AVAPL Mid Winter Meeting
February 26 – March 2, 2012

Mid-Winter Executive Meeting
Sunday, March 11, 2007
4:00 pm – 10:00 pm

In attendance:

Pam Fischer, Ph.D. President
George Shorter, Ph.D. Past President
Mary Levenson, Ph.D. President-elect
Ann Landis, Ph.D. Treasurer
Stephen Cavicchia, Psy.D. Secretary (present 2/28 through 3/1)

Dr. Fischer presented the schedule for the upcoming week of meetings. Responses from the recent survey sent to the membership were discussed. Dr. Ann Landis presented the treasurer's report that shows a present balance of $39,853.65 with 317 paid members. The Executive Board discussed the message we would present at VACO offices and some of the key issues to discuss with House and Senate Veterans Affairs Legislative Staff.

VACO:

1. The importance of clarity regarding the expectations for using EBPs and how we might collaborate with VACO to disseminate this information.

2. Ongoing concerns regarding promotions to GS 14s and 15s.

3. The need for clarity regarding mapping and productivity issues as well as workload expectations.

Legislative staff:

Need for ongoing support for mental health Integrated Care and the importance of the unique skills and expertise of psychologists whose skills reach beyond the mental health office to all aspects of health care.

February 27-28, 2012: Meetings with VA Central Office Leadership

Antoinette Zeiss, Ph.D., Chief Consult, Office of Mental Health Services and Sonja Batten, Ph.D., Assistant Deputy Chief Patient Care Service Officer for Mental Health

Approval of specific evidence based practices was raised as a topic of interest from the field as some locations appear to be unclear about the implementation of EBPs. Dr. Batten suggested that we lead people back to the handbook which does not specify which therapies to use and does

not limit the clinician's choices in specific situations. Since some veterans expect to be followed indefinitely, it would also be helpful to teach the clinician how to talk with the veteran about this paradigm shift and help revise their expectations. Great peer support models are emerging across the country to assist with continued care.

The Performance Measure requiring eight psychotherapy sessions in fourteen weeks is very focused. The VISN Director must have an action plan to address it if they fail. Its presence in the Composite Measure is actually very helpful and ensures attention at the VISN and Facility levels. The National Healthcare Delivery Committee is on board and supports implementation of EBPs.

Concern about progress in promotion to GS-14 and GS-15 was discussed. The issue is the decision is made at the facility and/or VISN Director level and admittedly is uneven across the country. If the Director says no to a promotion recommendation, the psychologist may choose to appeal. It was acknowledged that this is a difficult time given the pressure on the Directors and the mood around the country about Government Workers. Psychologists who are declined a promotion can take this forward with the complaint process; those that have done so have had some success.

Dr. Zeiss reported that the staffing model is pending approval. This should solve the variable administrative support that mental health providers have throughout the system. We need to educate the field to ask the question of "How am I mapped?" We also need to continue the work of the Productivity Directive and the training started by Bob Gresen last year. Psychologist contributions are likely to be misrepresented if a stronger understanding of mapping and productivity issues among front line staff (many of whom are new) does not occur.

On the topic of reorganization, Dr. Zeiss noted that is important to have a clear sense of the realignment, but not just in Mental Health. MH is a poster child for working together though there are some details to be finalized about who should be involved in what decisions. Dr. Agarwal is at a level that is the same as Mr. Schoenhard. There are entire service groups that have moved to Operations. For each side of Operations and Policy, there should be a liaison. The reorganization is right at the one year mark and has been facilitated by the fact that Psychologists generally communicate well with each other. Dr. Zeiss's Office is currently interviewing for the second OMHS Deputy position from all disciplines. There is overall very positive recognition in the field for the work that Drs. Zeiss and Schohn have accomplished.

Dr. Zeiss reported that there is a continued focused on monthly reporting from the field on position vacancy/status. The need for a directory of psychologists was discussed as well the need to understand where medical staff membership has occurred. A Field Survey is currently being drafted and was strongly encouraged by Drs. Zeiss and Batten as providing potentially helpful information about the state of Psychology nationally. It was acknowledged that the tyranny of the anecdote often rules in the absence of good data.

Loren Wilkenfeld, Ph.D., National Mental Health Director of Outpatient and Inpatient Care Services

Dr. Wilkenfeld discussed The Inpatient Handbook which is in process of concurrence. It will reconcile the mental health environment of care checklist and the design guide. There is a recommended addition to the EOC checklist adding a tab that includes recovery oriented actions. There is also recommended training for the field. The first of these will include LRC and MH liaisons and task them to develop VISN level strategic plans for development of Recovery-oriented inpatient units. The Inpatient Handbook defines the expectation that inpatient units will have three hours of programming daily. (OT, RT, Psych, Nursing, etc, including peers). The Handbook will also define the MH TX Team on Inpatient Unit to include an inpatient treatment coordinator.

The second recommended training (under 200) will train inpatient psychiatry staff to create a stronger recovery culture on the inpatient units. There is considerable variability in the field's understanding of Recovery and the EOC checklist of 2007 did not assist with strong movement toward a Recovery Culture. Dr. Wilkenfeld reported there is a Toolkit under development which is intended for primary care and mental health providers. There is an access requirement for one off tour and one weekend tour during each week for both PC/MH Staff services as well as the mental health clinic. In general, mental health outpatient settings have not worked on this sufficiently.

Dr. Wilkenfeld noted that there has not been an increase in inpatient admissions overall and that a 23 hour observation unit is mandated in the new inpatient handbook. She recommended that AVAPL consider additional education to the field on inpatient units, how to coordinate services, how to create a warm environment, how to manage readmissions therapeutically, how to establish connections with the PRRC, etc. It may be useful to consider a workshop focusing on specific skills that are needed by inpatient psychologists from a recovery perspective.

Susan McCutcheon, R.N., Ed.D., Director, Family Services, Women's Mental Health and Military Sexual Trauma, VACO Office of Mental Health Services

Dr. McCutcheon explained that her office was previously in Psychosocial Rehabilitation and Recovery Services but now reports to the Deputy Patient Care Services Officer.

During the past year in Family Services, Dr. McCutcheon's office successfully provided evidence based training in the family psycho-educational model for over 386 staff. Similarly, 194 staff were trained in Behavioral Family Therapy. As the training has grown, they are more under the umbrella of EBT. The newest training in Couples Therapy has resulted in 124 trained staff. Future trainings will address PTSD/Family needs and Substance Use Disorders, including a half day on intimate family violence and assessment, and a half day on parenting. Additionally, Parenting is the topic of a planned web-based application for patients. In all, Dr. McCutcheon's team will have three new products in the coming year.

Dr. McCutcheon reported on the status of the VA/NAMI Memorandum of Understanding which originally required that one VA in every state establish a partnership with NAMI. In actuality, 70 sites established these partnerships and 26 sites had two. The second MOU in effect requires

that all sites pursue a partnership. Dr. McCutcheon's program has successfully promoted the development of a positive relationship between VA and NAMI.

There are two strategic initiatives related to the SAFE Program addressing family resilience and development of the FOCUS program involving children. VA and DoD adopted Operation Enduring Family, so it is present in both systems.

Dr. McCutcheon noted that 55% of our new women Veterans are increasingly entering the VA for services. Approximately half have mental health diagnoses and 29% have PTSD. The rate of women using inpatient services has increased by 20% and outpatient demand for women has increased by 70%. Dr. McCutcheon is planning a survey for MH on women's issues which will include gender sensitivity and LGBT sensitivity. Additionally in FY 11, MST screening occurred for 98.4% of veterans with 23% of our women and 2% of our male veterans screening positive. Seventy-three percent of women rated VA Healthcare as excellent on survey. There is planned mandatory education for MH providers in the area of military sexual trauma.

After the Call Campaign: Access to the MST Coordinators has been evaluated across the country with this campaign in which male and female callers phone the medical centers and ask to speak with the MST Coordinators. The callers rate every facility's accurate responsiveness to this request. Those that fail are required to submit action plans to ensure their operators are well educated and responsive to caller requests for MST services.

The current travel restrictions have had an impact on staff availability for training. However, efforts to support provision of training for Family Services and MST are continuing.

Mary Schohn, Ph.D., Director, Mental Health Operations, VA Central Office

Dr. Schohn, accompanied by Dr. Lisa Kearney, reported that the Productivity Directive is nearing concurrence and is a good example of working together. Staff in the field should have a heads up before the Directive is released and be able to learn more about the mechanics of productivity measurement.

Site Visits: The original plan to visit 45 sites this year has been accelerated to include all sites by the end of the fiscal year. Visits will be consultative and evaluate the progress toward implementation of the Uniform Services Handbook program requirements. The goal is to identify problems and strengths and to provide technical assistance. The visits will help address the variability across the field.

On the topic of EBT and the reported concern by some front line staff, Dr. Schohn clarified that the goal is to provide EBTs to the Veteran and that we are not telling anyone there is a recipe. Staff must use their clinical judgment in selecting the treatment strategy with the Veteran and document their rationale clearly. Addressing reported concerns about alternative therapies being provided by other allied health staff, Dr. Schohn stated that the Medical Center Bylaws should address the processes for ensuring that alternative therapies have been reviewed and approved; as well as addressing the credentialing and privileging requirements for practitioners of these

therapies. Psychologists, as members of the Medical Staff can assist facilities to establish proper mechanisms and credentialing processes. These processes are evident during the site visits and are addressed in the protocol questions.

Dr. Schohn noted that her staff is working to create data bases with site visit results so that annual follow up will clearly demonstrate change. The field should begin to see changes in hiring fairly quickly. Thirty-seven facilities have been surveyed and 103 more will be completed by September 30.

In discussion of the Staffing Model, Dr. Schohn related that people in the field will be encouraged by the increased clerical staff to support providers and the increased clinical support for RNs. This will shape care and help develop a team to manage 1,000 patients. The Staffing Model will be piloted in VISNs 1, 4 and 22. The model needs to fit all settings and systems and is critical since it will influence care nationally.

Dr. Schohn explained that productivity and workload are viewed as complementary given the number of patients, programs and complexity levels. The Productivity Directive will require that managers review all programs and ensure correct mapping. Data will be based on the median level across all facilities in 2010. Of interest to front line staff is the pending release in April of new training addressing the business rules related to productivity. Three classes will be available on line and in Live Meetings to address labor mapping, VERA and DSS information. A Tool Kit is also anticipated for release to the field.

Regarding scheduling concerns, Dr. Schohn noted that there are several IG Audits, one of which is MH specific and one is general to VA. Our Scheduling Directive is very prescriptive and is not easy to follow. Many people are reported as dissatisfied and Dr. Schohn anticipates that there will be changes out within the next year.

In conclusion, Dr. Schohn urged AVAPL members to consider moving to areas outside of MH where their leadership and unique skill sets could be of use to the larger agency. She noted that many staff remain in MH and perhaps do not consider their suitability and the need within the larger organization.

Jeffrey Burk, Ph.D., National Mental Health Director for Psychosocial Rehabilitation and Recovery Services, VACO Office of Mental Health Services

Discussion of Peer Support Programs focused on their development and expansion with some concern that HR may be delaying their implementation. PL 110387 (2008) mandated the development of a "Peer Support Specialist." Prior to that, we hired under the Health Tech job series. There were many restrictions, including that we could not restrict hiring to Veterans and could not inquire about MH history. In 2010, we hired 237 peers and 120 WOC peers but there is wide disparity across the nation. The new Public Law has helped by saying that the Peer Support Specialist must be a Veteran with MH concerns and must be certified in their role. Certification is important because we need have standards addressing the skills that these staff should possess. There are organizations that provide Peer Support Certification and several states

have their own Peer Support Programs. The VA requirements are more stringent. Dr. Burk's office has paid the certification fees and travel and most are now certified. They are continuing to work with HR to develop the position descriptions and define the progression from grade to grade.

Dr. Burk also discussed the Caregiver Support Bill which includes a Peer Support provision. A contract for training has been established and monies have been allocated to address this requirement. Existing Peer Support Technicians should be able to migrate to the Peer Support Specialist position as their certifications are completed. Dr. Burk is asking for 500 additional peers to be doled out across the country since the biggest question from the field is "Will you give us the money?" Dr. Burk also noted that they are considering expanding peers to Primary Care/Behavioral Health in the future.

Approximately 90 PRRCs are up and running around the country. Sixty have been CARF accredited and 20 additional sites need PRRCs. The Site Visits in process are looking for the development of these services where required by the Handbook. Dr. Burk also noted that Consumer Liaison Services have encouraged the establishment of Veteran MH Councils at all facilities.

As discussed by Dr. Wilkenfeld, Dr. Burk discussed the pending release of the Inpatient Handbook and the importance of incorporating Recovery principles within the inpatient settings.

Jay Umoto, Ph.D., Deputy Director and Chris Crowe, Ph.D. from VA for the Defense Centers of Excellence(DCOE) for Psychological Health and TBI

Dr. Umoto related that 2010 to 2011 had been fairly tumultuous due to leadership changes, notably three leaders in one year within DoD. Dr. Hammer has now been in place for one year. Though there have been many distractions, there are concerted efforts to define the mission, identify gaps and move information to practice guidelines that can be pushed out to the field via the Surgeon Generals. There is a need to blend/resolve the dichotomy of existing paradigms that emphasize readiness/deployability with resilience. There is an identified barrier to care in the de-pathologizing of symptoms which subsequently creates resistance to seek treatment after discharge from the military. Veterans report liking availability of Peer Support, but rarely do they have access to this. Dr. Umoto reported there are 1500 resilience programs in DoD but none have data to measure what they are doing. This is because they are so focused on health/preparedness and do not acknowledge the presence of illness/symptoms. Toolkits, mobile applications and work with suicide prevention are all strong within DoD. Information on events leading to concussion will permit data on exposure information to be available in CPRS in the future.

In the future, a DoD Directive will align the DCOE under the Army. This is a huge effort. Secretary Panetta is reconsidering a reorganization with a Defense Health Agency and it would take legislative action to make any changes. The Integrated Mental Health Strategy includes 28 strategies that partner VA and DoD in research, clinical care and suicide prevention. DCOE has

18 of these and works to affect culture change that includes recognition of the individual and that person's problems.

Drs. Umoto and Crowe work in the area of program evaluation to encourage DoD to evaluate the initiative with the idea that some initiatives may be harmful if they prevent access to care for things that are treatable. They are promoting collaboration with the National Center for PTSD. Additionally, they are working to promote culture change by participating in the strategic planning process and reviewing what VA already knows. These efforts have been well received as they demonstrate metrics used in VA performance measures and site visits which are generally more positive than the traditional metrics of retention and disciplinaries.

February 28, 2012 – Tuesday – VACO

Robert Zeiss, Ph.D., Director, Associated Health Education and Debbie L. Hettler, OD, MPH, FAAO, Clinical Director, Associated Health Education.

AVAPL was thanked for assisting with some sites where internship positions were not being filled due to being counted as facility FTEE. 3/14/12 is the Post-Doc notification date. There will be no new positions this year. There will be no additional travel funding for post-docs this year (as was done last year). Discussed rural training sites. All positions were filled except one. A survey of trainees near the end of their training experience has been conducted over the past 13 years. Optometrist and psychology students are the most likely to be hired by VHA. This impacts the allocation of dollars. Discussed the benefits of these training programs including staff retention at training sites. Dr. Zeiss indicated that he did not anticipate training cuts in the next few years. Palliative care programs have not changed over the past years. APA is working on core competencies. AVAPL membership should be involved in development of these core competencies locally. It is important that these training programs remain viable and supported. There is no Fact Sheet available from Academic Affiliates. Dr. Zeiss reported that 107 of 140 medical centers currently have psychology training programs. Board members thanked Dr. Zeiss for his ongoing availability for consultation and questions from the field. He reported that there will be an increased emphasis on interprofessional programs. Psychology is represented on the National Affiliation Advisory Council.

Stacey Pollack, Ph.D., National Director, Program Policy Implementation

Dr. Pollack discussed Disabilities and Medical Assessment (DMA) chaired by Dr. Gerald Cross. The group interfaces with VBA regarding *C&P issues*. While there is no psychology representation, psychology input is frequently requested. The most recent point of discussion is related to C-files. VBA is beginning to scan C-files but progress is slow. VBA is considering not releasing C-files when C&Ps are being completed. VHA's position is that this information is vital in contributing to valid conclusions. VHA is also working to receive timely updated information on service connection awards especially PTSD. Dr. Pollack is also looking at

variations in the field related to cost of contracted C&Ps and time allocated for completion of C&Ps. The average time spent for an initial PTSD exam is now 3 to 3.5 hours. A list serve is being established for communication/training of contracted providers. A pilot is now in place to privilege a provider at one site and have them complete C&Ps (via Tele-MH) at other sites. Changes to the MH Treatment Coordinator and MST policies were circulated to the field for review. The *Uniformed MH Handbook* is in the process of being updated. Changes include noting that *EBPs* are not the only treatments that can be offered to veterans. Other treatments will not be listed. The *MH Treatment Coordinator* will be more clearly defined. This is not a new requirement. Reports received from the field regarding compliance are not believed to be accurate given the misinterpretation. The PTSD performance measure (8 therapy sessions in 14 weeks) is part of the MH Composite score. Failure to meet the measure will require development of an Action Plan.

Brad Karlin, Ph.D., National Mental Health Director, Psychotherapy and Psychogeriatrics

Dr. Karlin indicated that a specific treatment for a specific patient is made by the patient in consultation with the patient's provider. This may include treatments other than EBPs. Guidance is being prepared in the form of an EBP Handbook to educate local leaders on the local implementation of EBPs, which includes this information. There has been some impact on EBP training locally due to the restrictions on travel. This is being addressed on a case-by-case basis. An exception is being requested whereby EBP training will not count against the local medical center's travel expenditures. Patient Care Services is in support of this exception. He also reported on a new national initiative being developed to promote the use of Tele-MH for dissemination of EBPs at CBOCs and community settings. Small and medium CBOCs are not required to have EBPs onsite. It is possible for staff at contracted CBOCs to participate in EBP training as prioritized and supported by the VISNs. VISN and facility use of Tele-MH is being tracked. Ultimately, there are plans to decentralize EBP training them to the VISNs. Training that is decentralized will allow for even broader dissemination (e.g., interns may be able to participate). Outcome measures for EBPs are currently being tracked during the training phase. Each of the EBPs has a program evaluation component. Symptom reduction, quality of life and therapeutic alliance are being measured in several of the programs. Progress Note templates for documentation of EBP have been developed but delays have been experienced with IT. It is expected that these templates will be deployed by the end of this FY. Socialization to treatment is incorporated into several of the EBP protocols, as is utilization of Motivational Interviewing/motivational enhancement procedures. EBP equivalency training criteria have been developed by a workgroup of field-based, VISN, and VACO representatives; these criteria, which will allow for recognition of staff in the field who have completed similar, competency-based training in EBPs outside of VHA. When finalized, applications will be made available for applying for EBP equivalency training status, which will be submitted to the VHA EBP training group. Piloting of this before national release is being considered (encouraged by AVAPL). The

importance of emphasizing EBP training was discussed including outside VHA (private sector). Graduate programs should emphasize such training. Currently, competency-based training in EBPs at the graduate level varies significantly.

Anne Dunn, MSN, Deputy Director, Homeless Programs

NOTE: Lisa Pape was not able to meet with AVAPL due to emergent responsibilities.

Ms. Dunn handed out a folder with descriptions of all homeless programs and a fact sheet. The Secretary's goal is to end homeless by 2015. Lisa Pape and Pete Dougherty will be at hearings on homelessness on 3/14/12. Homeless programs were reviewed including those that focused on prevention (VJO and HCRV). There has been a 12% reduction overall in homelessness though this figure is somewhat "fluid." HUD-VASH vouchers are being monitored closely. Discussed the limited eligibility of dental care especially if a veteran misses one appointment. Future funding for the Safe Haven pilot is not guaranteed. Housing First is supported by the Secretary. There are no current changes to the Grant and Per Diem programs. Lengths of stay remain up to two years. "Transition in place" is being considered whereby existing transitional housing units will be shifted to permanent housing. The veteran will not need to move. AVAPL recommended that the delays in VBA processing of claims be reviewed in light of increasing the risk of homelessness. Ms. Dunn indicated this data had not been sought previously but would be considered.

David Carroll, Ph.D. (Lead for the initiative to Improve the Mental Health of Veterans – Office of Healthcare Transformation)

Dr. Carroll indicated that "Improve Veterans Mental Health" was 1 of 16 initiatives in T21. Seven are related to Healthcare. There are three areas that are the focus of his efforts: full implementation of the MH Handbook, Public Health Outreach and 28 Action Items related to MH between VHA and DOD. Dr. Carroll reviewed various Public Health initiatives. A toolkit is being developed to train community providers about services available to veterans. Outreach to college campuses is a new MH initiative. Fifteen sites were added to the five from last year. A toolkit is also being developed with Aetna (the largest supplier of EAP services) that will educate providers on VA services. Three call centers are in place. Dr. Carroll indicated that EBP training is also partially funded through the MH Initiative. There are now three regional Tele-MH centers with three providers in each center. These centers are available when there is a gap in facility or Network services. New emphasis is now being placed on integrating the 16 initiatives. Other efforts include developing a common platform for mobile Apps. At the end of the FY the MH Initiative (a time-limited effort) will transition back to the program office. Operations and Policy will work together with these initiatives.

Jan Kemp, RN, Ph.D., National Mental Health Program Director, Suicide Prevention

Discussed the impact of the various initiatives to reduce suicides among veterans. Most data is coming from the CDC and there is a 3-year lag. Only 16 states report suicide data specific to veterans. General findings from the 2009 data reveals a decrease in suicide among middle-aged men and those diagnosed with a mental health condition. Overall rates, however, appear unchanged over the past 40 years. Anecdotal information reveals those that call the Crisis Line are less likely to attempt or complete suicide. Data also shows that there is a correlation between MH staffing levels and suicide rates at VAMCs. More study is needed in this area. A texting program is being piloted (Safety App) which is outside the VA firewall. The meeting concluded with the discussion of the role of the Suicide Prevention Coordinators and utilization of the crisis line. The recent change of name of the crisis line from "Suicide Hotline" to "The Crisis Line" has resulted in an increase in usage. There are currently more than 500 calls received daily over half of which are from veterans.

February 29, 2012 – Wednesday – APA

Welcome from Diane Elmore, Ph.D., MHP – Associate Executive Director, Government Relations Office and Heather O'Beirne Kelly, Ph.D. – Sr. Legislative & Federal Affairs Officer, Government Relations Office

Executive Office - Norman Anderson, Ph.D. – CEO, L. Michael Honaker, Ph.D. – Deputy CEO, and Ellen Garrison, Ph.D. – Senior Policy Advisor

The Executive Office reviewed the APA strategic plan. Included in the plan is the goal of psychologists to participate in and be given the opportunity to lead interdisciplinary teams. AVAPL was asked how APA can be supportive in this area. VA's PACT model and other initiatives were discussed. Also discussed was a recent EBP initiative (CBT for Insomnia) where psychological interventions are first line treatments for insomnia. Public Health initiatives under the MH Initiatives (Dr. Carroll were also discussed). Dr. Anderson commented on how VA was so far ahead of the public sector in these initiatives. A funding model where services are bundled permits much better access to MH services versus the current private sector model of fee for service.

Education Directorate - Cynthia Belar, Ph.D. – Executive Director, Catherine Grus, Ph.D. – Deputy Executive Director, Nina Levitt, Ed.D. – Associate Executive Director, Government Relations Office and Susan Zlotlow, Ph.D. – Associate Executive Director, Accreditation

AVAPL discussed the recently filled rural internship positions. APA (Dr. Belar) was invited by VA (Dr. Malcolm Cox) to participate in an interprofessional education discussion regarding integrated care and training. A goal of the Education Directorate is for psychology to have its training affiliations on the same par as academic affiliations in medicine. AVAPL discussed the initiatives within VA for integrated care. Also discussed was the importance of training initiatives related to EBPs. AVAPL asked for an update on incorporating EBP training within

graduate and training programs. Also discussed was the difficulty in standardizing training/certification expectations. Also discussed were the inconsistencies in licensing boards to identify accredited doctoral programs. AVAPL (and its members) were invited to comment on competencies now posted on the Education website. The Committee on Accreditation (COA) is giving consideration to changing to a competency-based training model. Licensing Boards will need to be involved. The accreditation system needs standardization such that Licensing Boards are consistent in identifying the same degree-granting institutions as accredited. Also discussed was the impact of Masters-prepared therapists and VA's initiative to grant them status as LIPs. It was noted that the U.S. Dept. of Education does not recognize CACREP-Accredited programs. The Education Directorate is still looking at the inequity between APA-Approved Doctoral programs and APA-Approved Internships. There is no COA requirement or standard of performance that APA doctoral programs must meet regarding this. Programs are required to show the quality of internship training their students are receiving if not APA-Accredited. VA can influence COA and does have four VA psychologists represented (Loretta Braxton, Kim Dixon, Steve Holiday and Brad Roper).

Ethics Office – Lindsay Childress-Beatty, Ph.D., JD – Deputy Director

Dr. Childress-Beatty reported that the Ethics Office is now offering more training and workshops. Consultation services are also available including to non-members. VA staff has not taken advantage of this service. Staff may call 202-336-5930 to access this consultative service. Dr. Steve Menke, Director of the Ethics Office, also travels and conducts workshops on ethics (including at Vas). There is an Ethics Education Award which is now open to nominations. There is a change in this award in that the contribution may be state-wide or local. The deadline for submission is June 2012. A letter of recommendation is all that is needed. VA staff may be nominated. AVAPL discussed the growing use of Tele-MH and other technologies and the need to establish appropriate ethical guidelines. There is an APA task force task force that includes a VA psychologist (Sara Smucker-Barnwell – Puget Sound) and a military psychologist (Col. Bruce Crow – San Antonio). APA reported on its Member Initiative Task Force on Interrogation. It recognizes the role of psychology in National Security. Its goal is to pull together relevant policies to establish consistent guidelines. Several Divisions are involved (9 and 48) and include Dr. Linda Wolfe and Dr. Bill Strickland. Discussion ended with an offer of consultation on issues related to C&P exams and other issues facing VA psychologists.

1:00 PM – Practice Directorate – Randy Phelps, Ph.D. – Deputy Executive Director joined Dr. Kelly and Dr. Elmore

APA discussed a wide range of issues which are their current priorities:

1. Funding for the Department of Defense (DoD) and Department of Veterans Affairs (VA)

2. Mental and Behavioral Health Services for Military Personnel, Veterans, and their Families

3. Training Opportunities for Military and Civilian Psychologists

The following issues were identified and prioritized for discussion with Congressional representatives:

1. Dr. Shorter expressed appreciation for Congressional efforts in addressing vacant psychologist and MH positions.

2. Dr. Fischer formally introduced AVAPL. The following issues were presented in order of priority:

   A. The importance of Integrated Health Care and the role of psychology

   B. Community collaboration

   C. Evidenced-based treatments and dissemination

   D. Some of the signature wounds of OEF/OIF (e.g., PTSD, TBI, Suicide)

March 1, 2012 – Thursday – Visit to Capitol Hill

The AVAPL Executive Committee met with the majority and minority congressional staffers from the House and Senate Veterans Affairs Committees.

March 2, 2012 – Friday – Meetings with VSOs

Shane Barker, Senior Legislative Associate National Legislative Service – Veterans of Foreign Wars

Joy J. Ilem, Deputy National Legislative Director – Disabled American Veterans

John M. Bradley III, Senior Advisor – Disabled American Veterans

Thomas Miller, Executive Director – Blinded Veterans Association

Alethea Predeoux, Associate Director of Health Policy, Paralyzed Veterans of America
Bernard Edelman, Deputy Director for Policy & Government Affairs, Vietnam Veterans of America

A specific concern for all of the VSOs was the limited communication and perceived lack of receptivity at the VISN level where most feel an "air of secrecy" continues. It was noted that the VSO relationships with Drs. Zeiss, Schohn and Batten are very strong and greatly appreciated. However, there is a network of MH leads, some of whom are active and some are hidden in the

background. At times, they are described to "need a lot of prodding to respond to inquiries" from the VSOs. An additional concern was noted that it has been a real struggle to modify VA's male culture appropriately to the presence of increasing numbers of women veterans.

Thomas Miller inquired about the precise number of mental health staff within each discipline in VA and expressed concern that this is not forthcoming. He related that we had a much better measure of that when the CO dollars came directly to the facilities. The result of the hearings over veteran suicides was that money was available and VA made good use of those funds with the ability to provide help right in the Primary Care setting. However, the VSO's cannot get data such as the "Summary of Medical Programs" and are displeased.

Approval was expressed over the PTSD App and the Make the Connection Campaign. As VA moves to implement PACT concern was expressed to ensure that both Primary Care and MH services stay within VA and not be contracted out into the community.

A copy of the Independent Budget, developed annually by the Veterans Service Organizations was given to us for further review.

Mary Levenson, Ph.D.
Acting Secretary 2/27 and 3/2/12

Stephen Cavicchia, Psy.D.
Secretary