CBT and medication optimizes outcomes [32] and hospitalization may be necessary to ensure adherence and support intensive ERP. Treatment resistance may also warrant inpatient admission, where intensive CBT with ERP can be delivered and off-label medication intensively monitored.

The risk posed to self or others resulting from violent behaviour is another factor that influence the decision for inpatient care. Historical underestimations of suicide risk in OCD contrast with evidence showing a significantly elevated suicide risk, influenced by comorbidities such as mood disorders, substance misuse, personality disorders and body dysmorphic disorder ([33,34]; de la Cruz et al., [35]; [36]). Risk to others may include verbal or physical aggression towards caregivers (particularly if rituals are challenged) or neglect of dependents' needs. Extreme hoarding is a specific form of compulsive behaviour that can present societal risks and may require inpatient intervention.

3. Involuntary detention

Involuntary psychiatric hospital admissions are enabled by the Mental Health Acts in countries around the world. Typically, this is indicated if the individual is a risk to themselves or others, or if they are unable to care for themselves, due to a mental illness ([37]; UN Human Rights Office of the High Commissioner; [38]). Involuntary admission, however, is very uncommon for those with OCD, and is mainly observed for those who are actively suicidal, display psychotic symptoms, or have a mood disorder. The literature describing involuntary detention for patients with OCD is very limited. Typically studies and meta-analyses which have examined involuntary admissions do not mention OCD specifically, although it may be included in an "other disorders" category [39]. Those with OCD typically do not pose a risk to themselves, and even less so to others, however, some compulsions may put health at risk and limit the sufferer's ability to care for themselves [40]. Examples of such risks are often indications for admission and are given in the previous section of this paper. Structured assessments for comorbid conditions such as depression or a personality disorders may be useful as these diagnoses can increase the likelihood of involuntary admission and poorer outcomes. That said, involuntary detention should be avoided if possible [37]. Instead, voluntary inpatient treatment should be attempted first to protect the autonomy and dignity of the individual suffering from OCD, and to reduce the ethical challenges and risk of trauma associated with involuntary treatment [41].

Table 1
Papers reporting obsessive-compulsive disorder treatment programs in chronological order, and their outcomes.

Paper authors	Sample characteristics	Sample size	Program description	In-patient, residential or day program	Duration of program	Outcomes	Predictors of Y-BOCS reduction
Balachander et al., 2020a, b. Bengaluru, India (NIMHANS)	-Mean age 29.54 (SD = 10.77) -Y-BOCS mean 29.9 (SD = 4.5) -Non-responsive to >2SRIs (83%)	420 over six years (2012–2017)	-4-5 individual ERP sessions per week -Pharmacotherapy	In-patient	42.7 days (SD = 25.3)	-11.8 mean reduction in Y-BOCS -50% response	-Shorter duration of illness -Better insight -Less contamination/washing symptoms
Nanjundaswamy et al, 2020. Bengaluru, India (NIMHANS)	-Mean age 29.79 (SD = 11.67) -Y-BOCS mean 29.38 (SD = 5.7) -86% had received a trial of an SRI for >12 weeks -Mean number of SRI trials was 1.57 (SD = 1.19)	58 consecutive patients over 12 months (2015–2016)	-5-6 individual ERP sessions per week -Family involvement -Pharmacotherapy	In-patient	46.1 days (SD = 26.0)	-12.7 mean point reduction Y-BOCS -60% response -55% response at 2 month follow-up	-Better insight
Taube-Schiff et al, 2020 Toronto, Canada (Sunnybrook Hospital)	-Mean age 34 (SD = 14.55) -Y-BOCS mean 29.21 (SD = 5.9)	19 over 12 months (2017–2018)	-2-3 individual ERP sessions per week -3-4 h ERP per day -Group ACT, mindfulness, DBT and art therapy -Pharmacotherapy	In-patient with option to step down to day program	Variable, but often up to 84 days (12 weeks including a 4-6 week day program 2-3 times per week)	-12.2 mean reduction in Y-BOCS	-Not presented -Qualitatively, participants valued ERP, group therapy, the intensity of the service and staff support.
Hojgaard et al, 2020 Oconomowoc, USA (Rogers Memorial Hospital)	-Mean age 15.56 (SD = 1.20, range 13–17) -Mean CY-BOCS-SR = 25.65 (SD = 5.63)	314 over 11 years (2005-2016)	-26.5 h ERP per week -Pharmacotherapy	Residential	Average length of stay 75.43 days (SD = 34.24, range 5 to 213 days)	-11.35 point reduction in CY-BOCS-SR.	-No significant predictors of treatment response.
Siwiec, Riemann & Lee, 2019 Oconomowoc, USA (Rogers Memorial Hospital)	-Mean age 29.7 (SD = 11.5) -Mean Y-BOCS = 25.88	379 over 5 years (2012–2017)	-4.5 h ERP weekdays and 2.5 h ERP weekends -Group therapy -Pharmacotherapy	Partial hospitalization, intensive outpatient or outpatient treatment	Variable (Mean 58.8 days, range 202 days)	-11.65 mean reduction in Y-BOCS	-Lower obsession severity. -Less comorbid trauma reported at admission.
Veale et al, 2016 London, UK (Bethlem Royal Hospital)	-Mean age 37.6 (Range 18–80) -Y-BOCS mean 30.8 (SD = 6.00)	418 over 11 years (2001–2012) – 12 week program 54-2 week program Retrospective	-ERP (4 h individual per week) -Group sessions -Occupational therapy and activity scheduling -Home visits and assessments with families -Pharmacotherapy	Residential – 12 week and 2 week intensive program Travelling home over the weekend to carry out behavioural experiments was encouraged	84 days with option of extension of a further 28–42 days, or 14 days intensive	-12.2 mean reduction in Y-BOCS in 12 week program -8.2 mean reduction at 6–12 month follow-up -9.28 mean reduction in Y-BOCS in 2 week program (no follow-up Y-BOCS)	No significant predictors of Y-BOCS reduction. -Early discharge from the program was predicted by anti-psychotic use, employment, history of alcohol abuse and depression on admission.
Leonard et al, 2016. Oconomowoc, USA (Rogers Memorial Hospital)	-Adolescents with mean age 15.45 (SD = 1.22) -90% had attempted previous outpatient ERP therapy -84.9% were taking an antidepressant on admission	172 over eight years (2005-2013)	-ERP (26.5 h per week) -5 individual ERP sessions per week -Parents contacted once per week -Pharmacotherapy	In-patient	78 days (SD = 36)	-13.2 mean reduction in CY-BOCS -79.1% had a 25% reduction in CY-BOCS	*
Dowling et al., 2016. Melbourne, Australia (The Melbourne Clinic) [17]	-Mean age 32.31 (SD = 12.44) -Y-BOCS mean 28.69 (SD = 5.67) -88% had prior psychotropics	49 over 12 months (2013–2014)	-Fixed three-week program -Group ERP, psychoeducation, CT, mindfulness. -Pharmacotherapy	In-patient	21 days (fixed)	-8.4 mean reduction in Y-BOCS-SR -39% response -only 51% returned for one month follow-up	-Treatment adherence -Treatment adherence was predicted by treatment readiness, perfectionism and intolerance of uncertainty, greater

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Table 1 (continued)

Paper authors	Sample characteristics	Sample size	Program description	In-patient, residential or day program	Duration of program	Outcomes	Predictors of Y-BOCS reduction
Brennan et al, 2014. Belmont, USA (McLean Hospital)	-82% had prior psychological treatment -Mean age 33.5 (SD = 13.8) -Y-BOCS mean 26.7 (SD = 5.6) -87% had received either past ERP or medication -Duration of OCD 18.8y (SD = 13.4) -Age of onset 14.3y (SD = 9.6)	287 over two years (2011–2013)	-2-4 h per day ERP -Pharmacotherapy -Social work to address family dynamics and aftercare planning	In-patient or partial hospital levels of care	45 days average with 25% of patients staying at least 3 months.	and mean reduction had reduced to 6.29 -Not reported, but there appears to be 6–8 point Y-BOCS reduction from the graph. -Rapid reduction in the first month and more slow reduction in the next two months	insight, higher initial depression severity. -Higher baseline Y-BOCS scores. -Lower hoarding scores. -Less alcohol use in the past year.
Bjorgvinsson et al, 2013. Houston, USA (Menninger Clinic)	-Mean age 32.5 (SD = 11.2) -Y-BOCS mean 26.5 (SD = 5.9)	46 over four years (2004–2008)	See Bjorgvinsson et al, 2008.	Inpatient	Mean 43 days (range 14 to 84 days).	-7.5 mean reduction in Y-BOCS-SR score	-Higher baseline Y-BOCS scores. -Greater change in depressive symptoms. -Greater change in beliefs associated with responsibility and threat estimation.
Detto, Pozza & Caradeschi, 2013 Florence, Italy (Poggio Sereno Clinic) [18]	-Y-BOCS mean 28.7 (SD = 6.1)	38	*	Inpatient	35 days	-10.3 mean reduction in Y-BOCS score	*
Volderholzer et al., 2013 Friburg and Lubeck, Germany [19]	-Y-BOCS mean 25.3 (SD = 4.6)	60	*	Inpatient	Mean 91.0 days (SD = 39.9)	-11.2 mean reduction in Y-BOCS score	*
Adams et al., 2012 Rogers Memorial Hospital Oconomowoc, Wisconsin, US [20]	-Y-BOCS mean 27.4 (SD = 6.5)	160	*	Inpatient	Mean 58.1 days (SD = 25.1)	-12.2 mean reduction in Y-BOCS score	*
Gonner et al., 2012 Bad Durkheim, Germany [21]	-Y-BOCS mean 25.6 (SD = 5.4)	102	*	Inpatient	Mean 51.8 days	-9.0 mean reduction in Y-BOCS score	*
Zurowski et al., 2012 Lubeck, Germany [22]	-Y-BOCS mean 26.1 (SD = 3.7)	20	*	Inpatient	84 days	-12.9 mean reduction in Y-BOCS score (SD = 3.6)	*
Bochen et al., 2010 Springfield Hospital, London	-Y-BOCS mean 34.7 (SD = 4.2)	*	*	Inpatient	Mean 135.1 days (SD = 59.5)	-10.4 mean reduction in Y-BOCS score	*
Langner, Laws & Roper, 2009 Windach, Bavaria, Germany [23]	-Y-BOCS mean 24.2 (SD = 6.4)	*	*	Inpatient	Mean 77.7 days (SD = 27.3)	-10.9 mean reduction in Y-BOCS score	*
Stewart et al, 2009 Belmont, USA (McLean Hospital)	-Y-BOCS mean 24.7 (SD = 6.2)	61 over 12 months	See Stewart et al, 2005.	Intensive residential treatment	Outpatient treatment continued after discharge from residential treatment.	-8.4 mean reduction in Y-BOCS score -Improvement maintained at 1 month, 3 months and 6 months. -97.2% had significant and long lasting improvement.	-Relapse was associated with living alone, and not having comorbid illness.

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Table 1 (continued)

Paper authors	Sample characteristics	Sample size	Program description	In-patient, residential or day program	Duration of program	Outcomes	Predictors of Y-BOCS reduction
Bjorgvinsson et al, 2008 Houston, USA (Menninger Clinic)	-Mean age 15.3 (range 13–17) -Y-BOCS mean 23.9 (SD = 8.6) -All had failed to respond to outpatient treatment	23 over 1 year (2005-2006)	-ERP – 90 min supervised mornings, 60 min self-directed three times per week evenings -Goal setting -Communication with families -Aftercare planning -Pharmacotherapy	In-patient	Mean 66.5 days (SD = 3.96, range 28–147 days)	–9.6 mean reduction in CY-BOCS score	-Higher baseline scores were associated with larger reductions in OCD and depression severity scores (not significant).
Drummond et al, 2007 London, UK (Springfield Hospital)	-Mean age 37 (SD = 13.8, range 18–61 years) -Mean duration of OCD 18.4 years (SD = 10.9, range 4–40 years) -Y-BOCS mean 29.6 (SD = 5) -Moderate to severe depression (Mean BDI = 25.4)	26 patients over 1 year (2004–2005)	-Ten bed in-patient unit for those patients who cannot be managed as out-patients. - Daily, individualized behavioural therapy, -Cognitive reattribution or psychoeducational methods such as DIRT -Pharmacotherapy	In-patient	Mean 104 days (SD = 58.2, range 2 days to 6 months)	–10.7 mean reduction in Y-BOCS score	*
Fricke et al., 2006 Hamburg, Germany [24]	-Y-BOCS mean 25.6 (SD = 5.4)	*	*	In-patient	58.8 days (SD = 28.7)	–10.3 mean reduction in Y-BOCS score	*
Kuelz et al., 2006 Freiburg, Germany [25]	-Y-BOCS mean 24.1 (SD = 6.0)	*	*	In-patient	84 days	–10.4 mean reduction in Y-BOCS score	*
Rufer et al., 2006 Hamburg, Germany [26]	*	1993–1995	*	In-patient	70 days	–9.8 mean reduction in Y-BOCS score	*
Kordon et al., 2005 Germany [27]	-Y-BOCS mean 27.6 (SD = 5.8)	*	*	In-patient	102 days	–14.3 mean reduction in Y-BOCS score –14.9 mean reduction in Y-BOCS score at 1 year –12.5 mean reduction in Y-BOCS score at 2 years	*
Rufer, Hand et al., 2005 Multi-centre, Hamburg, Germany [28]	-Y-BOCS mean 27.6 (SD = 4.3)	1993–1995	*	In-patient	63 days	–11.2 mean reduction in Y-BOCS score –12.7 mean reduction at follow-up that occurred at a mean of 7.2 years.	*
Stewart et al, 2005 Belmont, USA (McLean Hospital)	-Mean age 32.9 (SD = 11.5, range 2–65 years) -Y-BOCS mean 26.6 (SD = 6.1) –96.9% had received either serotonergic medication and/or ERP	403 over 6 years (1997–2003)	–2-4 h CBT daily -Weekly pharmacotherapy review -Social work review -Weekly group psychotherapy on topic such as scrupulosity, violent obsessions and motivation.	In-patient	Mean 66 days (SD = 70, range 1–531 days)	–8.0 mean reduction in Y-BOCS score	-No predictors.
McKenzie & Marks, 2003 London, UK (Bethlem Royal Hospital)	-OCD had failed to improve with treatment elsewhere -Mean age 37 (range 18 to 65 years)	218 over 11 years (1989–2000)	-Self-exposure therapy -Training of relatives to become co-therapists -Pharmacotherapy -Home visits before discharge	Residential	*	–8.0 reduction in Y-BOCS score in 30 patients from 1996 to 1998.	*

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4. Hospital treatments

A frequent objective of hospitalization is to address treatment-related issues. One of the most common goals is to provide intensive exposure and response prevention (ERP), which may be combined with other psychosocial approaches. Patients may benefit from inpatient nursing support, learning distress tolerance strategies, the ward milieu and its structured daily activities and routines. Other objectives may be related to psychopharmacological strategies, such as introducing specific or experimental drug treatments, ensuring adherence to medication, and managing or monitoring side effects. Established predictors of refractoriness, such as sensory phenomena, tic comorbidity, poor insight, early-onset and comorbid personality disorders, e.g. anankastic, need to be considered as patients who are admitted to hospital are more likely to be treatment refractory [42,43]. Occasionally, patients have been unable to take medication as outpatients, whilst others may require nutritional support with nasogastric feeding.

Other types of treatments that may require hospitalization include the use of neurostimulation techniques. Among these, an electroconvulsive therapy (ECT) course may be used in certain cases [44], however ECT is not an accepted treatment for OCD and is more likely to be used when there is co-occurring severe major depression. Another neurostimulation technique is deep brain stimulation (DBS), which requires hospitalization both before electrode implantation and after neurosurgery to monitor initial outcomes and determine the optimal neurostimulation parameters. Commencement of a course of transcranial

magnetic stimulation (TMS) therapy may also be considered for inpatients especially when symptom provocation (with its similarities to ERP) is difficult to administer as an outpatient.

Although there are no specific tests to diagnose OCD, basic or extended laboratory tests, neuroimaging, electroencephalogram, and electrocardiogram may be necessary in some cases and may assist with predicting refractoriness [45]. A proper diagnostic workup is necessary to detect general medical causes of OCD, identifying physical factors that may limit treatment response, or preventing and managing side effects. A recent study [46] involving 61 OCD inpatients found a probable general medical cause in 8% of cases and a possible general medical cause in another 8% (mainly immune and genetic syndromes). This study also found that 17% of cases had ECG abnormalities, 7% showed EEG slowing, and 19% had relevant MRI abnormalities. Prolongation of the QT interval should be excluded with an ECG when high doses of clomipramine, citalopram or escitalopram are prescribed.

While a basic laboratory analysis—including a complete blood count, electrolytes, and basic biochemistry (glucose, lipids, electrolytes, liver function, and renal function)—is recommended for all inpatients, additional lab tests (thyroid hormones, prolactin, vitamin D, cobalamin, folic acid) or examinations may be determined on an individual basis depending on clinical findings. Furthermore, if symptoms are suggestive of Paediatric Acute-Onset Neuropsychiatric Syndrome, if there are signs of immune activation and vasculopathy, or if the clinical presentation is atypical [47,48], screening for immune activation markers may also be indicated.

Table 1 (continued)

Paper authors	Sample characteristics	Sample size	Program description	In-patient, residential or day program	Duration of program	Outcomes	Predictors of Y-BOCS reduction
Muller-Svitak et al., 2002	-Y-BOCS mean 25.8(SD = 5.4)	23	*	In-patient	72.1 days	-11.9 reduction in Y-BOCS score -11.7 reduction in Y-BOCS score at 3 month follow-up.	*
Bavaria, Germany (Inpatient unit) [29]							
Hohagen et al., 1998	-Y-BOCS mean 28.4 (SD = 3.8)	*	*	In-patient	63 days	-12.5 reduction in Y-BOCS score	*
Mannheim, Hamburg and Freiburg, Germany (Multiple in-patient units) [30]							
Drummond et al, 1993	-Mean age 40 (SD = 14, range 18–73 years) -84% failed to respond to previous treatments -Mean duration of disorder 16 years (SD = 13.5) -Mean of 9.9 months in acute admission wards prior to referral	49 over 3 years (1985–1988)	-ERP -Prompting and pacing -Audiotaped habituation -Thought stopping -Cognitive therapy -Pharmacotherapy -Surgery (leucotomy)	In-patient	*	-Y-BOCS was not used -63% had improved -Improvements maintained at 19 month follow-up -3 patients suicided within 4 h of admission -9 discharged against medical advice -5 discharged due to unacceptable behaviour -9.3 mean reduction in Y-BOCS score.	-Checking compulsions were more likely to be associated with good outcome.
London, UK (Springfield Hospital)							
Calvocoressi et al., 1993	-Y-BOCS mean 27.6 (SD = 8.8)	66 over 7 years (1985–1992)	-ERP -Pharmacotherapy	In-patient	Mean 101 days (SD = 53.9)		*
Connecticut, USA (Yale University General In-patient Ward) [31]							

Response is defined as >35% Y-BOCS reduction. BDI=Beck Depression Inventory, ERP = Exposure and response prevention therapy, CT = Cognitive therapy, DIRT = Danger Ideation Reduction Therapy, *Limited description, missing, or not presented in paper.

5. Pharmacotherapy

OCD is distinct from psychiatric disorders such as major depressive disorder, social anxiety disorder, and panic disorder, as it responds exclusively to serotonergic medications, while noradrenergic agents are ineffective [49]. Consequently, selective serotonin reuptake inhibitors (SSRIs), including clomipramine, fluoxetine, fluvoxamine, paroxetine, citalopram, sertraline, and escitalopram, are recommended as the first-line pharmacological treatment for OCD and related disorders (e.g. [44,50]). Despite regulatory guidelines from agencies such as the US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) suggesting dosage ranges similar to those used in major depression and other anxiety disorders, clinical guidelines [51,52] indicate that higher doses are often necessary for optimal treatment efficacy in OCD. A recent study [53] supports the safety and tolerability of high-dose SSRI treatment (except for clomipramine). The hospital setting may allow for more rapid increases in SSRIs and clomipramine, the closer monitoring of QT intervals and monitoring of blood levels when higher doses of clomipramine are used. When discussing management plans with patients and their carers, the slower response to high dose SSRI therapy in OCD relative to major depression, needs to be considered. If an admission of less than a month is planned and the maximum response to an SSRI occurs at three months, the goals of an admission should not focus solely on the reduction of OCD symptoms secondary to an oral SSRI.

Although intravenous clomipramine and citalopram have been suggested for severe and treatment-refractory OCD [54], the evidence is limited and larger, controlled trials are needed to draw definitive conclusions [55]. There is inadequate evidence currently to support the routine use of intravenous agents for OCD. This includes intravenous ketamine which may be useful when there is comorbid major depression. Should intravenous therapy be trialed, patients are best admitted to a hospital or day hospital to have their vital observations closely monitored as suggested by Koran et al. [51,52].

In cases where tic disorders are present, augmentation with low-dose dopamine partial agonists (e.g., aripiprazole 2.5 mg) or dopamine antagonists (e.g., risperidone 0.5 mg) has shown efficacy (Bandelow et al., [56]; [57]). The commencement of a low dose dopaminergic agent in the hospital setting may be useful for patients with behavioural disturbance, poor response to SSRIs, concerns about side effects, and may lead to a more rapid reduction in obsessions and compulsions than would occur with SSRIs. Optimal outcomes are typically observed when SRIs are combined with ERP. The inpatient setting may facilitate the introduction of higher doses of SSRIs and the commencement of ERP for more severe OCD with the hope that this can be continued in the outpatient or community setting.

6. Psychological therapy

Patients with severe, treatment-resistant OCD (Y-BOCS ≥ 30) may benefit from intensive, multi-professional CBT/ERP in a specialist inpatient setting. ERP is regarded as the gold-standard treatment [58] and achieves significant symptom reductions (11.8–13.2 Y-BOCS points), justifying its role in managing severe OCD [6,7,59,60]. To maximize engagement, ERP should be structured, graded, and delivered both individually and in groups, as group-based ERP enhances peer support and motivation [9,10,61]. Integrating ERP into daily ward routines ensures consistent practice and reinforces exposure principles, greater treatment adherence and long-term effectiveness [14,62,63]. It should be noted that patients can struggle to understand and to complete ERP tasks and this is often related to the distress associated with their symptoms.

A multidisciplinary approach is essential to support engagement and treatment fidelity [64]. Nurses and occupational therapists can embed ERP principles in ward-based tasks, reinforcing exposure throughout the day [65,66]. Ongoing staff training is fundamental to maintaining ERP

fidelity, ensuring that best practices remain embedded in-service delivery (NICE, 2005).

Subsequent home visits should facilitate real-world exposure [51,52], while family psychoeducation is necessary to reduce accommodating behaviours after discharge from hospital [67]. Structured follow-ups are vital to sustaining long-term improvements [68,69].

7. Social issues

Hospital admission represents a crucial aspect of stepped-care approaches for patients with severe OCD. Admissions to hospital can occur in the context of a range of social stressors such as loss of occupation, ultimatums given by partners or family members, separation, family conflict, or a new baby. Although an inpatient admission can be highly effective in reducing symptom severity when outpatient strategies are insufficient [70] and in providing an opportunity to intensively address social issues, an admission can also present significant psychosocial challenges, affecting treatment trajectories and social reintegration post-discharge.

One of the challenges of hospitalization is social stigma. Social stigma related to psychiatric hospitalization remains a significant obstacle to early treatment access for patients with OCD. Despite the ego-dystonic nature of OCD symptoms, patients often delay seeking help due to fear of social judgment, exclusion, or internalized shame, which can be exacerbated by the prospect of hospitalization [71,72]. Indeed, comorbidity with obsessive-compulsive personality disorder may further delay the treatment gap [73]. These stigma-driven aspects significantly contribute to a longer duration of untreated illness (DUI), consistently associated with poorer clinical outcome, increased treatment resistance, and greater functional impairment [74–76].

Shame related to unacceptable/taboo thoughts has been specifically associated with maladaptive coping strategies, including social withdrawal, delayed treatment seeking, and reluctance to express symptoms [77,78]. Intense shame and anxiety about giving up compulsive behaviours—which initially serve as maladaptive emotional regulation strategies—can reinforce social withdrawal and limit effective therapeutic engagement. Another significant concern from the patients' viewpoint is the fear and anxiety associated with behavioural changes required by new treatments and settings. Since compulsive behaviours play a critical role in daily emotional regulation, patients might fear that treatment-induced behavioural changes could exacerbate their anxiety [79].

Ultimately, the psychosocial impact of hospitalization extends beyond the individual patient to family systems. Family members often experience emotional exhaustion, financial burdens, and high levels of involvement in accommodating OCD symptoms [80,81]. While hospitalization may temporarily reduce caregiver burden, insufficient family engagement during inpatient care risks long-term disempowerment and suboptimal treatment outcomes.

In light of these considerations, targeted psychoeducation interventions and long-term follow-up should be integral components of inpatient care models. Moreover, structured family involvement throughout inpatient treatment and discharge planning is essential to support therapeutic outcomes in patients with OCD.

8. Family accommodation

Family accommodation is a significant barrier to effective treatment in OCD. Family members can inadvertently support or enable the individual's compulsive behaviours, thereby reinforcing the disorder [82]. Family accommodation (FA) involves actions taken by care-givers to alleviate the distress of the patient, often at the expense of their own well-being and the overall treatment process. Behaviours may include participating in rituals, providing reassurance, or making lifestyle adjustments to avoid triggering obsessions [83]. In inpatient settings, addressing family accommodation might be crucial for promoting

patient independence and enhancing treatment outcomes [84].

One of the first steps in managing family accommodation is to provide psychoeducation to both patients and their families [82]. Inpatient treatment provides a unique opportunity to foster independence among patients; moreover, it offers a safe setting to use exposures that at home might be more difficult and risky to implement due to possible problematic and even aggressive behaviours. Family members should be encouraged to establish firm, yet supportive boundaries regarding the patient's compulsive behaviours [83]. This may involve limiting physical proximity during rituals or implementing structured family visits that prioritize therapeutic goals [84].

On one hand, family members may be more likely to engage in accommodating behaviours when OCD symptoms are severe in order to alleviate the affected individual's distress and facilitate functioning. While FA severity was found to correlate with OCD symptom severity [80], it is not clear whether it associates with treatment outcome [85]. In adults, family-integrated therapy has shown superior efficacy compared to individual ERP across several outcomes [86]. Interventions that explicitly addressed family accommodation were correlated with stronger effects on functional impairment [81] and more substantial reductions in patient-reported depression [86] than those that did not directly address FA. FA may reduce OCD symptom improvement and affect long-term outcome of inpatient/residential intensive therapy. Treatment results may be enhanced by addressing FA when patients transition to the home setting, thus attempting to extend the therapeutic benefits to the familial context and reducing the risk of symptom recurrence.

In a study investigating 315 adults with OCD undergoing an intensive/residential treatment involving ERP with family-integrated approach, the authors found that increases in FA from discharge to 1-month follow-up predicted increases in OCD symptom severity from 1-month to 6-month follow-up [84]. The findings have therapeutic relevance, indicating that elevated FA during follow-up may diminish long-term therapy benefits and predispose to relapse [85]. Therefore, enhancing the emphasis on FA throughout persons' transfer home, possibly via videoconferencing sessions or consultations with outpatient physicians, may optimise treatment efficacy and facilitate the preservation of clinical progresses.

9. Common complications

While inpatient admissions aim to improve OCD symptomatology, the potential for severe complications, must be carefully considered and monitored. Suicidality is important to consider, especially in severely depressed or highly agitated patients. Drummond [87] highlighted a tragic instance where a patient with comorbid severe Major Depressive Disorder (MDD) completed suicide within four hours of admission. Veale et al. [11] also highlighted increased suicidality as a complication of intensive residential programme (IRP) leading to early discharge. The risk of self-harm and suicidality due to the significant distress associated with exposure and response prevention (ERP), close interpersonal interactions, and the use of communal spaces requires comprehensive assessment. This risk is particularly pronounced in patients with emotional regulation issues, such as those diagnosed with Emotionally Unstable Personality Disorder (EUPD) or Autism Spectrum Disorders (ASD) necessitating close monitoring and intervention. Aggression and frustration stemming from interrupted OCD rituals may also increase risks to caregivers or result in unacceptable behaviours, potentially necessitating early discharge or more restrictive interventions [87]. Hospital risk assessment protocols are useful in assessing for, monitoring and managing risks of harm to self or others.

Some patients with OCD requiring inpatient care are unable to access specialist psychotherapy wards, e.g., owing to general unavailability of specialist services, or because they are acutely suicidal, severely depressed, or detained involuntarily. In such cases, inpatient care takes place in a general psychiatry ward and this presents specific challenges

as staff may be unfamiliar with the needs of patients with OCD including the rigid application of specific OCD-related rules, such as the need for personal access to toilets. Importantly, inconsistency in the way different staff members approach a patient with OCD can lead to conflict and poor outcomes. Hospital In-reach by clinicians experienced in the treatment of OCD to educate and support inpatient staff on a case-by-case basis can be very helpful in such situations.

Concerns about using hospital toilets due to fear of contamination may lead patients to drastically restrict food and fluids during the initial admission phase, increasing the risk of acute kidney injury (AKI) and malnutrition. These patients require vigilant nursing to ensure adequate intake and may need immediate discharge if these interventions fail. Drummond et al. [88] reported chronic kidney impairment, marked by elevated blood urea and creatinine levels, in patients with severe and treatment-resistant OCD. These risks are especially pertinent given the common (17%) comorbidity of eating disorders (ED) with OCD [89]. Restrictive eating behaviours or purging may intensify under ERP-related distress. Additionally, excessive fluid intake needs monitoring, as compulsive drinking—often driven by beliefs about water's cleansing properties or until it “feels right”—can lead to potentially lethal hyponatremia [90].

An admission may also detect pre-existing or exacerbated dermatological problems due to excessive washing and the use of harsh detergents or abrasive tools. These practices can result in conditions such as atopic dermatitis, irritant toxic dermatitis, or dry skin eczema (eczéma craquelé) [91]. Such skin integrity disruptions can lead to secondary infections, necessitating close monitoring. Other reported complications of OCD that may lead to early discharge include severe self-neglect, alcohol misuse—which is also linked to poorer outcomes—and disengagement [11,12]. The potential for serious complications necessitates rigorous risk assessment, vigilant monitoring, and careful patient selection prior to admission.

10. Admissions for people with ocd and autism spectrum disorders

Although OCD is frequently comorbid with ASD, research on inpatient treatment for individuals with both diagnoses is limited. Overall, there is evidence for less favorable outcomes for those with OCD and ASD, compared to OCD alone, in structured inpatient CBT treatment programs [92]. Factors that negatively influence treatment outcomes in this population include poorer insight, limited abstraction capability, greater cognitive and behavioural inflexibility, worse global functioning and social communication impairment, along with more frequent additional comorbid psychopathology, and higher levels of family accommodation [93–96]. Adjustments to evidence-based inpatient treatment is also needed for those with OCD and ASD, including providing longer treatment duration, prioritizing distress tolerance over habituation to exposures, addressing sensory sensitivities, incorporating adaptive and daily living skills, and limiting cognitive techniques that utilize abstraction [96]. Additional lifestyle modification interventions should include improving ADL's, dietary changes, planning for employment, and developing a routine schedule that includes exercise and chores. Individuals with OCD and ASD have challenges generalizing information from treatment to the real-world, so caregivers and family members should consistently be involved in the treatment plan and be taught how to reinforce distress tolerance skills and reduce accommodation of disruptive and obsessive behaviours. Incorporating mindfulness skills, dietary interventions, modeling social interactions, and providing behaviour-specific praise, in addition to emotional support for the caregiver and family members, is also key [97]. Lastly, upon discharge from an inpatient program, an intensive outpatient program may be required to provide the needed practice and reinforcement to retain new skills for those with comorbid ASD and OCD. Comprehensive programs such as the Regulating Together intensive-outpatient program [98], target multiple domains using both cognitive and behavioural strategies

to build social-cognitive understanding, reduce maladaptive behaviours, [99] and decrease emotion dysregulation in those with ASD [98,100].

11. Hospitalisation in low- and middle-income countries

A public mental health perspective emphasises that most mental health resources should be provided at a primary care level in outpatient settings [101]. Fewer resources are given to specialist services, and considerations of affordability and access entail that most individuals requiring such services would be seen in the community. When specialist services are integrated at primary care level, they should be delivered using “collaborative care models”, in which case managers coordinate the care of many individuals, with specialists providing targeted input as needed [102].

For historical reasons, however, most low- and middle-income countries rely extensively on inpatient treatment for people with psychiatric disorders, and global mental health advocates have therefore emphasized the importance of deinstitutionalization, and of expanding community-based outpatient clinics in such settings [101]. Global mental health has, however, largely focused on “serious mental disorders” (exemplified by schizophrenia) and “common mental disorders” (such as mood, anxiety, and substance use disorders). This has paid relatively little attention to OCD, despite its severe impact on functioning, and its relatively high prevalence [103].

It is notable that specialist centres of excellence for OCD have been established in several low- and middle-income countries including Brazil, China, India, and South Africa. These centres play an important role in evaluating and treating individuals with more severe OCD, and in helping to build expertise in interventions for OCD at primary and secondary care levels. While the bulk of those seen at such specialist centres of excellence are seen in an outpatient setting, more severe patients may be provided with inpatient care, allowing optimization of both pharmacotherapy and CBT, particularly exposure and response prevention [59,60]. Intensive, inpatient-based care for OCD has been shown to be an effective option for patients who are often resistant to medications and are either unresponsive or unable to practice outpatient CBT [59,60,62,63].

Further research is necessary to demonstrate the efficacy and cost-efficacy of specialist centres of excellence in low- and middle-income countries, both with regards to outpatient and inpatient services. Much work has been done on efficacy and cost-efficacy of task-shifting, with the involvement of community health workers, in such settings. However, in conditions such as OCD, specialist centres that provide a broad range of services – including inpatient hospitalizations – and that strengthen primary care and secondary services by accepting referrals and by knowledge-sharing, may have a key role.

12. Virtual hospitalization

Virtual hospitalization is an innovative approach to delivering intensive, continuous care in the frame of outpatient clinic, and could also replace physical hospitalization. Virtual hospitalization utilizes technology—including WhatsApp groups, remote monitoring, and specialized applications—to provide real-time support. At the Israeli Center for OCD, patients and their families are integrated into dedicated WhatsApp groups, facilitating 24/7 immediate communication with the treatment team. Patients report obsessive thoughts or compulsive urges as they arise, enabling prompt intervention. Some patients are required to record and share videos of their exposure exercises, ensuring adherence to therapeutic guidelines and preventing maladaptive coping mechanisms, such as reassurance-seeking from the environment (i.e., family members, friends, ChatGPT).

This model not only enhances patient accountability within their natural environment but also fosters independence rather than reliance on hospital staff. It allows for precise exposure therapy, guided by a consensus-driven approach among clinicians regarding intensity and

technique. Furthermore, virtual monitoring enables the safe administration of high-dose serotonin reuptake inhibitors (SRIs) while closely tracking side effects. Over the past decade, this approach has demonstrated effectiveness across a wide spectrum of patients, particularly those with severe OCD. Exclusion criteria include individuals at risk of suicide, aggression, or severe impulse control issues, who require different programs before joining virtual care. Given OCD's context-dependent nature, virtual hospitalization presents an effective additional intervention for outpatient treatment, and also an ecologically valid alternative that may replace traditional inpatient care.

13. Length of admission

The length of admission to an inpatient psychiatric facility varies according to the reasons for the admission and the duration of an inpatient program where this is being offered (see Table 1). Factors associated with longer inpatient psychiatric admissions include: comorbid major depression, comorbid psychotic disorders, self-harm, being single, being female, homelessness or stressors at home [104]. Clinical experience indicates that these factors are also associated with increased length of stay for people admitted for OCD. Admissions to psychiatric inpatient units for OCD vary in length from one day to over a year with most treatment programs being between 21 days (Dowling et al., [17]) to 135 days (Boschen et al., [105]) in duration (see Table 1). The mean duration of the inpatient programs listed in Table 1 is 69.5 days ($n = 27$). Longer admissions tend to include a component of psychiatric rehabilitation focusing on living skills, whereas shorter admissions may involve the need for a short period of containment when there are safety issues or acute stressors. Length of admission is also influenced by funding, for example in Australia, health funding reduces significantly when patients stay longer than three weeks and so programs are designed for a three-week period. Admissions may be shortened by a patient being unable to tolerate their exposure to obsessions, e.g. contamination obsessions, or the inability to complete compulsions. Treating staff may also encourage a shorter admission for patients at risk of avoidance and dependency to enable the patient to face their distressing home or work environment. Short admissions may have a role in containing risk, starting medication or exposure therapy, whereas longer admissions may be required to rehabilitate people with impaired function. Hence it is unlikely that there is an optimal length of admission for people with OCD. The programs listed in Table 1 appear to have resulted in similar reductions in Y-BOCS scores regardless of their duration. This finding supports the notion that the objectives of an inpatient admission are varied and are not only to reduce Y-BOCS scores.

14. Discharge planning

Effective discharge planning should ideally begin on the first day of admission, with community team involvement from the outset [106,107]. The goal is to support patients in maintaining the benefits of hospitalization within their home environment post-discharge, ensuring a smooth transition of care. Considering the severity and complexity of the kinds of illnesses requiring hospital-based care, the pre-discharge assessment should include an evaluation of daily living functioning to determine the patient's capacity for independent living, as well as a risk assessment, considering the high relapse risk [14,68,69], sometimes linked to suicide [108], neglect, and the need for caregiver support [68,69,109].

A multidisciplinary, integrated discharge plan involving patients, carers [109], hospital teams, and community mental health services is essential [107,110]. Efficient communication between these actors is of pivotal importance in effective discharge planning [111]. In many services, this takes place at a formal discharge planning meeting, where roles and responsibilities are agreed and documented.

For stable patients with mild to moderate OCD, the care plan should include ongoing outpatient psychiatric support, medication

management, and community therapy services [107]. Post-discharge, community-based treatments should focus on relapse prevention, starting with encouraging and monitoring long-term adherence to medication, as this is the critical evidence-based method for protecting against relapse [4]. Additionally, CBT booster sessions should be provided to support relapse prevention in the home environment [61]. Social and occupational support should be offered, including coordination with employers for reasonable work adjustments and a gradual return to work [112]. Peer support [113] and a focus on early relapse detection and intervention are crucial. Given that living alone is associated with a higher relapse risk [68,69], these patients may particularly benefit from enhanced social and occupational support. For patients unable to return to independent living due to ongoing severe or extreme OCD (including compulsive hoarding and other resistant symptoms), a comprehensive social care and occupational therapy assessment is necessary to determine the need for residential care in a specialized facility. This facility should be supported by staff with expertise in managing compulsive behaviours, and community psychiatric support should be provided alongside.

15. Education and training

Targeted training and education for mental health professionals, to optimise patient outcomes and mitigate mismanagement risks is critical for Obsessive-compulsive disorder (OCD), treated in general inpatient psychiatric units.

OCD is frequently mischaracterized in acute psychiatric settings due to its broad symptomatic heterogeneity, the often-concealed nature of its symptoms, and the distress associated with intrusive thoughts. Additionally, psychiatric inpatient units are often structured to manage other types of disorders (affective, psychotic, eating or personality in the case of specialist units), which makes the management of severe OCD presentations a challenge for many healthcare professionals. A critical barrier to effective inpatient management of OCD is the limited awareness of the disorder's presentation, particularly in first presentation cases (i.e. not previously diagnosed OCD) and in relation to the relatively diverse content of obsessional thoughts and compulsions that can be experienced (both within an individual and across cases of OCD). As obsessional thoughts are inherently unobservable and often concealed due to shame or fear of stigma, a clinician lacking expertise in OCD may overlook or misattribute these symptoms [114]. Similarly, compulsions—whether overt or covert (e.g., mental rituals)—may go unrecognized or misinterpreted, leading to inaccurate assessments and inappropriate treatment plans. Training programs should emphasize structured and empathetic clinical interviews to elicit intrusive thoughts and compulsive behaviours. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) Symptom Checklist [115] is a valuable tool in this regard, facilitating a comprehensive assessment of symptom domains, used alongside the core Y-BOCS itself (to quantify severity on admission and any change in response to treatment).

Misdiagnosis is a common pitfall in psychiatric units when treating severe OCD. Intrusive thoughts involving harm, aggression, or blasphemy may be mistaken for psychotic delusions, leading to unwarranted treatment with antipsychotic medication, where there is absence of offer of first line OCD treatments. Body-dysmorphic disorder obsessions can be misunderstood as psychotic symptoms – evaluating insight is critical in those cases [116]. Food avoidance due to contamination obsessions can be mistaken for an eating disorder (e.g. restriction of calories due to fear of fatness, like in the case of anorexia nervosa), particularly when there are physical sequelae of emaciation and malnutrition. Such misclassifications can result in unnecessary pharmacological burden and exacerbate distress or misguide psychological formulations. Differentiation between OCD and other comorbidities is paramount, as individuals with OCD frequently present with concurrent anxiety, depressive, or personality disorders. Co-existence of OCD and other disorders, such as hoarding disorder or alcohol use disorder, can worsen outcomes [14].

Training should incorporate case-based learning to refine differential diagnostic skills and ensure precise clinical formulations and diagnosis. The OCD phenomenology should become a key component in every mental health professional's quiver [4]. In some cases, a correct OCD diagnosis might then lead to consideration of transfer to a specialized unit for OCD, if available, for a specialized inpatient intervention [117].

Risk assessment frameworks in psychiatric units must be adapted to accommodate the complexities of OCD. A particularly problematic scenario arises when clinicians misinterpret intrusive ego dystonic thoughts about harm, experienced as part of OCD, as indicative of an imminent risk to others [7]. For example, a patient experiencing distressing obsessions about harming their child, as part of OCD, may be erroneously classified as high risk to others, leading to inappropriate restrictive interventions such as heightened supervision or unnecessary safeguarding actions. The same can happen to other types of obsessional thoughts e.g. self-harm, sexualized obsessions [118] or obsessions related to paedophilia. Training should reinforce the importance of distinguishing ego dystonic obsessions from genuine intent, with a structured approach to assessing actual risk. This necessitates a nuanced understanding of OCD phenomenology, requiring input from experienced clinical psychiatrists and psychologists.

Given the vast thematic variation in OCD symptoms, standardized training should familiarize staff with the range of obsessions and compulsions encountered in severe cases. A key component of staff upskilling is the use of specialized educational resources, such as pre-recorded webinars from independent OCD charities (like OCD-Action [119] and Orchard OCD [120] in the UK), as well as structured training modules developed by specialist treatment centres. Online platforms and professional networks provide additional avenues for continuing education, allowing staff to remain updated on best practices in evidence-based OCD management.

In particular cases, direct access to specialist services for advice on management is a crucial support mechanism for inpatient units with limited expertise in treating OCD. In some jurisdictions, regional or national OCD centres provide consultation services, offering expert guidance on complex cases and, in certain circumstances, accepting referrals for intensive treatment. Collaboration with these centres enhances the capacity of inpatient units to provide appropriate care, ensuring that severe OCD is managed in accordance with current clinical guidelines.

The role of psychological expertise in inpatient settings is indispensable. Clinical psychologists with experience in OCD should play a central role in formulating individualized care plans, guiding exposure and response prevention (ERP) strategies, and guiding the multidisciplinary team (MDT) members to maximize chances for an effective intervention. One key challenge in inpatient OCD management is the inadvertent reinforcement of compulsive behaviours by staff, family members, and/or peers. For example, well-meaning caregivers may unknowingly accommodate compulsions by providing excessive reassurance or facilitating avoidance behaviours. Staff supervision and training programs could address these maladaptive interactions, ensuring that staff adopt a stance that supports symptom reduction rather than reinforcement. The successful management of severe OCD in psychiatric units requires a robust, multi-faceted training approach encompassing diagnostic accuracy, OCD-phenomenology-informed risk assessment, and specialist consultation plus treatment plans. By implementing targeted educational initiatives and fostering collaboration with expert centres, mental health professionals can improve their competency in treating this complex disorder within the context of psychiatric units, ultimately enhancing patient outcomes and ensuring that inpatient care aligns with evidence-based principles.

16. Discussion

This consensus concludes that there is a role for inpatient admission of people suffering from OCD when necessitated by acute risk and or

significant functional impairment. The indications for admission may vary significantly and management plans need to be adapted to meet the individual patient's needs. Although the indications for admission vary and this can lead to variable lengths of admission, the delivery of education to patients, carers and staff, principles of exposure and response prevention therapy, family interventions, and pharmacotherapy were common components of inpatient treatment programs. A hospital admission also allows for more rapid titration of pharmacotherapy, a suitable environment for exposure when outpatient psychological therapies have failed, and an opportunity for lifestyle interventions.

As with admissions for other psychiatric disorders, admissions for OCD require a coordinated multidisciplinary team, investigations for precipitating biological factors, home visits and discharge planning. However, the risk of suicide from increased distress resulting from the admission should not be underestimated in patients with OCD and unique medical complications such as renal impairment and dermatological complications need to be considered. In low- and middle-income countries, there is a need to develop alternative community based or primary care treatment programs to avoid unnecessary admissions. Whilst in Israel, innovative and cost-effective programs such as virtual hospitalization are being implemented.

This consensus statement has attempted to be representative of world experts in the study of OCD by inviting members of the International College of Obsessive-Compulsive Spectrum Disorders (ICOCs). However, it is acknowledged that there are many other experts that did not contribute to this consensus statement and who may have had differing views in regard to the inpatient treatment of people suffering from OCD.

In conclusion, OCD can be a very distressing and disabling disorder and admissions may assist patients at times of heightened distress, heightened risk of self-harm and/or suicide, and reduced function. Clinicians need to be mindful of the importance of staff education (particularly in general wards that are not tailored for admissions of people with OCD), the risks of admissions, and the exposure principles that are helpful in caring for sufferers of OCD.

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