Department of Veterans Affairs **VHA DIRECTIVE 1198**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **January 24, 2019**

INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes VHA policy regarding the Intimate Partner Violence Assistance Program (IPVAP).

2. SUMMARY OF CONTENT: This directive sets forth roles and responsibilities for developing, maintaining and establishing an IPVAP to serve all VA medical facilities. Compliance with this directive will apply to newly formed programs as well as existing programs.

3. RELATED ISSUES: VA Handbook 5019; Employee Occupational Health Service, dated August 3, 2017; VHA Directive 1101.05, Emergency Medicine, dated September 2, 2016; VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated November 28, 2017; VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009; VHA Directive 1330.01, Health Care Services for Women Veterans, dated February 15, 2015.

4. RESPONSIBLE OFFICE: The VHA Office of Care Management and Social Work (10P4C) is responsible for the content of this directive. Questions may be referred to 202-461-6780.

5. RESCISSIONS: None.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of January 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

/s/ Lucille B. Beck, PhD.
Acting Deputy Under Secretary for Health
for Policy and Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on January 29, 2019.

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1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy, roles, and responsibilities for the implementation and maintenance of an Intimate Partner Violence Assistance Program (IPVAP) at all Department of Veterans Affairs (VA) medical facilities. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. VA is committed to ensuring that Veterans, their partners, and VA employees who are directly impacted by intimate partner violence (IPV) are provided with a comprehensive network of services to include education, assessment, and intervention, and that all are treated with dignity and respect.

b. This policy supports the implementation of key recommendations of the Domestic Violence/Intimate Partner Violence (DV/IPV) Task Force as outlined in the VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program (2013). ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

c. This policy addresses the issue of IPV with limited reference to the full scope of domestic violence (see also paragraph 3, Definitions). Research suggests that Veterans may be at greater risk for using and/or experiencing IPV than their civilian counterparts. The estimated prevalence among women Veterans experiencing IPV is as high as 33 percent. Additionally, multiple medical organizations, including the American Medical Association, recognize that medical and behavioral health professionals have an ideal opportunity and responsibility for identifying Veterans and their partners who experience and/or use IPV for the purpose of linking these individuals to appropriate services. Further, the US Prevention Service Task Force (USPSTF) recommends, at a minimum, universal screening for all women of childbearing age.

d. The IPVAP outlined in this policy establishes an integrated, comprehensive approach to identify and address IPV among Veterans, their partners and VA employees. Existing services will be utilized where available and new services will be developed and implemented to meet the needs of Veterans, their partners, and employees. ***NOTE:*** *For the purposes of this directive, employee is defined in accordance with VA Handbook 5019, Employee Occupational Health Service, Part VII: Domestic Violence, Sexual Assault, and Stalking in the Workplace, dated March 27, 2015.*

3. DEFINITIONS

a. **Domestic Violence (DV).** Any violence (e.g., physical, non-physical) or abuse that occurs within the “domestic sphere” or “at home,” and may include child abuse, elder abuse, and other types of interpersonal violence.

b. **Employee.** In accordance with VA Handbook 5019, Employee Occupational Health Service, Part VII: Domestic Violence, Sexual Assault, and Stalking in the Workplace, an employee is defined as any person appointed by VA. This does not include employees of private contractors hired by VA. For the purposes of this policy, the term employee includes volunteers working at the VA. ***NOTE:*** *Health professions trainees (including students, interns, residents and fellows) appointed under 38 U.S.C. 7405 or 7406 are not considered employees for the purposes of this directive*.

c. **Intimate Partner Violence (IPV).** Any violent behavior including, but not limited to, physical or sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner that occurs on a continuum of frequency and severity which ranges from one episode that might or might not have lasting impact to chronic and severe episodes over a period of years. It can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation.

d. **Trauma-informed.** Programs and services based on understanding, recognizing and responding to the effects of trauma emphasizing physical, psychological, and emotional safety, encouraging healing and empowerment.

e. **Recovery-oriented.** The Recovery-Oriented System of Care (ROSC) model provides a coordinated network of VA and community services that build upon the strengths and resilience of individuals and families with an expectation of improving relationships and quality of life.

f. **Veteran who Experiences Intimate Partner Violence.** A Veteran who is the recipient of violent behavior in the context of an intimate relationship. Traditionally referred to as victim or survivor of IPV.

g. **Veteran who Uses Intimate Partner Violence.** A Veteran who uses violent behavior within the context of an intimate relationship. Traditionally referred to as batterer, abuser, or perpetrator.

4. POLICY

It is VHA policy that every VA medical facility implements and maintains an IPVAP. Veterans, their intimate partners, and employees impacted by IPV (experiencing or using) will have access to services including resources, assessment intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN);

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all of the VA medical facilities within that VISN; and

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Deputy Under Secretary for Health for Policy and Services (10P).** The Deputy Under Secretary for Health for Policy and Services (10P) is responsible for:

(1) Communicating the contents of this directive across 10P.

(2) Ensuring that the IPVAP has sufficient resources to fulfill the terms of this directive.

(3) Providing oversight to assure compliance with this directive.

(4) Consulting on program modifications submitted by the Chief Consultant, Office of Care Management and Social Work, Veteran Integrated Service Network and/or VA medical facility Directors as deemed necessary.

d. **Office of Care Management and Social Work (10P4C).** The Office of Care Management and Social Work (CMSW), is responsible for the implementation, management, administration, and evaluation of the IPVAP.

(1) **The Chief Consultant.** The Chief Consultant promotes and leads effective collaborations with Network and medical facility Directors to support the implementation of the IPVAP across all VA health care systems.

(2) **The National Director of Social Work.** The National Director of Social Work oversees the development and implementation of national directives, program initiatives and VHA guidance related to the delivery of IPV assistance to Veterans, their intimate partners and VA staff who are directly affected by IPV and provides direct guidance and support to the National IPVAP Manager.

(3) **The National IPVAP Manager.** The National IPVAP Manager supports the implementation of IPVAP services across the VA health care system to facilitate the delivery of services to Veterans, their partners, and VA employees directly affected by IPV through:

(a) Oversight of the implementation, maintenance, and reporting requirements to support all components of IPVAP to include, but not limited to, promoting education and training, raising awareness, implementing screening, enhancing safety, and providing intervention.

(b) Leadership in development, enhancement and improvement of national standards, policies, and guidelines to improve the quality and effectiveness of the IPVAP.

(c) Support at the national, VISN, and field-level activities by providing clinical program and policy guidance to accomplish strategic plans and initiatives related to the IPVAP.

e. **VISN Director.** Each VISN Director is responsible for:

(1) Ensuring that all facilities in their VISN have an established IPVAP as outlined in the VHA Plan for Implementation of the Domestic Violence Intimate Partner Violence Assistance Program (2013) and this directive. ***NOTE:*** *This is an internal VA Web site that is not available to the public.* Ensuring that a point of contact (POC) is designated to serve as the VISN representative on IPVAP issues. The VISN POC will be responsible for supporting the responsibilities of the IPVAP Coordinators (IPVAP-Cs) to assist with program implementation and evaluation.

(2) Providing periodic reports on program implementation status to the Deputy Under Secretary for Health Operations and Management as requested.

f. **VA Medical Facility Director.** Each VA medical facility director is responsible for ensuring that:

(1) The facility IPVAP is implemented in accordance with this policy and the Task Force recommendations as outlined in the VHA Plan for Implementation of the Domestic Violence Intimate Partner Violence Assistance Program (2013). ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(2) A local protocol is developed to define roles, responsibilities, processes, and procedures for the administration of the IPVAP in accordance with national program guidance.

(3) A facility IPVAP Coordinator is appointed. The IPVAP Coordinator must be licensed at the Independent level in their discipline and recognized as a Licensed Independent Provider (LIP) (i.e. an Independently Licensed Clinical Social Worker, Psychologist, Licensed Professional Mental Health Counselor, Advanced Practice Nurse, or Physician). The IPVAP Coordinator must possess sufficient knowledge, skills and experience in the area of Intimate Partner Violence to be deemed competent and proficient in the role. The IPVAP Coordinator must have the necessary resources to fulfill the responsibilities outlined herein. Although some facilities have established the IPVAP Coordinator as a full-time position which is optimal, it is permissible for the role to be assigned as a collateral duty. If this is the case, care must be taken to ensure that the IPVAP Coordinator is given adequate protected time to fulfill the responsibilities of the role. Facility size and complexity, number of associated CBOCs, the size of the facility's catchment area, and the size of the local IPV population are to be considered in making this assessment.

(4) Local protocol is established in accordance with national IPVAP Screening Toolkit to implement routine screening to identify populations at-risk for IPV Screening may be in the form of a clinical reminder or other methods that adhere to the national IPVAP Screening Toolkit found on the IPVAP National SharePoint site. ***NOTE:*** *This is an internal VA Web site that is not available to the public.* This protocol should also include guidance for intervening when Veterans who experience or use intimate partner violence are identified via self-report, case finding, or other means.

(5) All staff engaged in screening for IPV are provided with skills-based training and support.

(6) VA Employees (see VA Handbook 5019 for definition of employee) who experience IPV are afforded a means of safe, secure, and confidential access to IPVAP related services through the Employee Assistance Program (EAP) or Workplace Safety team in collaboration with the IPVAP Coordinator.

(7) Staff comply with all mandatory state, Federal, and VA reporting requirements for abuse, neglect, and DV/IPV. ***NOTE:*** *See VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated November 28, 2017.*

(8) IPVAP services promote a Veteran-centered, trauma-informed approach that allows Veterans/patients to make informed choices about what is documented in their medical records in relation to IPV. Please see the IPVAP Documentation Toolkit. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

g. **IPVAP Coordinator (IPVAP-C).** The IPVAP Coordinator is the facility subject matter expert (SME) and POC for matters related to intimate partner violence. The IPVAP-C is responsible for:

(1) **IPVAP Coordination.**

(a) Ensuring that the IPVAP is implemented in accordance with the VHA Plan for Implementation of the Domestic Violence Intimate Partner Violence Assistance Program (2013), national policies (see paragraph 6, References), and adapted to comply with future national guidance that modifies those recommendations.

(b) Ensuring that the program follows a trauma-informed, recovery-oriented approach to care for Veterans who experience and/or use IPV.

(c) Attending regularly scheduled national IPVAP training calls and quarterly VISN program implementation calls.

(d) Establishing a back-up coverage plan when appointed IPVAP-C is not available.

(e) Ensuring that contact information for the IPVAP-C and/or program is posted/distributed in prominent locations throughout the facility (e.g., main entrance(s), Emergency Department, Women's Health Clinics, Web sites, directories, etc.).

(2) **Awareness and Education.**

(a) Providing on-going efforts to raise awareness about IPV and the effects on health and psychosocial issues through targeted facility and community wide campaigns and coordination of domestic violence awareness month events.

(b) Providing/coordinating general local training for all staff on IPVAP services at new employee orientation and at least annually thereafter. Orientation and training specific to IPV may be conducted in conjunction, or in collaboration, with existing educational or training opportunities.

(c) Offering staff training for all providers and key personnel that addresses the dynamics of IPV to include definitions, epidemiology, health consequences, clinical signs/symptoms, screening and response practices, employee services, documentation, safety planning, and resources for referral. This education or training may be held face-to-face or be presented in an electronic manner.

(d) Arranging specialized in-depth training in assessment, screening, and treatment intervention for staff or providers who are directly engaged in these activities.

(e) Providing training to facility staff on the IPVAP documentation guidelines which aim to ensure that Veterans who may be at risk of experiencing or using IPV are identified and provided care to increase their safety and reduce risk for themselves and others and are treated with dignity and respect. See IPVAP Documentation Guidelines.
NOTE: *This is an internal VA web site that is not available to the public.*

(3) **Screening and Identification.**

(a) Developing and implementing local protocol for screening at-risk populations for IPV in accordance with the national IPVAP Screening Toolkit. While the US Prevention Service Task Force (USPSTF) recommends that all women of childbearing age be screened for IPV, the VHA encourages screening any at-risk population across diverse settings. Local protocol should also include guidance for intervening when Veterans who experience or use intimate partner violence are identified.

(b) Ensuring that Veterans who are identified as endorsing experiencing IPV (via screening, self-report, case finding, etc.) are assessed for risk during the same episode of care in which the disclosure was made in accordance with the IPVAP Screening Toolkit or referenced instructional materials found on the IPVAP SharePoint site.
NOTE: *This is an internal VA Web site that is not available to the public.*

(c) Ensuring that Veterans who have a positive response to the risk assessment are provided with information and resources as well as offered additional support including safety planning if needed or referrals to treatment in the VA or community resources during that episode of care. Guidance on responding to positive risk assessments can be found in the IPVAP Screening Toolkit or referenced instructional materials found on the IPVAP SharePoint site.

(d) Responding to, or coordinating response to, facility referrals for IPV, including providing safety planning to at-risk Veterans as needed and/or guiding facility staff on options for responding to all positive screenings.

(4) **Coordination of Services.**

(a) Building a community of practice with internal and external stakeholders to provide the appropriate services and follow-up care for Veterans and staff impacted by IPV.

(b) Internal stakeholders are a vital component of integrated IPVAP implementation across the VA health care system. Key internal stakeholders include, but are not limited to, Veterans Justice Outreach, VA Police, Women's Health, Family Services, Readjustment Counseling Services (VET Centers), Caregiver Support Program, Social Work Services, Homeless Veteran Programs, Mental Health, Emergency Department, Urgent Care, Primary Care. Occupational Health, Workplace Violence Prevention Program, and/or Employee Assistance Program (EAP).

(c) External stakeholders are a vital component of comprehensive IPVAP implementation. Key external state and/or local stakeholders include, but are not limited to, domestic violence coalitions, law enforcement, the court or legal system, domestic violence/intimate partner violence/sexual assault advocacy groups, veteran's service organizations, emergency and/or domestic violence shelters.

(d) Coordinating support services for Veterans experiencing IPV within VA and with community resources to assist them with safety planning, housing, and other needs as appropriate.

(e) Developing and maintaining a list of IPV-related community agencies and resources.

(f) Developing local protocol for extending services to VA Staff and Employees through collaboration with the Employee Assistance Program, Employee Occupational Health, Workplace Safety and other support services in accordance with the IPVAP Serving VA Employees Toolkit.

(5) **Providing Intervention.**

(a) Serving as a resource to Veterans, their partners, and VA Employees (in coordination with Employee Health, EAP, etc.) regarding IPV community resources and facilitating referrals to outside agencies as needed.

(b) Coordinating, or implementing, evidenced-based, Veteran-specific, treatment interventions for Veterans who use or are at risk of using IPV (as identified by client self-report, screening, assessment and/or court mandate). Interventions offered could be in the form of referrals to existing services offered in the VA or community or the implementation of new programs to meet identified needs of this population. ***NOTE:*** *IPVAP intervention programs may or may not be recognized as meeting court-ordered*

treatment requirements as these vary and are determined by state and local jurisdiction. The IPVAP-C should be aware of these requirements and processes when choosing to implement programs.

(c) Coordinating or implementing evidenced-based, Veteran-specific, treatment interventions for Veterans who have experienced IPV.

(d) Working with Occupational Health, Workplace Violence Prevention Program, and/or Employee Assistance Program (EAP) to develop procedures to provide IPVAP awareness, resources and services to VA Handbook 5019; Employee Occupational Health Service.

(6) **Program Evaluation.**

(a) Collecting and reviewing data regarding IPV screening, referrals, and services rendered within the medical facility to identify needs and opportunities for program improvement.

(b) Monitoring provider adherence to national and local procedures for screening, referral, documentation, and safety planning, including reporting findings to facility leadership and providing feedback to providers as appropriate.

(c) Reporting data to the VHA National IPV Assistance Program Manager or designee when requested. Assisting with VHA National IPVAP evaluation efforts as requested.

(d) Tracking and monitoring referrals from VA providers for Veterans who experience and/or use IPV. ***NOTE:*** *Data collection and reporting is to be implemented on an ad hoc basis, at the direction of 10P4C, until a schedule is developed.*

6. TRAINING REQUIREMENTS

There are no formal national mandatory training requirements associated with this directive. IPV-specific training recommendations are referenced herein.

7. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive must be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. If you have any question to the regarding any aspect of records management, you should contact your facility Records Manager or your Records Liaison.

8. REFERENCES

a. VA Handbook 5019; Employee Occupational Health Service, dated August 3, 2017.

b. VHA Directive 1101.05, Emergency Medicine, dated April 14, 2017.

c. VHA Directive 1199, Reporting Cases of Abuse and Neglect, dated November 28, 2017.

d. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

e. IPVAP Documentation Toolkit. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

f. IPVAP Screening Toolkit. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

g. IPVAP Serving Employees Toolkit. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

h. VHA Plan for Implementation of the Domestic Violence Intimate Partner Violence Assistance Program (2013). ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

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