My comments to the agencies supplemental report of investigation
OSC File Number DI-14-3337

In response to the recommendations for Regional Office. It is completely unacceptable that a "Team Leader" a Clinical Psychologist, working for the Department of Veteran Affairs for over twenty years can plead "I didn't know any better" or "I wasn't trained" regarding clinical documentation and clinical productivity reports. These are very basic skills that even a brand new "green" therapist knows very early in their career. It was my impression and the impression of my colleagues that the Team Leader was completely aware of the unethical conduct. This awareness goes even further when you consider the time and work put into intentional false documenting and false reporting in order to "cover our ass". The deception was INTENTIONAL with an "alibi" was created before the commitment to unethical practices were made. It was made very clear to me that the intention from the beginning was to falsely inflate numbers and reporting clinical encounters. It was my impression that the regional office is more concerned with the perception of the Vet Center and not actually admitting to the problems in order to repair them. What I fear and what is ultimately going to happen here is the Regional Office will continue to "resolve" problems the same way as the VA. No actual consequences or progressive change will be evident in their "resolve". The worst thing that could happen here is, a letter of reprimand and a "check the box" retraining. I have seen it before in the Army and in the VA that the Team Leader will continue to operate under the radar and justify unethical conduct by hiding behind vague "job descriptions", and a lack of policies. There needs to be an objective non-va/non-vetcenter clinician conducting reviews and oversight. If we continue to "address" problems this way there will be no actual change and our Veterans will continue to suffer.

I remember an email from the new Secretary of Veteran Affairs responding to the misconduct at the Phoenix VA. It said something in regards to holding supervisors accountable for unethical conduct and practices. That email gave me hope that positive systemic change is possible under the competent leadership of our new Secretary. I feel that if he really knew what happened he would not tolerate it for one second. A "second waitlist" or "unofficial waitlist" (like at the Phoenix VA) is definitely unethical. What do we do when everyone on a waitlist is completely erased or files closed like what happened at the Federal Way Vet Center in 2014?