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Current Levels of Knowledge and the Impact of Psychoeducational Interventions on Understandings of Paediatric OCD Among School Staff: A Systematic Narrative Review

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Abstract

Obsessive-compulsive disorder (OCD) can be devastating for children, young people and their families. School staff are well-placed to aid early identification, as observed in other mental health conditions. As yet, little is known about their knowledge of OCD or the effectiveness of interventions to support young people with OCD, this systematic narrative review synthesised existing evidence. Six studies published between 1980 and 2023, involving 952 participants, were included and assessed using the National Institutes of Health Study Quality Assessment Tools. Findings indicate limited OCD knowledge among school staff, particularly regarding classroom accommodations and support. While interventions show promise in enhancing knowledge and support for young people with OCD, low methodological quality and limited lived experience involvement raises concerns around intervention effectiveness. Further, the validity of outcome measures used to assess effectiveness is unclear and does not involve families and young people to comment on any benefits resulting from support provision in schools. Future work should adopt participatory approaches to develop and evaluate interventions, including those with lived experience to create relevant and impactful content, ensuring knowledge of school staff and subsequent support is beneficial. This review underscores the need for rigorous, inclusive research to better equip educators to support students with OCD.

Lay Abstract

Obsessive-compulsive disorder (OCD) significantly affects children and young people (CAYP), with most cases beginning before age 25. Schools play a crucial role in identifying early signs of OCD, as they do with other mental health conditions. Little is known about school staff's understanding of OCD or of the training programmes aimed at improving this knowledge and ability to support CAYP with OCD. This work reviewed six studies published between 1980 and 2023, involving 952 participants, to evaluate current evidence. Findings show that school staff often lack the knowledge to provide appropriate support for CAYP with OCD in schools but do show potential for interventions to help improve this knowledge. However, the quality of studies in this review was low and often did not include CAYP and families with lived experience of OCD for creating interventions or checking if they work. Future work should include CAYP and families with lived experience of OCD to make sure interventions to improve knowledge of and support for CAYP with OCD are beneficial for CAYP. This work shows a need for support to improve school staff knowledge of OCD and ultimately support CAYP with OCD in schools.

Keywords

Obsessive-compulsive disorder, psychoeducation, interventions, OCD, education, educators, teachers, school staff, mental health literacy

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Background

Obsessive-compulsive disorder (OCD) is a mental health condition affecting 1% to 4% of the global population (BMJ Best Practice, 2022; NICE, 2024), with onset before age 25 in approximately 64% of cases (Solmi et al., 2022). OCD involves obsessions – distressing, persistent thoughts – and compulsions, or anxiety-relieving overt or covert behaviours, which perpetuate a distressing cycle of compensatory behaviour (APA, 2013; NICE, 2024). Compulsions are often contextually excessive or unrelated to the feared event or obsession (NICE, 2024). In children and young people (CAYP), OCD symptoms often involve family members and may include superstitious thinking, such as fearing harm to loved ones if rituals are not performed (WHO, 2023). CAYP may struggle to articulate these experiences or recognise their irrationality (APA, 2022; Lewin et al., 2010).

CAYP experiencing OCD symptoms may face academic and social challenges due to their attention being focused on obsessions and completing, or concealing, compulsions (Leininger et al., 2010). OCD symptoms can impact an individual's productivity and academic performance (APA, 2000; Woolcock & Campbell, 2005). For example, CAYP may demonstrate separation anxiety out of fear something may happen to loved ones, or a desire to return home to carry out checking rituals. Further, pressure to perform academically can increase stress levels and exacerbate symptoms in CAYP with OCD (Woolcock & Campbell, 2005). Therefore, it is perhaps unsurprising that education professionals can play a key role in identifying support through schools. This is important as early intervention is critical (Sharma & Math, 2019), yet limited resources and stigma hinder disclosure and support (Brock et al., 2024; French & Nesbit, 2009; Vallani et al., 2023; Westwell-Roper & Stewart, 2019).

Recommended areas of knowledge for educators to develop their understanding and awareness of OCD include transition challenges (Chaturvedi et al., 2014), typically low self-esteem (Besiroglu et al., 2007), social isolation (Canavera et al., 2010), and the lack of control CAYP feel they have over their own compulsions (Merlo & Storch, 2006). This understanding can inform accommodations that can support CAYP with OCD, while not impeding those without OCD (Leininger et al., 2010), such as structured routines, flexible deadlines and avoiding punitive measures for behaviours stemming from compulsions (Boucher, 1999; Dornbush & Pruitt, 1995; March & Mulle, 1998). Encouraging self-regulation (Adams, 2004), collaborating with families and therapists (Herren et al., 2016), and understanding medication side effects (Woolcock & Campbell, 2005) are further suggested strategies to convey. Without appropriate support, this risks long-term impacts on CAYP's self-confidence and academic performance (Bubrick, 2023; Pérez-Vigil et al., 2018).

Psychoeducation offers promise in improving educators' OCD knowledge. Definitions are heterogenous, however, psychoeducation in this review is defined as informing individuals to help them understand their own, or somebody else's, condition, to promote personal understanding, acceptance and empowerment to live well with the condition (Bai et al., 2015; Ferrin et al., 2014; Powell et al., 2021, 2024). Psychoeducation can be standalone or part of wider therapeutic efforts (Sarkhel et al., 2020). Being mindful of language use within psychoeducation is also crucial, as evidence suggests language can impact an individual's self-perception and mental health experiences (Colbert & Powell, 2025). Assessing the effectiveness of psychoeducational interventions can be challenging, and has been associated with how relevant, accessible, engaging and applicable it is to the audience (Mulla & Bawazir, 2020; Reinke et al., 2011). Participatory approaches, including co-design, are demonstrated to be more likely to lead to impact (Greenhalgh et al., 2016). Given educators' heavy workloads, psychoeducational programmes must be tailored to their needs (O'Farrell et al., 2022). Such interventions could enhance school staffs' ability to identify OCD symptoms and initiate referrals, ultimately improving outcomes for CAYP. Previous research incorporating aspects of psychoeducation have been demonstrated as effective in addressing symptoms of OCD and improving family functioning (Baruah et al., 2018; Peris et al., 2017; Şimşek & Seçer, 2022). However, while psychoeducation has improved understanding of conditions including Attention Deficit Hyperactivity Disorder (ADHD) (Awadalla et al., 2016), anxiety and depression among educators (Cunningham & Suldo, 2014), its potential for enhancing understandings of OCD is underexplored within the educational context.

To the authors' knowledge, there is currently no systematic narrative evidence synthesis of the level of school staff knowledge of OCD, or effectiveness of interventions to improve this. This review seeks to address this gap, providing an overview of current knowledge, existing interventions, and factors influencing their success. The findings aim to inform practical recommendations for future research and intervention development, ultimately improving outcomes for CAYP with OCD in schools.

Method

Pre-Registration

The protocol for this systematic narrative review aligns with principles recommended by the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) and Meta-Analysis Reporting Standards (MARS) (APA Publications and Communications Board Working Group on Journal Article Reporting Standards, 2008; Moher et al., 2009).

Inclusion Criteria

Searches took place between November 2023 and February 2024. Searches were limited to publications from 1980 onwards, dating from the inclusion of OCD in the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-3) (APA, 1980). The inclusion criteria and search terms were refined using the Population Intervention Comparison Outcome Study Design (PICOS) framework (Richardson, 1995), as recommended in the Cochrane Handbook (McKenzie & Brennan, 2023). Participants included in the studies of this review consist of school staff, or school staff in training. Included studies must either look at: current levels of school staff knowledge of OCD, or an intervention aimed at improving school staff knowledge of OCD. Interventional studies must include a psychoeducational component, in line with the definition adopted in this review (Powell et al., 2021, 2024). Included studies must be primary research and published in English language between 1980 and 2023.

Study Selection

A title and abstract search were conducted across eight databases: Medline, Web of Science (Core Collection), Scopus, CINAHL, ProQuest, Cochrane Database, ASSIA and PsycInfo. Search strategies, Medical Subject Headings (MeSH) and text terms are detailed in Supplemental Appendices 1 to 8. Screening of titles, abstracts and full texts was conducted independently by author EC and verified by author LP for compliance with the inclusion criteria. Any study design was deemed appropriate due to the infancy of the research topic.

The methodological quality of included studies was assessed by EC and LP using National Institutes of Health Study Quality Assessment Tools (NIH, 2017), tailored to specific study designs (Supplemental Appendix 9). These tools evaluate methodological flaws, bias and study power. Studies were scored based on "yes", "no", "cannot determine (CD)", "not reported (NR)" or "not applicable (NA)" responses, though numerical scores were used only as guidance. Contextual considerations informed quality assessments. Studies were categorised using Weiss levels of evidence (Weiss et al., 2009) to evaluate potential bias risks. Discrepancies in scores were resolved through in-depth discussion.

Extracted data were narratively synthesised with text and tables highlighting participant composition, intervention content, delivery, outcomes (e.g., school staff's OCD knowledge) and study quality. Due to inconsistencies across outcome measures, a meta-analysis was not conducted.

Authors' positionality is transparently acknowledged: EC has lived experience with OCD, and LP brings expertise in psychoeducation and lived experience of ADHD and autism. These perspectives enriched interpretation and synthesis of results (Bertilsdotter Rosqvist et al., 2023), offering a nuanced and experiential lens to this review.

Results

The literature search yielded 20,686 records following de-duplication. After screening for title and abstract relevance, 58 papers were retained for full-text screening (Supplemental Appendix 10). A total of six studies across six papers met the inclusion criteria. This included two further studies that were selected via hand picking methods. Three studies measured level of OCD knowledge among school staff (Foster, 1995; McGrath et al., 2023; Vallani et al., 2022), and three studies measured the effectiveness of an intervention to improve school staff knowledge of OCD (Chaves et al., 2021; Jassi et al., 2016; White et al., 2011). Studies were published between 1995 and 2023, sampling 952 participants across the United Kingdom, the United States of America, Canada and Spain. Study characteristics are found in Table 1, and quality assessment and corresponding levels of evidence are summarised in Table 2.

Study Participant Composition

Of the 952 participants, 596 were involved in studies measuring OCD knowledge, while 356 participated in intervention studies, with 285 completing follow up, including controls. One study reported a dropout rate of 52.99% (White et al., 2011). White et al. (2011) was the only study to distinguish between staff classroom settings: 52% mainstream, 19% specialist, 19% non-academic (e.g., PE, art and music), and 10% unclassified.

Level of OCD Knowledge Among School Staff: Pre- or No Intervention

OCD Symptoms and Recognition. Outcome measures varied across studies. Participants across all studies showed some basic knowledge of OCD, such as common symptoms, both pre-intervention and in studies containing no intervention.

One study found pre-intervention OCD knowledge higher than for ADHD and Tourette syndrome (TS), though scores ranged widely (10%–100%) (White et al., 2011). Similarly, Chaves et al. (2021) reported 78.7% of participants recognised obsessions as a primary symptom, and 82.1% identified OCD symptoms in a vignette of a young person demonstrating OCD symptoms within the classroom. However, only 46.3% of participants recognised the difficulties described in the vignette as a mental health condition. McGrath et al. (2023) found that educators also reported relatively high levels of knowledge regarding OCD definitions and characteristics, with 77% and

Table 1. Reported Demographic Information of Included Studies.

Author, year; country	Participant (*n*); who participants are	Participant age mean, years (SD)	Participant sex assigned at birth % (M, F)	Participant ethnicity
Vallani et al. (2022); Canada	Participant triads: 89 (*n* = 267) OCD-affected youth: 89 Proxy raters: Parents: 89 (89% mothers = 79, 11% not mothers = 10) Education staff: 89 (72% (*n* = 64) teachers, 28% (*n* = 25) not teachers (e.g., school counsellor, 'special educator', administrator)	OCD-affected youth: 13.2 (3.2) Range 6–18 Adult participant age not reported	OCD-affected youth: F = 49%, M = 51% Adult sex not reported	NR
Foster (1995); USA	Total (*n* = 25) Counselling students: 14 School administration students: 11	NR	Counselling students: F = 93%, M = 7% School Admin. Students: F = 92%, M = 8%	NR
McGrath et al. (2023); Canada	Teachers (*n* = 274)	27.01% age 26–30, 34.67% age 40+ Mean, SD, range not reported	F = 86.50%, M = 13.50%	White: 89.42% Remaining not reported
Jassi et al. (2016); UK	School staff (*n* = 127) Teachers, SENCOs (Special Educational Needs Coordinator) = 48.5% School nurses = 45.5% Education psychologists = 6%	NR	NR	NR
White et al. (2011); USA	Teachers (immediate workshop: 85(52); delayed workshop/control: 59(11)) 63 participants completed pre- and post-test (52 study, 11 control). Characteristics of these participants not reported independent to pre-dropout participants	44 (12.12), Range 22–68	F = 116 (87%) M = 18 (13%)	NR
Chaves et al. (2021); Spain	Teachers (*n* = 95)	43.29 (10.63) Range 24–65	F = 64.2% M = 35.8%	NR

Note. F = female; M = male; NR = not reported; OCD = obsessive-compulsive disorder.

Table 2. Summary of Included Studies.

Author, year, study design, level of evidence	Intervention, description; length (if applicable)	Context (location); who delivered intervention	Control description (if applicable)	Outcome measure(s) (knowledge of OCD)
Vallani et al. (2022); cross-sectional cohort study; III	NA	NA	NA	BRIEF; CBCL (CBCL-OCS, TRF-OCS)
Foster (1995); Cross-sectional cohort study; III	NA	NA	NA	10-item questionnaire
McGrath et al. (2023); Cross-sectional cohort study; III	NA	NA	NA	One open-ended question, 8 Likert scale questions rating OCD knowledge (not at all knowledgeable to extremely knowledgeable)
Jassi et al. (2016); Prospective pre–post, repeated measures design; IV	School intervention: 4-page information pack written by two clinical psychologists and consultant psychiatrist – collaboration with OCD Action Charity Aim: raise awareness of OCD in teachers (improve identification), practical advice on managing OCD in school (where, when to access professional support). OCD questionnaire before and after reading pack 1 day during meeting	In-school; charity volunteer	No control	10-item questionnaire
White et al. (2011); pre–post-intervention, repeated measures; II	2h training workshop – 60 PowerPoint slides developed by committee with expertise in TS, OCD, ADHD Information included definition, clinical picture, history, epidemiology, manifestations in classroom, treatment and classroom management approaches	In person, location NR; NR	6 weeks wait period, teacher subgroup ($n = 11$)	27-item multiple choice test. 11 items about TS, 10 on OCD, 6 on ADHD. Average item difficulty = .54 (range .09-.90). 2 versions of test created to avoid practice effects
Chaves et al. (2021); Independent measures; II	2-page OCD fact sheet, 630–650 words long Included: definition of disorder, obsessions and compulsions, prevalence, treatment, where to access support and classroom detection. Questionnaires repeated pre- and post-\intervention. No time length reported	In person, location NR; NR	Healthy diet fact sheet ($n = 46$)	Vignette-based questionnaire; *AQ-9* scores; OCD general knowledge questionnaire

Note. ADHD= Attention Deficit Hyperactivity Disorder; AQ-9 = Attribution Questionnaire-9, assessing public stigma relating to mental illness (Corrigan et al., 2014); BRIEF = Behavior Rating Inventory for Executive Function, available in parent and teacher forms to assess behaviour associated with executive function, such as social functioning and self-regulation (Gioia et al., 2003); CBCL = Child Behaviour Checklist, a parent report questionnaire to measure emotional and behavioural difficulties in children (Achenbach, 1991a); CBCL-OCS = Obsessive-Compulsive Symptom subscale, derived from select CBCL items; NA = not applicable; NR = not reported; OCD = obsessive-compulsive disorder; TRF-OCS = Teacher Report Form, teacher version of the CBCL to assess academic performance and adaptive functioning over previous two months (Achenbach, 1991b); TS = Tourette syndrome.
*Non-significant findings.

74.45% self-rating as 'somewhat', 'moderately' or 'extremely' knowledgeable, respectively. A further study reported mean pre-intervention knowledge scores of 63%, but did not specify knowledge areas (Jassi et al., 2016).

White et al. (2011) reported no significant differences between teachers' OCD knowledge from mainstream and specialist education classrooms. Similarly, Foster (1995) found no significant differences between counselling and school administration students. This finding may highlight a lack of OCD-specific training for specialist teachers or counselling students, however, the latter study did not focus on OCD knowledge specific to schools, and the statistical analysis used may have lacked power due to the study's small sample size ($n = 25$).

One study found a statistically significant moderate correlation between school and parent executive function ratings (BRIEF) ($r = .413$, $p < .001$), even after controlling for ADHD, Autism Spectrum Disorder (ASD) and Tourette's Disorder (TD) ($r = .373$, $p < .001$) (Vallani et al., 2022). However, small, non-significant correlations were found between school and parent ratings, such as obsessions ($r = .186$, $p = .09$), compulsions ($r = .209$, $p = .053$) and 'strange ideas' ($r = .072$, $p = .513$). Stronger correlations were found for general psychiatric symptoms, such as perfectionism ($r = .332$, $p = .002$), worrying ($r = .249$, $p = .021$) and guilt ($r = .252$, $p = .02$). Schools identified 58% of youth as above OCD threshold, compared to 83% by parents. This suggests that general signs of mental health difficulties are more consistently observed across settings, however OCD-specific indicators may be under-recognised within educational settings.

Strategies to Support in the Classroom. Despite some awareness of OCD symptoms, knowledge of effective classroom strategies to support students with OCD was generally low.

Chaves et al. (2021) demonstrated that although 94.7% of participants recommended seeking support for OCD, knowledge of classroom strategies for compulsions ranged from 46% to 58%. Similarly, McGrath et al. (2023) found that over 60% of educators reported having little or no understanding of instructional strategies (64.6%), accommodations and modifications (66.42%), assistive technology (81.38%), available resources (78.47%), transition processes (75.91%), and family perspectives (69.71%). Only 1.5% of educators rated their teaching ability as 'excellent,' while over half (53.28%) rated it as 'poor' or 'fair.' Professional (38.38%) and personal (24.72%) experiences were cited as the primary sources of knowledge, whereas Educator Preparation Programs were reported to have the least influence (4.8%).

Intervention Effectiveness

One study found an overall increase of 2.13 correct answers from school staff after reading information packs, meaning there was a significant difference in scores pre- ($M = 6.8031$, $SD = 1.5173$) and post-intervention ($M = 8.937$, $SD = 1.2582$; $t(126) = -14.414$, $p < .0001$) (Jassi et al., 2016).

A further study found a significant decrease in pre- to post-test scores on OCD items ($t(51) = 2.19$, $p < .03$) (White et al., 2011). This suggests that the training workshop was ineffective in improving OCD knowledge among school staff, and may infer that the information given challenged participants' existing knowledge of OCD.

One study found that following the intervention, OCD knowledge increased in the experimental group across 12 of 20 variables related to OCD mental health literacy (Chaves et al., 2021). A significant increase was found in participants who correctly identified the vignette as describing OCD (14.3%, $p = .039$), recognised difficulties presented as a mental health problem (14.3%, $p = .039$), and selected cognitive-behavioural therapy (CBT) as the most appropriate treatment for OCD (34.7%, $p = .000$). For general OCD knowledge, a significant increase was found in participants' recognition of OCD as a mental disorder ($p = .007$), OCD prevalence ($p = .0001$), recognition of obsessions and compulsions as primary symptoms ($p = .006$; .0001), and definitions of obsessions and compulsions ($p = .039$; .021). A significant increase in scores was also found in the identification of seeking perfection as an observable classroom sign ($p = .013$), as well as continuing with the class schedule ($p = .0001$) and giving more time ($p = .0001$) as potential support strategies. There was a significant reduction of pity scores ($p = .04$) and increase in willingness to help ($p = .006$).

Quality Assessment and Level of Evidence

Overall, studies included in this review were of low quality, with two papers deemed 'fair', and four papers being deemed as 'poor' in quality, finding significant inconsistencies in transparently reporting recruitment methods, drop-out rates and the extent confounding variables were factored into analysis (NIH, 2017). Level of evidence was limited, varying between level IV (Jassi et al., 2016), level III (Foster, 1995; McGrath et al., 2023; Vallani et al., 2022) and II (Chaves et al., 2021; White et al., 2011) (Weiss et al., 2009). A more comprehensive rationale for the quality assessment can be found in Supplemental Appendix 9.

Discussion

This systematic narrative review examined school staff knowledge of OCD and the effectiveness of interventions to improve it. Two of six studies reported staff knowledge focused on OCD definitions and characteristics but found limited understanding of classroom accommodations (Chaves et al., 2021; McGrath et al., 2023). Two of three intervention studies showed significant post-intervention

knowledge improvements (Chaves et al., 2021; Jassi et al., 2016), highlighting the potential of informational interventions. However, study quality varied, with two rated "fair" and four "poor," necessitating caution in conclusions.

Depth of Knowledge and Practical Application

Inconsistent OCD knowledge among school staff was observed across studies, likely due to a lack of consistent training and evidence-based guidance on supporting CAYP with OCD. Participants demonstrated surface-level knowledge but lacked the depth to apply it in the classroom in both pre- and non-intervention measures (Chaves et al., 2021; McGrath et al., 2023). This aligns with Bloom's Taxonomy, where participants mainly demonstrated awareness and recall of OCD definitions at the 'remember' level, without progressing to true comprehension or application (Adams, 2015; Anderson & Krathwohl, 2001; Dwyer, 2020, 2023). This limited understanding correlates with educators' low confidence in supporting CAYP with OCD (McGrath et al., 2023).

In addition, Foster (1995) found no significant differences between counselling students and school administration students' level of OCD knowledge. This not only highlights a general lack of OCD specific training for counselling students, but also a knowledge gap among professionals who may work with young people with OCD in the future. The article also refers to school administration students as 'educators' – although this connection is not made explicit by the author, it does highlight the importance of the broader education workforce who need appropriate knowledge of mental health needs in order to provide whole-school support for CAYP.

Two of three intervention studies showed significant post-intervention improvements in school staff's OCD knowledge (Chaves et al., 2021; Jassi et al., 2016). Chaves et al. (2021) assessed recognition and application of OCD knowledge using a case vignette. As such, participants' ability to identify OCD was assessed using a worked-example of a young person with OCD within the classroom. However, it is noted that the vignette focused on order and contamination obsessions – common in media portrayals (Cathey & Wetterneck, 2013). This is evident as participants answered questions relating to order compulsions correctly even prior to the intervention. While these symptoms were easily recognised, this focus overlooked OCD's heterogeneity and more stigmatised dimensions, such as obsessions related to sexuality, aggression, and religion (Durna et al., 2018). This raises concerns about the vignette's ecological validity in assessing applied knowledge.

Conversely, White et al. (2011) reported a significant decrease in OCD knowledge post-intervention. This may reflect confusion from covering multiple conditions (OCD, ADHD and TS) or the disruption of prior misconceptions (Coles et al., 2013), possibly due to superficial understanding or ineffective content delivery (Mørk et al., 2020).

The findings highlight the critical need for targeted, evidence-based training for school staff to move beyond surface-level knowledge of OCD, ensuring that educators are equipped not only to recognise symptoms but also to apply this understanding effectively in the classroom. This is essential to improving both staff confidence and the support provided to children and young people with OCD.

Symptom Visibility and Recognition Across Home and School Contexts

Symptom recognition varied between home and school. Vallani et al. (2022) reported that while executive function was similarly rated by teachers and parents, school staff identified fewer OCD symptoms. This suggests compulsions may be less observable at school, consistent with research indicating 77% of symptoms occur primarily at home (Sabuncuoglu & Berkem, 2006). Children may suppress or mask compulsions in school due to stigma or discomfort (Chaturvedi et al., 2014; Ivarsson & Valderhaug, 2006; Pérez-Vigil et al., 2018), though this does not diminish their distress and anxiety (Clarizio, 1991; Kaur et al., 2023; Kiliç et al., 2022; Merlo & Storch, 2006; Pertuit, 2014).

Similar levels of acknowledgement of the impacts to executive function from both parents and school staff indicate an awareness of discomfort in CAYP, however it may be that school staff may not be aware of these impacts as indicative of OCD. This is consistent with findings from Chaves et al. (2021), who noted that only 46.3% of participants correctly identified symptoms as signs of a mental health condition within the vignette-based questionnaire. As such, classroom presentations of OCD may be more discreet (National Collaborating Centre for Mental Health, 2006) – fatigue due to extensive bedtime rituals, lateness, perfectionism and frequent bathroom visits (Pertuit, 2014).

Furthermore, trust in teacher responses has been shown to influence disclosure: students are more likely to share their experiences if they feel supported (Vallani et al., 2023), underlining the importance of not just recognising but appropriately responding to symptoms.

Intervention Format, Context and Delivery

Effective interventions in two studies used paper-based informational materials (Chaves et al., 2021; Jassi et al., 2016), challenging assumptions that only intensive training leads to improved professional development (Landry et al., 2009). The success of these simpler formats may reflect their accessibility and flexibility – critical for time-pressured

school staff when engaging with mental health content (Mulla & Bawazir, 2020; Rothì et al., 2008).

By contrast, White et al. (2011) delivered a 60-slide, 2 hour workshop covering multiple disorders, possibly overwhelming participants (Smolen et al., 2016). Rapid delivery (2 minutes per slide) likely left little time for reflection, which may explain the decline in post-test scores. 'Massed training' has been shown to reduce retention (Yeung et al., 2020), whereas smaller, spaced content delivery can yield better long-term outcomes (Raman et al., 2010). Similarly, McGrath et al. (2023) noted that preparatory programmes had minimal impact on existing knowledge of OCD. Authors note that the education preparation programmes are designed to provide educators' with information to teach all students, including a foundational curriculum for special education. It is noted, however, this may indicate the programmes are not adequate in preparing educators' for working with CAYP with OCD. Alternatively, such programmes may not highlight that the special education skills described are also transferable in supporting those with OCD.

Intervention effectiveness was assessed through questionnaire scores. It may be that questionnaires only measure individuals' short-term recall rather than their actual understanding, or the benefits of such increased knowledge, such as whether CAYP feel more supported in the classroom. The review also highlighted the lack of follow-up evaluations in effective interventions, leaving questions about long-term retention unanswered (Chaves et al., 2021; Jassi et al., 2016). Only Jassi et al. (2016) explicitly noted the intervention setting (a school), limiting insights into how context influences outcomes. This could be aided by the integration of qualitative data to begin to understand which elements of the context or intervention are most helpful. Digital and web-based interventions, shown effective in improving ADHD and autism knowledge (Bruck et al., 2021; Corkum et al., 2019), could be explored for OCD to address implementation barriers.

Inclusion of Lived Experience and Applicability of Intervention Design

None of the included intervention studies involved individuals with lived experience of OCD in the design or creation of interventions, nor did they incorporate perspectives of school staff (Chaves et al., 2021; Jassi et al., 2016; White et al., 2011). This lack of participatory methods may result in insufficient representations of the needs of CAYP with OCD and school staff (Mon-Williams et al., 2024). Without tailoring content to teachers' needs or understanding what they already know, interventions may fall short – potentially contributing to decreased knowledge post-intervention (White et al., 2011). An approach that recognises existing abilities and seeks to build on them could empower educators and enhance knowledge production.

Furthermore, excluding lived experience in intervention development raises moral and ethical concerns. Ignoring the insights of CAYP with OCD misses an opportunity to represent the condition's heterogeneous nature (Kühne et al., 2021) and to convey relevant information to school staff, which may improve the intervention's engagement and impact (Greenhalgh et al., 2016; Powell et al., 2021). Involving those with lived experience is crucial, as highlighted in autism research (Mon-Williams et al., 2024; Powell et al., 2024). Research on OCD should similarly prioritise conducting studies 'with', rather than 'for', key populations (Benz et al., 2024).

Participant Demographics and Representation

Four of six studies reported participant sex, revealing a disproportionate number of female participants (64.2%–93%) compared to males (7–35.8%) (Chaves et al., 2021; Foster, 1995; McGrath et al., 2023; White et al., 2011). While the impact of sex assigned at birth on OCD symptom severity is limited, variations in symptom dimensions and hormonal influences have been noted (Benatti et al., 2022; Raines et al., 2018). Additionally, only one study reported participant ethnicity (McGrath et al., 2023), providing data only on White participants (89.42%) without further details on other ethnicities. This lack of transparency and representation is problematic, as OCD experiences and barriers to care have been shown to differ across cultural and socioeconomic backgrounds (Cheung, 1991; Staley & Wand, 1995; Wilson & Thayer, 2020).

Moreover, transparency about schools' socioeconomic status and training access is essential to acknowledge the intersections between socioeconomic factors, training provision, mental health literacy, and prevalence (Wu et al., 2024; Zhang et al., 2023). Without representation of diverse sex, ethnicity and socioeconomic backgrounds, interventions may fail to meet the needs of all individuals.

Strengths and Limitations of The Current Review And Included Studies

This review is the first to systematically synthesise school staff knowledge of OCD and interventions to improve it. The limited number of studies ($n = 6$) indicates a lack of published literature on this topic, reflecting broader public misunderstandings of OCD (García-Soriano & Roncero, 2017; Stewart et al., 2018; Vallani et al., 2023). Therefore, this review hopes to prompt continuation of such work, which does justice to the prospective beneficiaries – CAYP with OCD.

A strength is the involvement of authors: EC, who has lived experience of OCD – providing valuable insights

and enhancing the understanding of the condition – and LP, who has lived experience with ADHD and autism (Beames et al., 2021; Bertilsdotter Rosqvist et al., 2023; Sonuga-Barke et al., 2023).

The studies in this review included a range of educator roles (teachers, SENCOs, nurses, educational psychologists), who may have differing pre-existing knowledge of OCD. This may potentially influence findings – pastoral staff may have higher pre-existing knowledge of OCD for example. This is important to note as two studies did not account for these differences in their analyses (Jassi et al., 2016; Vallani et al., 2022). However, the lack of difference between knowledge levels of school administration and counselling students contrasts this assumption (Foster, 1995).

Moreover, interventional studies included in this review (Chaves et al., 2021; Jassi et al., 2016; White et al., 2011) did not include information on how OCD commonly co-occurs with other conditions. This is important to address as it has been suggested that 69% to 90% of individuals with OCD are affected by other co-occurring conditions (Sharma et al., 2021). The lack of this information may impact the potential effectiveness and relevance of training for those supporting CAYP with OCD who may be affected by further conditions.

While this review focused on psychoeducational interventions, its inclusion criteria may have inadvertently excluded qualitative studies, resulting in a reliance on quantitative methods, which might not fully capture participants' understanding. Qualitative research could provide deeper insights into the needs of stakeholders. The review relies on available evidence, and all studies lack long-term follow up which means that conclusions about the retention of knowledge gained are not possible. Four studies did not use validated outcome measures to evaluate OCD knowledge (Chaves et al., 2021; Foster, 1995; Jassi et al., 2016; McGrath et al., 2023).

Finally, the quality of included studies ranged from 'fair' (Jassi et al., 2016; Vallani et al., 2022) to 'poor' (Chaves et al., 2021; Foster, 1995; McGrath et al., 2023; White et al., 2011), limiting conclusions that can be drawn. For instance, one study reported an overall knowledge improvement, but failed to analyse significant decreases in OCD knowledge and did not address variability in results nor the relevance of assessment content. The implications of the low Kuder-Richardson 20 score (.55) were also overlooked. While the NIH (2017) quality assessment tools are not standardised, they facilitated flexible evaluations and productive discussions on quality ratings.

Future Research Directions And Recommendations

Overextended healthcare systems and rising numbers of CAYP with mental health challenges highlight the need for collaborative identification and support approaches (Honingh et al., 2020; Lyon et al., 2016). Education staff are well-positioned to positively impact CAYP's physical and mental health both in the short- and long term (Lowry et al., 2022). This review underscores the potential of psychoeducational interventions to enhance school staff knowledge of OCD and their confidence in supporting affected students. Based on these findings, the authors propose recommendations for future research and intervention development:

1. Future research and intervention development must adopt participatory methods involving those with lived experience as a matter of moral and ethical responsibility (Thornicroft et al., 2022). This includes both the inclusion of key stakeholders, such as CAYP with OCD and their families, as well as the end users, that is, education professionals. Involvement of participatory methods ensures an informed perspective which is representative of the views of those with lived-experience of the condition and which is effective in addressing the needs of the end-user;
   (a) Intervention content should be reviewed by clinical and educational professionals, CAYP with OCD, and their families to ensure relevance. Topics may include differentiating behaviours driven by OCD from those linked to neurodevelopmental conditions including autism and ADHD;
   (b) Interventions should reflect OCD's heterogeneity by addressing lesser-known symptoms and challenging stereotypes;
2. Diverse perspectives from marginalised groups, including individuals from different genders, ethnicities and socioeconomic backgrounds, must be represented, with transparent reporting on demographic inclusion and participation in research and intervention design.
3. Follow-up periods should be incorporated to assess the long-term sustainability of benefits, which was absent in studies reviewed;
4. A synthesis of qualitative evidence is needed to deepen understanding of effective interventions and identify gaps requiring further exploration;
5. Clear and transparent reporting as to the creation and delivery of the intervention must be provided in order to uphold standards as highlighted by the NIH Study Quality Assessment Tools (2017). This consideration includes transparency in how exactly those with lived experience were involved in the development of such interventions to reduce superficial efforts of inclusion and tokenism (Smith & Dransfield, 2019).

Conclusion

School staff are uniquely positioned to contribute to the early identification of CAYP with OCD. Enhancing knowledge of OCD can boost their capability and confidence in supporting affected students. Reviewed studies indicate that educational interventions can effectively improve school staff knowledge, however future materials must incorporate the perspectives of individuals with lived experience and relevant stakeholders. Future research should utilise participatory methods which leverage the existing knowledge of school staff while integrating insights from CAYP with OCD and their families.

While increasing knowledge among school staff is important, the continuous involvement of those with lived experience is essential to ensure interventions are representative and meaningful. Results highlight that engaging individuals with OCD in research and intervention development is essential. By incorporating participatory approaches, school staff working with CAYP with OCD can focus on the most relevant areas and gain insights that directly enhance their ability to support these students. Without such insights, any perceived improvement in understanding may be incomplete. Moreover, it is vital that CAYP and their families feel supported by school staff; thus, their involvement in the design and assessment of interventions is critical.

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Supplemental Material

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