



## VHA providers' knowledge and perceptions about the diagnosis and treatment of obsessive-compulsive disorder and related symptoms



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### ABSTRACT

National Veterans Health Administration (VHA) data suggest that Veterans with obsessive-compulsive disorder (OCD) are often unrecognized and poorly treated. We investigated the experience of VHA mental health providers in treating Veterans with OCD and related disorders and perceptions of available resources. Psychiatrists, psychologists, social workers and nurses were invited through email distribution lists to complete an anonymous 25-question survey through [www.surveymonkey.com](http://www.surveymonkey.com) from 10/20/14 to 12/19/14. Questions pertained to experience and knowledge of treating Veterans with OCD and related disorders, such as body dysmorphic disorder, hoarding disorder, trichotillomania and excoriation disorder. Of 166 completers, 81 (49%) had seen 10 or fewer Veterans with OCD and related disorders at the VHA, and 147 (88%) were seeing 10 or fewer of these patients at survey completion. Only 38 (23%) had received specialized training in treating these patients. Participant-recommended treatments for these conditions did not correspond with evidence-based practice: only 47% recommended exposure and response prevention. Most reported insufficient assessment and treatment resources for Veterans with OCD. Many VHA mental health providers lack sufficient knowledge and expertise in diagnosing and treating OCD and related disorders. Additional resources need to be developed to facilitate improved care for Veterans with OCD and related disorders.

Obsessive-compulsive disorder (OCD) is a chronic and debilitating disorder that compromises well-being and functional abilities. The public health impact of OCD is high, given its associated work disability and healthcare costs (Macy et al., 2013; Markarian et al., 2010). Evidence-based treatments for OCD include both medication and behavioral treatment, although many people with OCD remain underserved (Ruscio, Stein, Chiu, & Kessler, 2010; Torres et al., 2007). These issues are of particular interest among Veterans in the Veterans Health Administration (VHA), where prevalence of OCD is high; but rates of recognition and treatment are low (Barrera et al., 2014; McIngvale, Lindsay et al., 2015).

OCD and related symptoms occur commonly among Veterans, but

estimated prevalence varies widely (0.4–28%), based on the nature of the target population and methods of case identification (McIngvale, Van Kirk, & Stanley, 2015). OCD prevalence is higher among combat Veterans (Miller, Fogler, Wolf, Kaloupek & Keane, 2008), as well as Veterans with substance use (Galarza, Ramirez, Guzman, Cabalero & Martinez, 1996), depression (Scherrer et al., 2010) or posttraumatic stress disorder (PTSD; Orsillo et al., 1996), than among Veterans without these disorders. Among Veterans with PTSD, prevalence of coexistent OCD is as high as 41% (Nacasch, Fostick, & Zohar, 2011).

OCD in civilian samples is associated with substantial role impairment across multiple domains (home, work, relationships, and social life; Ruscio et al., 2010) and significant delays in obtaining treatment

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(up to 17 years) that increase costs for individuals, families, the mental health system and society (Garcia-Soriano, Rufer, Delsignore, & Weidt, 2014). Although fewer data have addressed related dysfunction among Veterans, OCD in this population is associated with substantial physical and mental health impairment (Gros, Magruder, & Frueh, 2013) and high rates of coexistent depression (72–88%), PTSD (42–69%), alcohol use disorder (23–27%), and drug abuse (17–22%; Gros et al., 2013; McIngvale, Lindsay et al., 2015). Therefore, untreated OCD likely increases VHA healthcare costs.

National VHA data suggest that Veterans with OCD are often unrecognized and poorly treated, despite significant impairment. Prevalence of recognized cases is low (0.54–0.63%; McIngvale, Lindsay et al., 2015) relative to figures obtained with the use of systematic screeners and/or structured diagnostic interviews to estimate occurrence (e.g., 1.5–10.8%; McIngvale, Van Kirk, & Stanley, 2015). Even when Veterans with OCD are recognized, inadequate care is provided, given that the frequency of VHA mental health visits in the year following initial OCD diagnosis (e.g., 3.9 individual therapy visits; 1.2 medication management visits) has been reported as being below recommendations for evidence-based care (McIngvale, Lindsay et al., 2015). Under-recognition and inadequate treatment may result at least partially from lack of systematic OCD screening or assessment, low rates of patient self-report in the absence of direct provider inquiries, diagnostic overlap and high rates of coexistent PTSD (Nacasch et al., 2011), and insufficient provider knowledge or resources.

The VHA Uniform Mental Health Services Handbook (Department of Veterans Affairs, 2008) requires that all Veterans with anxiety disorders must have access to evidence-based psychotherapy. Although OCD and OC-related disorders (OCRDs) are now classified separately from the anxiety disorders (American Psychiatric Association, 2013), evidence-based psychotherapy for OCD is anchored in behavioral anxiety reduction strategies, and a vast body of literature supports the effectiveness of exposure and response prevention (ERP), which is considered the psychosocial treatment of choice for OCD (Abramowitz, 2006; Ost, Havnen, Hansen, & Kvale, 2015). General cognitive-behavioral treatment (CBT) also has demonstrated some efficacy for OCD, although the inclusion of behavioral experiments that mirror ERP is crucial to positive outcomes (Abramowitz, 2006). ERP also is part of evidence-based treatment for two OCRDs, body dysmorphic disorder (BDD) and hoarding disorder. Other CBT-based procedures that do not involve ERP are effective for other OCRDs (trichotillomania [TTM] and excoriation disorder; Abramowitz & Jacoby, 2015), although we know very little so far about the prevalence and impact of OCRDs among Veterans (Kelly, Zhang, & Phillips, 2015).

Veterans with OCD should have access to ERP, a unique form of CBT that requires specialized clinician training; and CBT that often includes elements of ERP (e.g., treatment for BDD and hoarding disorder) should be offered to those with OCRDs. However, the VHA and Department of Defense have not issued an evidence-based clinical practice guideline for OCD and OCRDs, nor rolled out ERP training programs for clinicians. Further, data related to frequency of individual therapy visits for Veterans with identified OCD (3.9 sessions/year) indicate insufficient contact to complete a typical course of ERP (approximately 16 sessions; Abramowitz, 2006). More data are needed, however, with regard to the experience and knowledge of VHA providers in the diagnosis and treatment of OCD and OCRDs, as well as the resources available for Veterans with these disorders and the providers who see them. This project investigated the experience of VHA mental health providers, including psychologists, psychiatrists, and social workers, in providing care for Veterans with OCD and related disorders and their perceptions of resources available for Veterans and providers.

**Table 1**

Number and percentage of Veterans with Obsessive-Compulsive Disorder and Related Disorders Seen (Ever and Currently) in a Sample of Veterans Health Administration Mental Health Providers (N = 166). Reported values are raw percentages.

|                           | Number of Veterans Ever Seen, n (%) <sup>*</sup> |                |                |             | Number of Veterans Currently Seeing, n (%) <sup>**</sup> |                |               |            |
|---------------------------|--|----------------|----------------|-------------|--|----------------|---------------|------------|
|                           | 0–10 (n = 81)                                    | 11–20 (n = 39) | 21–30 (n = 26) | 31+(n = 20) | 0–10 (n = 146)   | 11–20 (n = 14) | 21–30 (n = 4) | 31+(n = 2) |
| Time in VHA, years, n (%) |  |                |                |             |  |                |               |            |
| 0–1 (n = 20)              | 19 (95.0)  | 1 (5.0)        | 0 (0.0)        | 0 (0.0)     | 20 (100.0)   | 0 (0.0)        | 0 (0.0)       | 0 (0.0)    |
| 2–5 (n = 65)              | 38 (58.5)  | 13 (20.0)      | 11 (16.9)      | 3 (4.6)     | 56 (86.2)  | 7 (10.8)       | 1 (1.5)       | 1 (1.5)    |
| 6–10 (n = 43)             | 15 (34.9)  | 13 (30.2)      | 8 (18.6)       | 7 (16.3)    | 35 (81.4)  | 5 (11.6)       | 2 (4.7)       | 1 (2.3)    |
| 10+ (n = 36)              | 9 (25.0)   | 11 (30.6)      | 7 (19.4)       | 9 (25.0)    | 33 (91.7)  | 2 (5.5)        | 1 (2.8)       | 0 (0.0)    |
| Not reported (n = 2)      | 0 (0.0)  | 1 (50.0)       | 0 (0.0)        | 1 (50.0)    | 2 (100.0)  | 0 (0.0)        | 0 (0.0)       | 0 (0.0)    |

VHA = Veterans Health Administration.

<sup>\*</sup> Fisher's Exact Test for the relationship between Time in VHA and Number of Veterans Ever Seen:  $p < 0.0001$  (Time in VHA "not reported" is excluded from this analysis).

<sup>\*\*</sup> Fisher's Exact Test for the relationship between Time in VHA and Number of Veterans Currently Seeing:  $p = 0.73$  (Time in VHA "not reported" is excluded from this analysis).

## 1. Method

### 1.1. Participants

Participants were VHA mental health providers (psychiatrists, psychologists, social workers and nurses) recruited through the following email distribution lists: 1) Michael E. DeBaKey Veterans Affairs Medical Center Mental Health Care Line; 2) national program office lists for social work, psychiatry, psychology, and mental health; 3) Association of VHA Psychology Leaders listserv; and 4) American Psychiatric Association Caucus of VHA Psychiatrists listserv. Of the 179 participants who started the survey, 166 (92.74%) were considered completers (defined as those who answered at least 20 of the 25 survey items [80%]).

Of survey completers, 162 indicated their current position in the VHA; 42% were social workers ( $n = 68$ ), 39% were psychologists ( $n = 63$ ), 18% were psychiatrists ( $n = 29$ ), and 1% were nurses ( $n = 2$ ). Among those who indicated their number of years of VHA service ( $n = 164$ ), 12% indicated 0–1 year ( $n = 20$ ), 40% indicated 2–5 years ( $n = 65$ ), 26% indicated 6–10 years ( $n = 43$ ), and 22% indicated 10+ years ( $n = 36$ ) (see Table 1). Of the 163 survey completers who reported their gender, most (71%,  $n = 115$ ) were women; and of the 152 who reported their age, mean age was 43.4 years ( $SD = 10.23$ ).

### 1.2. Procedure

Email messages distributed to each of the aforementioned distribution lists invited all providers receiving the message to complete an anonymous survey through [www.surveymonkey.com](http://www.surveymonkey.com). The message stated that participation was voluntary, and the study was approved by the Baylor College of Medicine Institutional Review Board and the Michael E. DeBaKey Veterans Affairs Medical Center Research and Development Committee. Survey participants did not receive compensation. Given that the survey was distributed via listservs, some of which had overlapping members, and because some program offices chose to forward the message to members of their service, we were

unable to track the number of individuals who received the survey and therefore cannot estimate response rate. Survey data were collected from 10/20/14 to 12/19/14.

### 1.3. Survey

The online survey included 25 questions that asked participants to provide information about their experience and knowledge with treating Veterans who experience OCD and OCRDs (BDD, hoarding disorder, TTM, and excoriation disorder) and their perceptions about the need for additional OCD resources for both Veterans and providers. The survey included both closed- and open-ended questions. The initial draft was created by a team that included experts in OCD treatment, Veteran and non-Veteran consumers, VHA mental health providers, and VHA mental healthcare leaders/educators. Initial items were created and pilot tested with five local mental health providers (psychology, psychiatry, and social work) who offered suggestions for modification. Final survey items addressed 1) participant demographics (discipline, age, gender, years in VHA service), 2) participant experience (number of Veterans with OCD and OCRDs ever seen and currently being seen, receipt of specialized training in OCD), 3) participant knowledge (confidence in diagnosing and treating OCD and OCRDs, treatments recommended), 4) perceptions of resources available for Veterans with OCD and OCRDs (whether resources are sufficient, how effective VA is in meeting needs, what services are needed), and 5) perception of resources available for providers (whether resources are sufficient, value and nature of additional specialized training).

Response options for close-ended questions were either yes/no or selection of points on Likert-type scales. Open-ended questions asked participants what treatments they recommend for Veterans with OCD and OCRDs; what services they believe these Veterans need; what additional resources would be helpful for providers who work with these Veterans; and, for those who indicated prior specialized training in the treatment of OCD and OCRDs, what type of training they had received.

### 1.4. Analytic plan

Responses to open-ended survey items were initially reviewed by three of the coauthors with significant expertise in OCD (MAS, EM, ET) who decided which categories were most important and meaningful. Next, two raters (EM, TB) independently coded responses into these categories. Kappa coefficients indicated strong interrater agreement (0.79 - 0.91). Descriptive statistics are provided for responses indicated by 5% or more of respondents. Pairwise deletion was employed, such that all available data were included for any given analysis, resulting in slightly different sample sizes across analyses. The total *n* for each analysis is indicated in the description of study findings.

A series of Fishers' Exact tests were conducted to examine differences between survey completers and non-completers on categorical demographic variables (e.g., gender) as well as relations between time in VHA and 1) number of Veterans with OCD and related disorders ever and 2) currently seen. We also evaluated differences in participant experience with OCD, participant knowledge, perceptions of resources available for Veterans with OCD, and perceptions of resources available for providers between survey respondents who had ever seen fewer (0–10) versus more (11+) Veterans with OCD, using a series of chi-square or Fisher's Exact tests (when expected cell frequencies were less than 5).

## 2. Results

### 2.1. Survey completers versus non-completers

Survey completers and non-completers did not differ with regard to

gender (Fisher's  $p=0.22$ ). Due to significant missing data for survey non-completers and resultant small cell sizes (or non-existent cells), we were unable to compare completers and non-completers on other demographic variables (current position, age, and number of years in VHA).

### 2.2. Participant experience with OCD

Survey responses indicated that 48% ( $n=81$ ) of providers had seen 10 or fewer Veterans with OCD and OCRDs during their work in the VHA, while 52% ( $n=85$ ) reported having seen 11 or more Veterans with these disorders. The majority of respondents (88%,  $n=146$ ) were seeing 10 or fewer of these patients at the time of survey completion (see Table 1). Number of years in the VHA correlated significantly and positively with the number of Veterans with OCD and OCRDs ever seen ( $r_{SB}=0.44$ ,  $p<0.001$ ).

Of the 165 providers who answered the question "Have you received specialized training in OCD and related disorders?" 23% ( $n=38$ ) reported receiving such training. The percentages of respondents who reported receiving specialized training were equivalent among those who had seen 11 or more Veterans with OCD and related disorders (27%) versus those who had seen 0–10 (18.75%;  $\chi^2(1)=1.61$ ,  $p=0.21$ ). In response to an open-ended follow-up question about the nature of training received, 36 of these 38 respondents offered information about the method and content of training. Reported training methods included workshops (19%,  $n=7$ ), clinical supervision (17%,  $n=6$ ), literature review (11%,  $n=4$ ), and consultation (6%,  $n=2$ ). Reported training content included ERP (19%,  $n=7$ ), general OCD training (14%,  $n=5$ ), CBT (42%,  $n=15$ ), and anxiety disorders treatment (17%,  $n=6$ ). Training in treatments for PTSD was also reported, including prolonged exposure (11%,  $n=4$ ) and cognitive processing therapy (6%,  $n=2$ ).<sup>1</sup>

### 2.3. Participant knowledge

Most survey respondents reported at least moderate confidence in diagnosing OCD and related disorders (82.4%) and in differentiating OCD from PTSD or anxiety disorders (81.8%; see Table 2). However, only 50.6% of respondents indicated moderate or higher confidence in treating OCD and related disorders, especially in the context of other comorbid conditions (see Table 2). Responses did not differ significantly between those who had seen 0–10 versus 11 or more Veterans with OCD (all Fisher's  $ps > 0.05$ ).

Despite some level of confidence in treating OCD and related disorders, participant-recommended treatments for these conditions did not show correspondence with evidence-based practice. Of the 144 providers who responded to the open-ended question about recommended treatments for Veterans with OCD and OCRDs, only 47% of respondents ( $n=67$ ) recommended ERP, and 38% ( $n=34$ ) recommended medication (19% medication [ $n=27$ ]; 12% recommended serotonergic or serotonergic/noradrenergic reuptake inhibitors [ $n=17$ ], and 7% recommended tricyclics [ $n=10$ ]). Over half of respondents (52%,  $n=75$ ) recommended CBT for Veterans with OCD and OCRDs, 11% ( $n=16$ ) recommended psychotherapy, 10% ( $n=15$ ) indicated they would refer, and 6% ( $n=8$ ) said they would recommend Acceptance and Commitment Therapy.<sup>1</sup>

Responses to a related open-ended question about what services are needed for Veterans with OCD and related disorders also revealed poor correspondence with evidence-based practice. Of the 132 respondents who answered this question, only 22% ( $n=29$ ) indicated that Veterans with OCD/OCRDs need ERP; and only 23% ( $n=30$ ) suggested the need for medication. Similar percentages of respondents indicated the need

<sup>1</sup> Because respondents were able to provide more than one response to this question, totals sum to over 100%.

**Table 2**  
Self-reported confidence in diagnosing and treating OCD among Veterans (N =165, unless otherwise noted).

| Please rate your confidence with...   | NotConfident n (%) | SomewhatConfident n (%) | ModeratelyConfident n (%) | Very Confident n (%) | ExtremelyConfident n (%) |
|---|--------------------|-------------------------|---------------------------|----------------------|--------------------------|
| DIAGNOSING OCD and related disorders  | 5 (3.03)           | 24 (14.55)              | 64 (38.79)                | 57 (34.55)           | 15 (9.09)                |
| DIFFERENTIATING OCD and related disorders from PTSD and other anxiety disorders(e.g., generalized anxiety disorder, specific phobia, social anxiety disorder) | 5 (3.03)           | 25 (15.15)              | 60 (36.36)                | 59 (35.76)           | 16 (9.70)                |
| TREATING OCD and related disorders  | 28 (16.97)         | 43 (26.06)              | 59 (35.76)                | 24 (14.55)           | 11 (6.67)                |
| TREATING OCD and related disorders in the context of other comorbid conditions suchas PTSD (N = 166)  | 26 (15.66)         | 56 (33.73)              | 50 (30.12)                | 28 (16.87)           | 6 (3.61)                 |

OCD = obsessive-compulsive disorder; PTSD = posttraumatic stress disorder,

for general CBT (23%, n =30) or psychotherapy (21%, n =28). Fewer respondents suggested needs for evidence-based practice (14%, n =18), a specialized OCD clinic (9%, n =12), supportive treatment (9%, n =12), intensive treatment (8%, n =11), group therapy (8%, n =10), out-of-office care (8%, n =10), and additional assessment/diagnostic services (5%, n =7)<sup>1</sup>.

**2.4. Perceptions of resources available for veterans with OCD and related disorders**

Most respondents reported that insufficient assessment and treatment resources are available in their VHA settings for Veterans with OCD (see Table 3). The majority (65%) were unaware of individuals at their facility with expertise in assessing/treating OCD and related disorders who might be available for consultation or referral (yes/no response option). A similar percentage (65%) were unaware of local community providers with appropriate expertise who might be available for non-VHA referrals (yes/no response option), and 62% never used these kinds of referrals for Veterans with OCD. No differences in any of these responses were observed for respondents who had seen 11 or more versus 0–10 Veterans with OCD (all ps > 0.05).

In terms of using community referrals, 30% answered only rarely, 7% answered occasionally, and less than 1% answered frequently. Overall, providers believed that the VHA is not adequately meeting the needs of Veterans with OCD and related disorders (24% not effectively, 43% somewhat effectively, 30% moderately effectively, 3% very effectively).

**2.5. Perceptions of resources for providers**

Most respondents indicated that training and consultation resources are insufficient in their VHA settings for providers (like themselves) who work with Veterans with OCD and related disorders (see Table 3). The majority of respondents reported that additional specialized training in OCD diagnosis/treatment would be valuable (19% extremely valuable, 35% very valuable, 22% moderately valuable, 22% somewhat valuable, 2% not valuable). No differences in these responses were observed for respondents who had seen more (11+) versus fewer (0–10) Veterans with OCD (both Fisher's ps > 0.05). A

**Table 3**  
Perceived resource availability for the treatment of OCD among veterans by participating providers (N =166).

|   | Not at alln (%) | Very littlen (%) | Somen (%)  | Very muchn (%) | Manyn (%) |
|---|-----------------|------------------|------------|----------------|-----------|
| Are sufficient assessment and treatment resources available in your VHA for Veterans with OCD?  | 34 (20.48)      | 54 (32.53)       | 67 (40.36) | 10 (6.02)      | 1 (0.60)  |
| Are sufficient training and consultation resources available within your VHA providers (including yourself) who work with Veteranswith OCD and related disorders? | 40 (24.10)      | 78 (46.99)       | 39 (23.49) | 8 (4.82)       | 1 (0.60)  |

OCD = obsessive-compulsive disorder; VHA = Veterans Health Administration.

total of 102 providers answered an open-ended question about additional resources that would be helpful for them in their work with Veterans with OCD and related disorders. Preferred additional resources included education/training (48%), resource lists and procedures (19%), consultation (18%), availability of specialty services or providers (11%), information/literature (6%), and intensive treatment options (5%).

**3. Discussion**

Data from survey respondents suggest that many VHA mental health providers lack sufficient knowledge and expertise in diagnosing and treating OCD and OCRDs. Fewer than half of survey respondents reported ever having encountered a Veteran with OCD/OCRD, and only slightly over 10% indicated that they were currently treating a Veteran with one of these conditions. As demonstrated by prior research, these low rates likely reflect providers' poor recognition of these conditions. The treatment suggestions made by survey respondents also corresponded poorly with evidence-based practice, despite self-reported confidence in diagnosing and treating these conditions. Less than half of respondents, for example, indicated that they would recommend ERP, the gold-standard behavioral treatment for OCD (Abramowitz, 2006; Ost et al., 2015). Although the potential value of other psychosocial treatments for OCD and OCRDs (e.g., CBT, Acceptance and Commitment Therapy; Twohig et al., 2015) is supported by some evidence, these interventions were not robustly recommended. Fewer than 40% of respondents indicated that they would recommend medication, another well-supported evidence-based approach (Goodman, Grice, Lapidus, & Coffey, 2014); and among those who recommended medication, some suggested the use of tricyclics, which are not a treatment of choice for OCD.

Survey respondents indicated that VHA resources for Veterans with OCD and OCRDs are insufficient. Many respondents also indicated that they would value having access to additional resources and specialized training in OCD and related disorders. Recommended resources included general education/training (including information and literature), lists of resources, and increased availability of specialized services, providers, and consultants. These data, in combination with evidence of inadequate VHA care for Veterans with OCD and related

disorders, strongly support the need for development of OCD-OCRD training and consultation resources within the VHA. Initial low-cost options might include easily accessible literature summaries; lists of evidence-based screening and assessment instruments; clinician training manuals; and Veteran materials, including informational pamphlets and workbooks.

More intensive training methods that include in-person workshops with follow-up expert consultation are effective (Reese et al., 2016); but national VHA training efforts have now moved away from this kind of costly, in-person model (Smith et al., 2016). Online training courses with follow-up expert consultation may be a good alternative to in-person conferences (Beidas, Edmunds, Marcus & Kendall, 2012; Dimeff et al., 2009; Gega, Norman & Marks, 2007; Kauth, Adler, McCandless & Leopoulos, in press). Any training resources made available will need to address barriers to the use of ERP-related skills that include extended-duration sessions and the importance of conducting in vivo exposure exercises outside a clinic office.

One VHA training option with some promise is a teleconsultation and training program known as Specialty Care Access Network—Extension of Community Healthcare Outcomes (SCAN-ECHO; Arora et al., 2007; Kirsh, Su, Sales & Jain, 2014). The VHA SCAN-ECHO program was designed to use VHA telecommunications technology (e.g., videoconferencing) to provide training and consultation to non-specialist clinicians in remote locations where specialists are less accessible (e.g., small community clinics; Kirsh et al., 2014). The model includes case-based discussion and didactics, as well as continuing education hours. SCAN-ECHO has been used successfully to offer training and consultation for providers working with Veterans; and the approach is a cost-effective, efficient way to train VHA providers in specialty care areas (e.g., women's health, transgender Veteran's health, pain management; Cordasco et al., 2015; Frank et al., 2015; Kauth et al., 2015). Although this method has been used to extend specialized expertise from larger medical centers to smaller and more remote clinics, it has also been used to train VHA providers at medical centers in less familiar practices, such as transgender care (Kauth et al., 2015). This method might provide an efficient way to offer additional resources to providers in any VHA setting who are working with Veterans with OCD and related disorders.

The development of training resources to improve care for Veterans with OCD and related disorders might use a stepped-care approach that might involve (1) creation of online and printed self-help resources for Veterans and informational resources for providers, (2) establishment of a national OCD/OCRD consultation team of experts in psychosocial and pharmacological treatment that could offer regularly scheduled or ad hoc calls to provide case consultation, (3) development of a SCAN-ECHO service to facilitate development of provider expertise in remote VHA settings, and (4) creation of a national VHA policy that requires mental health intake assessments to include appropriate screening and referral to guideline-supported treatments for these disorders.

Limitations of the current study include the likely biased sample of survey participants who took part because they had a particular interest in this topic. We are unable to estimate participation rate, although the study sample surely represents only a small percentage of mental health providers within the VHA who received the email invitation to participate. The survey also failed to separate questions about OCD from OCRDs. Given meaningful differences in clinical features and appropriate treatment approaches across these conditions (Abramowitz & Jacoby, 2015), it is therefore difficult to report with clarity when survey respondents were providing information about OCD knowledge versus knowledge of other related conditions (e.g., BDD, hoarding, TTM, and excoriation disorder). Finally, response options provided for quantitative questions were sometimes inadequate; for example, items related to the number of Veterans with OCD/OCRDs seen were grouped such that 0 was not included as a unique option (see Table 1), thus not allowing evaluation of number of

providers who have never seen a Veteran with OCD/OCRD. These issues would need to be addressed in future survey research to support development of appropriate resources.

Regardless of limitations, however, the data here strongly support the need for developing additional resources to facilitate improved care for Veterans with OCD and related disorders. Improved care for these Veterans will alleviate what is now an often unrecognized source of significant distress and disability and will enhance providers' ability to offer evidence-based evaluation and treatment for this currently underserved group of Veterans.

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## Conflicts of interest

None.

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