Dear VA Psychologist Colleagues-

About 40 years ago, a small group of psychologists formed the Association of VA Chief Psychologists in response to threats to the autonomy and interests of our profession within the VA. From the beginning, our organization was built on the belief that a dedicated group of determined individuals could make a difference for our profession. Although the focus of our collective actions has varied over time, the tradition of advocacy remains a defining feature of our organizational ethos. In the more recent past, AVAPL has proactively engaged in the debate over privatization to such effect that we are now viewed as a leader and useful ally among those who share our belief that the VA is a unique, highly effective healthcare system that must be bolstered, not dismantled, for the good of our nation’s Veterans.

In the past year, AVAPL initiated an extensive advocacy campaign that caught the eye of journalists and important public figures. Representatives from AVAPL were invited to present testimony to the Commission on Care, highlighting the overwhelming effectiveness of VA behavioral healthcare for Veterans. We also produced a comprehensive systematic review of the empirical literature, which compared VA and private sector healthcare outcomes, and findings indicated the superior quality of VA healthcare and directly countered the predominant public narrative at the time. The document was disseminated widely to numerous parties, including key public officials, the Commission on Care, and the incoming administration’s VA transition team. We believe this effort helped to disarm those who had been painting an inaccurate and unfavorable picture of the VA in the service of arguments for privatization. In response to the Commission on Care Final Report, AVAPL led an effort to build a coalition of nine organizations to produce a policy brief addressing the inaccuracies and problematic recommendations articulated in the report. This document was disseminated widely, and it was entered into House and Senate Veterans Affairs Committees official proceedings in support of VSO testimony on the Final Report. To our knowledge, there has been no other collaborative effort in the history of the VA, and the coalition continues to work together productively to this day. Most recently, the Disabled American Veterans have asked us to produce a white paper outlining the scope and uniqueness of VA mental health services that will be shared with other VSOs and will be used to brief their leaders and members for their own visits to the hill and other legislative campaigns.

I feel very privileged to be part of this effort, and I am in constant awe of the dedication, wisdom, and talent endemic to the individuals who form our organization. It may surprise many of you to know that prior to being elected for the AVAPL Executive Committee, I had minimal experience doing the type of advocacy work that has been our focus during the 18 months I have served as President-elect and now President. While the idea of serving as a voice for our interests was initially daunting, I quickly learned through experience that we as psychologists are exceptionally adept at engaging in advocacy. Here are some examples of the skills I have found critical to our success:

1) our ability to evaluate the empirical literature and other sources of data and to articulate compelling arguments based on the assimilation of that information,

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2) our ability to anticipate resistance, to identify cognitive distortions and logical fallacies, and to work through, gently and patiently, all the resulting noise to address both the emotional and rational elements of a deeply held conviction,

3) our ability to join with another to create the interpersonal space in which meaningful dialogue can occur, and

4) our ability to integrate new data and perspectives into our own, and to use this new view to reshape our approach in a way that increases its likely effectiveness.

These are just a few of the competencies that I believe we as psychologists use every day in our clinical and administrative work in the VA, and I think that fully recognizing and employing these abilities is one step toward the self-empowerment that is part and parcel of advocacy. Perhaps what has been most gratifying about this work has been your response to this work. Invariably upon hearing about our efforts, that response has been “How can I help? I want to join the fight but I don’t know how.” This sentiment is particularly strong now at a time when principled people want to provide a voice to the values that we collectively hold as a profession. Taking action is an adaptive response to the societal and institutional challenges that we currently face, and my own experience has taught me that you already have the competencies required to be effective. It is now our job as an organization to provide you with specific tools and guidance to help you take action, and we are currently thinking about how to do that. One piece of this initiative will be an advocacy-focused one-day conference planned to coincide with APA this year. We plan to provide other tools through the advocacy page on our website in the coming year, and we welcome any other ideas that you might have. Our collective voice is our strength, and we want every one of you to be heard!

—Ron Gironda, Ph.D., President, AVAPL
On the fifth of May, 1977, Oakley Ray, Chief Psychologist at the Nashville, Tenn. VA Hospital, sent a letter to every Chief Psychologist in the Veterans Administration's far-flung hospital and clinic system. In this letter, he harked back to an impromptu meeting of several Chief Psychologists which had occurred during a recent get-together of VA Chiefs of Psychiatry and Psychology. The impromptu discussion had produced an imposing array of problems challenging the fullest utilization of Psychology in the system. And that same group had agreed wholeheartedly that a very promising way of helping to deal with this mountain of problems was to form an Association of Chief Psychologists.

So, accompanying the May 1977 letter was a questionnaire asking the Chiefs their views of the main problems and exploring if they would be interested in being part of an organization of Chiefs. The 80% "FOR" return was not just some weak, pro forma response. The respondents listed a host of areas of concern of their own; what's more, they volunteered excitedly to join in the proposed association and to serve on the several committees that would be needed.

An organizational meeting was set for August 27, 1977, at the APA Convention in San Francisco. More than 50 Chiefs, plus VACO observers, overflowed the meeting room, clearly showing by their enthusiasm (and by the fact that no one left the room during the entire two-hour allotted time!) that the time had come to formalize a Chiefs' group.

In the eyes of your archivist, the Association of Psychology Chiefs in VA (yes, that was the original name) was born on that day!

True, the "governing body' was still called a steering committee, made up mainly of regional representatives, with Oakley Ray as the Chairperson; terms like President, President-Elect, and Secretary-Treasurer had not yet been invented. A group was directed to set about devising bylaws and constitution statement. The bylaws were approved and accepted in December 1977 and efforts for a newsletter with an earliest possible first publication date were initiated.

Phil Laughlin, Chief at Knoxville, Iowa, was named Interim Editor and produced the first issue in January 1978; he was to remain editor until the start of his term as Association President in 1983-1984. And what a startup that newsletter had! The first twenty months of the Association's existence saw eight editions of the newsletter published (some of them as long as 32 pages!) and the listing of areas of concern (and proposals on how to deal with them) erupted from these pages. When Phil moved up to the presidency, Tom Miller (Lexington, KY) smoothly assumed the editorship and continued the high-level binding of the membership together, communication-wise.

Early in 1978, the first election was held. Oakley Ray was elected President; Hal Dickman (Palo Alto), President-Elect; and Joe Schenkel (Albuquerque) Secretary-Treasurer. Seven representatives from each RMEC (those were the regions into which VADM&S was divided at the time) were elected: Sturm, Cummings, Boudewyns, Holliday, Laughlin, Paige and Rickard. They joined the three officers to form the Executive Committee of the Association of Psychology Chiefs in VA (sic soon to become the Association of VA Chief Psychologists.)

The fledgling organization was incredibly fortunate to have the calibre of folks standing ready to take up the presidential duties during those vital formative years that followed: after Ray and Dickman, there were Sid Cleveland (Houston), Rod Baker (San Antonio), Laughlin, and Orv Lips (North Chicago). And, when Joe Schenkel stepped down as Secretary-Treasurer, Ken Klauck (Milwaukee) picked up the baton and wielded it with high effectiveness until very recently.

(Editor's Note: Jon Cummings "forgot" to mention his own role as fourth President and Archivist for the Association. His contributions have and continue to be significant.)

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In putting together an historical essay such as the present one, sooner or later a tormenting question presents itself: which of the many names officers, task force leaders, committee chairs, cogent letter writers, etc. should be specifically cited. The question is at least partly solved for the writer by simple space limitations. But still agonizing choices must be made. For better or worse, I have chosen to list only those early officers of the Association, including the ex-officio newsletter editors.

What really was this new organization all about? What were its intentions?

Early in 1978, right at the time that all this was going on, I was having coffee with a member of a certain colleague discipline at my hospital. "So', he said, rather unpleasantly, "I see you folks have formed a union." A union? Interesting; I hadn't thought of AVACP/PL in those terms before. But, believe me, the Association was then and I think to the very present is about as unlike the stereotype of a union in our culture as anything I've ever seen. Stereotypes are usually as unflattering as they are invalid, but I think one is justified, when presented with the stimulus word "union", to think right off the bat about some kind of self-servingness. In the history of trade unionism, this feature is certainly not downplayed.

But, where AVACP/PL is concerned, it just doesn't wash! In virtually every corner of its activities from the very start, this Association has defined itself in terms of helping others! Perhaps foremost has been the notion of helping the VA

Central Office Psychology staff. Now, not for a moment were these folks Peck, Stenger, Davis, and the others seen as anything but very competent psychologists. But they were trying to direct the activities of about 1400 psychologists in the field, located in over 150 medical centers from coast to coast. They needed help, and the new association saw providing this help as its highest priority mission. The specifics of such help were set down boldly in the very first days of the group. Indeed, in Ray's May 1977 letter to the chiefs, he named a few: selection and training of new chiefs; the development and measuring of qualifications for chief psychologists; privileging; and (arguably the number 1 priority among all concerns) the health and welfare of the doctoral training program.

It will be remembered that Ray had sent out a questionnaire with that early letter, asking for other areas of interest and concern; when returns were in from that request, the potential agenda had increased manyfold. Consider this: the first eight issues of the Newsletter about two years' worth refer to just about as many interests, crusades, and possible lines of actions to be taken as there are folders currently in the archives' "interests, crusades, and actions" section, twenty years later! Ultimately, the list did include some issues bearing on the more personal needs of the chiefs (e.g. The ABPP bonus, medical staff membership, and perhaps Title 38). But at every point, those matters were defined, discussed, and acted upon, not as avenues of personal gain but entirely as ways to improve psychological services to patients.

As I listened to the Association's proceedings at the APA convention in San Francisco last August, I was once again impressed by both the breadth of concerns/activities and the basic altruism that have persisted to this day. I am sure the
Could you summarize the background for the development of the Measurement Based Care in Mental Health (MBC) Initiative?

The goal of the MBC Initiative is to advance the standard of care by using measures of Veteran-reported outcomes over time to tailor mental health treatments to individual needs. There were multiple influences for the development of this initiative, including the Interagency Task Force on Military and Veterans Mental Health that recommended our initial four symptom measures be incorporated into clinical care, and the Institute of Medicine recommendation for a measurement-based PTSD management system. However, we believe the primary reasons for implementing MBC are two-fold: effectiveness and value. First, MBC is consistent with the high quality, evidence-based mental health care already provided by VA. There is an increasing body of research suggesting MBC improves outcomes when compared to non-MBC approaches. Second, the focus on using Veteran-reported outcome measures in shared-decision making will improve Veterans’ experience and engagement, facilitate positive outcomes, and further put into action VA’s values of providing patient-centered, recovery-oriented mental health care.

What are the principles behind MBC?

The VA’s MBC Initiative is based on three core principles: Collect, Share, Act. “Collect” refers to obtaining patient-reported outcome data. Veterans complete reliable, validated, clinically appropriate measures at intake and at regular intervals as one part of routine care. “Share” means the data collected are immediately shared with the Veteran, and the repeated measurements are tracked over time. These data can also be shared with other providers involved in the Veteran’s care. Finally, “Act” means that together, providers and Veterans use these and other data to collaboratively develop treatment plans, assess progress, and inform shared decisions about changes to the treatment plan over time.

What should clinicians and Program or Department Leads know about MBC?

In some ways, MBC is simple. It’s just a structured way to track and promote conversations about treatment progress and shared experience as Veterans and providers work together. The focus of MBC is on the provider-Veteran interaction, and using patient-reported outcome measures as one data source to help guide conversations about individualizing mental health care. It’s about getting systematic input from Veterans about their own care. However, as with many things, the devil is in the details. That’s why we’re building and testing educational tools and consultation systems to help with the logistics. We’re learning a lot about our existing information technology and where we need to move forward. As we develop tools we’ll share them on our MBC Pulse Site, https://www.vapulse.net/community/focus-areas/mbc

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This will be a major advancement for mental health care in VHA. Could you explain the plan for implementation?

We are currently in the first phase of the initiative, which is a partnership with Champion Sites. The goal is to learn from Champion Sites, get feedback about challenges, and gather success stories so we can create a learning infrastructure and implementation process which will guide future stages of the initiative. This is a large mental health initiative and we don’t want to presume we can anticipate all of the implementation needs of different types of programs and settings all across the country. We look forward to planning the next phase guided by the recommendations of current Champion Site participants.

As an individual clinician, how can I begin implementing MBC?

The list of Champion Sites is on the MBC Pulse Site. If you’re not at one of the Champion Sites, the first step might be to see who else at your facility is already practicing MBC. Support is always helpful when you try something new. Providers practicing evidence-based psychotherapies (EBP) and/or your Local EBP Coordinator are good bets, but there may be others who have been using MBC principles in their clinics. Ask around. Then it’s just a matter of picking measures that are appropriate for the Veterans with whom you work and coming up with a system for Veterans to complete them. We encourage people to use a widely-available system that gets the data into the medical record, such as the Behavioral Health Lab (BHL) or the Mental Health Assistant (MHA). Becoming familiar with those systems can help you with measure selection. Then check out some of our educational offerings on the MBC Pulse Site. A MBC module is available in the EES Talent Management System and is accessible through this link: https://www.tms.va.gov/learning/user/deeplink_redirect.jsp?linkId=ITEM_DETAILS&componentID=31368&componentTypeId=VA&revisionDate=1482151680000.

What AVAPL means to me...

As a seasoned Psychologist who is new to the VA, AVAPL has been invaluable in providing information, history, support and a network of colleagues. This sort of nationwide networking, collaboration, and sharing of resources and ideas is my favorite thing about the VA and the source of its strength.

—Cynthia Z. Mealer, Ph.D.

I would be late career, I admit with some hesitancy. AVAPL has given me access to the best minds in VA psychology and allowed me to keep informed about developments that directly affect professional psychology at the VA.

—James DeLamatre, Ph.D.

I wish that I had joined AVPL much earlier in my VA career, but I was unaware that program managers and supervisory psychologist could join. Joining AVAPL has been invaluable for making me feel like part of a larger psychology leadership community. I no longer feel isolated, and understand that I have a group of people to ask advice from about practice issues. Invaluable!

—Cheryl A. Lowman, Ph.D.
You serve as the Chief Mental Health Officer for VISN 17. Could you shed some light on how you advanced to this level?

During my early and mid-career in VA, I frequently volunteered for hospital-wide committees, projects and work groups. I was on the team that wrote up our Carey Award submission, which we won on the second re-submission. I served on several Administrative Investigation Boards, which are formal investigations of alleged wrongdoing by employees. I attended local, VISN, and national VA leadership training programs. I volunteered to write several major program expansion proposals to expand FTE and MH programs. These activities allowed me to get to know other emerging leaders and attract the attention of local and VISN senior leaders.

You have encouraged many individuals to pursue “professional hobbies.” For those new to this concept, could you give us examples of your professional hobbies?

A “professional hobby” is something you do at work that is completely different from your assigned duties and is useful to the organization. For me, it was psychology training and neuropsychological research. I was heavily involved in the Psychology Training Committee at my facility throughout my VA career, eventually became Training Director and this led directly to opportunities for national networking and leadership roles in my state’s Psychological Association, AVAPL, and APPIC. My research activities (mostly done on my own time) led to great collaborations with physician researchers at our affiliated medical school. I was co-investigator on several grants studying neuropsychiatric manifestations of lupus; these grants funded our neuropsychology postdoc position for the first few years and funded my travel/presentations at national and international scientific meetings. I became known as a psychology subject matter expert in this area, resulting in invitations for NINDS study sections, journal reviews, and consensus conferences.

You have credited your mentors for your advances as a psychologist and administrator. Could you tell us how you went about searching for mentors?

I was fortunate to have a very supportive service chief as my primary mentor, but I also sought out other facility leaders for advice and support. AVAPL meetings and work groups also provided me with additional informal mentors.

What’s one piece of advice you’ve given the most to early and mid-career psychologists?

Network! Get involved with others beyond your psychology service. The more people that know what you can do and see you are a useful collaborator, the further you will go in VA!
Driven by the President’s New Freedom Commission (2003) recommendation that “recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings…” and the Uniform Mental Health Services Handbook (2008), peer support practitioners have become invaluable members of interdisciplinary teams across VA mental health programs. Since initial funding was secured in 2006, 973 peer provider positions have been filled using very specific position descriptions and legal criteria, as well as a unique stop code and a new person class developed for workload tracking. When moving beyond the realm of mental programs, peer services have been piloted in primary care and other specialty care areas (e.g., amputation, stroke), but often on an unpaid/volunteer basis. Unique to VA Spinal Cord Injury and Disorders (SCI/D) divisions, peer support efforts have been a fundamental component of care for decades. Key functions of peer support include assistance with daily management of health-related behaviors, social and emotional support, linkage to clinical care and community resources, and ongoing personalized support (Daaleman & Fisher, 2015). These aims align perfectly with VHA Handbook 1176.01’s description of SCI peer services noting they are provided “to assist Veterans with SCI/D and their family adjust to new onset disability; understand the rehabilitation process; develop new social skills and relationships; and transition to community living.” The challenge has been that there was a lack of standard “how to” or structure; thus, the nature of their service offerings has varied greatly across time and facility.

As supervisory psychologists of peer providers, our goals are to enhance Veteran-driven care, foster inter-professional collaboration, and promote the development of peer support programs across...

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VA. We encourage those interested in learning more, psychologists who supervise peer support specialists, and even those considering doing so to consult the following resources and feel free to contact us directly.

Guiding VA Documents:

- VHA Handbook 1176.01: Spinal Cord Injury and Disorders (SCI/D) System of Care
- VHA Handbook 1160.01: Uniform Mental Health Services
- VHA Handbook 1163.01: Psychosocial Rehabilitation and Recovery
- VHA Handbook 1163.05: Psychosocial Rehabilitation and Recovery Services Peer Support
- Peer Specialist Toolkit: Implementing Peer Support Services in VHA

Other References:


—Jessica Brundage, Ph.D., Erin Williams, Ph.D., and Roger Williams, Ph.D.

AVAPL membership has fostered my professional growth through participation in its mentorship program and ample networking opportunities. I feel more connected to my colleagues across the country and up-to-date on issues that impact my practice as a VA psychologist.

—Jessica A. Brundage, Ph.D.

I joined AVAPL as an intern and through the years I have learned so much from being around our great leaders – and I consider all our members leaders! As an active member I was provided numerous opportunities to strengthen my leadership and networking skills. I was also able to forge relationships with individuals who continue to touch my life to this day, such as Dr. Jim Besyner.

—Ann Landes, Ph.D.

I have learned about the huge range of experiences among VA psychologists. I have also gained a voice at the highest levels of functioning in the VA and government that I would never have had otherwise.

—John R. McQuaid, Ph.D.
Save the Date!

The 20th Anniversary of the VA Psychology Leadership Conference
Engaging Partners in Shaping the Future of VA Integrated Care
May 17 - May 20, 2017
The Westin Riverwalk
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Key Highlights
Keynote address by 2017 APA President Antonio Puente, Ph.D.
Invited plenary by Terri Tanielian, M.A., Senior Social Research Analyst, RAND Corporation.

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A 20th Anniversary Celebration for the VA Psychology Leadership Conference!
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For more information, contact Amee Patel, Ph.D., VA Psychology Leadership Conference Chair: (601) 364-7871 or Amee.Patel@va.gov

The American Psychological Association Division 18: Psychologists in Public Service (Division 18) is the continuing education sponsor for this VA Psychology Leadership Conference. Division 18 is approved by the American Psychological Association to sponsor continuing education for psychologists. Division 18 maintains responsibility for this program and its contents.

This conference is co-sponsored by the Association of VA Psychologist Leaders (AVAPL), the American Psychological Association (APA), and Division 18 of APA.

Interested in submitting articles to the AVAPL Newsletter?
We have created an article submission portal. You can access it from your VA computer.

http://vaww.mysite.r02.portal.va.gov/personal/vha17_vhactxtsanj/AVAPL%20newsletter/default.aspx

- Click on “article submission”
- Keep submissions to 500-word limit and include a picture, image, or graph with each submission if possible.

If you have ideas about content, please contact Genevieve Davis at Genevieve.Davis@va.gov

Association of VA Psychologist Leaders

http://www.avapl.org/