INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM

1. SUMMARY OF MAJOR CHANGES:

a. Amendment dated September 9, 2024: Updates implementation schedule on transmittal sheet.

b. As published June 11, 2024:

(1) Clarified staffing requirements for Intimate Partner Violence Assistance Program Coordinator (IPVAP-C) in paragraph 2.i.(2).

(2) Clarified responsibilities in paragraph 2.g., 2.i., 2.j. and 2.k.

(3) Added roles for Veteran Integrated Service Network (VISN) Intimate Partner Violence Assistance Program (IPVAP) Lead in paragraph 2.h. and Department of Veterans Affairs (VA) Licensed Practitioners in paragraph 2.k.

(4) Updated expectations for annual Relationship Health and Safety (RHS) screening in paragraph 2.i.(11).

(5) Clarified and updates training requirements in paragraph 3.

(6) Added definitions for eligible intimate partners, eligible employees and RHS screenings in paragraph 6.

(7) Updated the definition for VA covered professional and licensed professional in paragraph 6.

2. RELATED ISSUES: Veterans Health Administration (VHA) Directive 1199, Reporting Abuse and Neglect, dated November 28, 2017; VHA Directive 1115(1), Military Sexual Trauma (MST) Program, dated May 8, 2018; VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021; VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022; VHA Directive 1330.01(7), Health Care Services for Women Veterans, dated February 15, 2017.

3. POLICY OWNER: Care Management and Social Work Services (12CMSW), Office of Patient Care Services, is responsible for the content of this policy. Questions may be referred to the National Social Work Program at VHA12CMSWSW@va.gov.

4. RESCISSIONS: VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019, is rescinded.

5. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: This directive is effective 6 months after publication to allow for VISNs and VA medical facilities to make necessary changes to comply with this directive. ***NOTE:*** *The mandatory FTE requirement for one VA medical facility IPVAP-C is subject to any VHA guidance on specific purpose funded positions or may be waived using the waiver process found at: https://dvagov.sharepoint.com/sites/VACOVHACBI/VHAPolicyWaivers. This is an internal VA website that is not available to the public.*

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ M. Christopher Saslo
DNS, APRN-BC, FAANP
Assistant Under Secretary for Health
for Patient Care Services/CNO

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 June 12, 2024.

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INTIMATE PARTNER VIOLENCE ASSISTANCE PROGRAM

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1. POLICY

It is Veterans Health Administration (VHA) policy that every Department of Veterans Affairs (VA) medical facility maintains an Intimate Partner Violence Assistance Program (IPVAP). Veterans, their eligible intimate partners, and eligible employees impacted by intimate partner violence (IPV) will have access to services including resources, assessment, intervention and referrals to VA or community agencies as deemed appropriate and clinically indicated and as authorized by law and by VHA policy. Compliance with this directive applies to both newly formed programs and existing programs. **AUTHORITY:** 38 U.S.C. § 7301(b).

2. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer (CNO) is responsible for supporting Care Management and Social Work Services (CMSW) with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

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

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Care Management and Social Work Services.** The Executive Director, CMSW is responsible for:

(1) Overseeing IPVAP.

(2) Promoting and leading communication with PCS leadership and VISN Directors to support the implementation of IPVAP across all VA medical facilities.

(3) Supporting the National Program Manager, IPVAP, when directive non-compliance is identified and providing guidance for the resolution of non-compliance.

e. **Director, VA Social Work.** The Director of VA Social Work is responsible for:

(1) Providing guidance to the National Program Manager of IPVAP.

(2) Supporting the development of national directives, program initiatives and oversight related to IPVAP.

(3) Supporting the delivery of IPV assistance services or resources to Veterans, their eligible intimate partners and eligible VA employees who are impacted by IPV and IPV-related issues.

f. **National Program Manager, Intimate Partner Violence Assistance Program.** The National Program Manager of IPVAP is responsible for:

(1) Implementing, managing, administering and evaluating IPVAP.

(2) Providing oversight for program operations across VA medical facilities to facilitate the delivery of applicable services to eligible Veterans and their eligible intimate partners.

(3) Overseeing the distribution and use of IPVAP Special Purpose funding.

(4) Ensuring that VA employees directly affected by IPV have access to available IPV resources for which they are eligible.

(5) Leading the development, enhancement and improvement of program requirements procedures and materials to support and improve the quality and effectiveness of IPVAP.

(6) Developing and monitoring reporting requirements to support all components of IPVAP, including, but not limited to, prevention, education and training, raising awareness, screening, enhancing safety and providing and coordinating interventions.

(7) Providing administrative and clinical program guidance at the national, VISN and VA medical facility levels in order to accomplish strategic plans and initiatives related to IVPAP operations.

(8) Initiating requests for corrective action plans when a facility is found to be out of compliance.

g. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing the Assistant Under Secretary for Health for Operations and the Director, IPVAP when barriers to compliance are identified.

(2) Ensuring that national and VISN action items and reports are submitted in a timely manner as requested. This specifically includes the annual Program

Implementation Evaluation (PIE) and the provision of other program assessment or operations actions.

(3) Appointing a VISN-level representative to serve as the VISN IPVAP Lead.

h. **Veterans Integrated Services Network Intimate Partner Violence Assistance Program Lead.** The VISN IPVAP Lead is responsible for:

(1) Promoting awareness of the IPVAP within the VISN and VA medical facilities within the VISN.

(2) Facilitating regular communication between the facility IPVAP and VISN leadership. ***NOTE:*** *This includes monthly conference calls with IPVAP Coordinators (IPVAP-Cs) within the VISN, attending national quarterly VISN Lead calls, utilizing VISN IPVAP email groups, responding in a timely manner to IPVAP-C inquiries and providing program progress reports to VISN leadership*.

(3) Providing guidance and support to the IPVAP-Cs and other program staff within the VISN as needed to assist with program implementation, operations, actions and evaluation.

(4) Monitoring compliance with administrative actions related to IPVAP.

i. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring VA medical facility compliance with this directive and that appropriate corrective action is taken when non-compliance is identified.

(2) Appointing a VA medical facility IPVAP-C. Each VA medical facility must have a minimum of 1.0 full-time employee equivalent (FTEE) IPVAP-C who is a VA Licensed Practitioner working within their licensure and scope of practice. VA medical facilities that do not have a minimum 1.0 FTEE assigned as the IPVAP-C must provide justification that IPVAP programming is successfully implemented as outlined in this directive and must receive approval from the IPVAP National Program Manager to certify the justification at least annually. ***NOTE: NOTE:*** *The mandatory FTE requirement for one VA medical facility IPVAP-C is subject to any VHA guidance on specific purpose funded positions or may be waived using the waiver process found at: https://dvagov.sharepoint.com/sites/VACOVHACBI/VHAPolicyWaivers. This is an internal VA website that is not available to the public.*

(3) Ensuring that the IPVAP-C possesses sufficient clinical knowledge, skills and experience in the area of IPV and delivery of clinical interventions to oversee or provide specialized clinical services to Veterans, their eligible intimate partners and eligible VA employees. This may include providing the IPVAP-C with clinical training, consultation and direct services as needed.

(4) Ensuring that a minimum of 50% of the IPVAP-C's dedicated time is protected as administrative time to support the oversight of program operations, including but not

limited to managing the program, providing training, engaging in outreach, responding to actions, record-keeping and evaluating program efficacy.

(5) Ensuring that the hiring process for an IPVAP-C is initiated within 30 calendar days of a vacancy, or that an appropriately licensed clinician is formally detailed into the IPVAP-C position if the vacancy is expected to last longer than 90 days.

(6) Ensuring that the IPVAP-C is implementing the IPVAP in accordance with this directive and that all interventions for IPVAP use and experience follow a person-centered, trauma-informed, recovery-oriented approach.

(7) Ensuring the proper management of IPVAP special purpose funding, including but not limited to IPVAP staff salaries and benefits, program development, training and travel. ***NOTE:*** *This funding can only be used for direct support of the IPVAP. Staff who are supported by IPVAP special purpose funding may not have any duties assigned that are not directly in support of the IPVAP.*

(8) Ensuring that contact information for the IPVAP-C is posted and distributed across the medical facility, and that a back-up coverage plan is established for when the appointed IPVAP-C is not available.

(9) Providing the IPVAP-C's and other program staff with the necessary resources to fulfill the responsibilities outlined in this directive. This includes access to space sufficient to operate the program, private space in which to conduct direct care as needed, administrative program support and all necessary equipment and technology. IPVAP-C's must have a visible presence within the assigned VA medical facility and clinics and the flexibility to physically visit various clinics to provide training, consultation and services.

(10) Ensuring that IPVAP-related clinics are set up in accordance with the IPVAP Clinic Set-up Guide. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(11) Ensuring annual Relationship Health and Safety (RHS) screening of all women Veterans of childbearing age and at-risk Veteran cohorts in compliance with the IPVAP Screening and Assessment Guidance. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.* Medical Centers may implement IPV screening for additional at-risk Veteran cohorts as advised by their facility IPVAP Coordinators, clinical and executive leadership.

(12) Establishing written local Standard Operating Procedures (SOP) to inform IPVAP operations. The SOP must promote Veteran-centered, trauma-informed and recovery-oriented approaches that empower the recipient of care to make informed choices about their care and referral options. An IPVAP SOP template is available for

use by local medical facilities. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public. The Human Factors Engineering (HFE) division in the Clinical Informatics and Data Management Office (CIDMO) of the Office of Health Informatics (OHI) may be able to provide advice and consult with systems design and usability. The HFE division may be able to provide design support of clinical tools such as, but not limited to, the study, design, and evaluations of templates, forms, notices, documentation tools, clinical reminder order checks, SOPs, webpages, dashboards, and tracking systems.*

(a) At a minimum, the local guidance must include:

1. Defining roles, responsibilities, processes and procedures for the administration of IPVAP.

2. Responding to disclosures of IPV experience or use whether identified via screening, self-report, case finding or other means which include:

a. Providing universal education and resources.

b. Conducting screening.

c. Responding to positive screenings or disclosures.

d. Conducting safety planning and further assessment.

e. Referring for IPV specific intervention within the VA or community.

f. Reporting abuse in accordance with VHA Directive 1199(1), Reporting Abuse and Neglect, dated November 28, 2017.

3. Documenting services and contacts in accordance with IPVAP Trauma-Informed Documentation Guidance. For more information, see https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public*. Documentation of services and contacts includes:

a. Using and maintaining Reports of Contact.

b. Contacts with non-Veteran eligible intimate partners.

c. Maintenance of collateral charts.

4. Ensuring services are available to eligible intimate partners of Veterans.

5. Ensuring all VA employees, as defined in VA Handbook 5019, Employee Occupational Health Service, dated August 3, 2017, who are impacted by IPV are

afforded safe, secure and confidential access to IPVAP-related services for which the employees are eligible and as authorized by law and by VHA policy.

(13) Ensuring that all staff who provide IPV and IPV-related services document their services using approved templates and documentation practices as outlined in the IPVAP Trauma-Informed Documentation Guidance. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

j. **VA Medical Facility Intimate Partner Violence Assistance Program Coordinator.** The VA Medical Facility IPVAP-C is responsible for:

(1) Serving as the VA medical facility subject matter expert and point of contact for matters related to IPV and other IPV-related issues.

(2) Coordinating IPVAP at the VA medical facility, including:

(a) Implementing the VA medical facility IPVAP and adapting it as required by future national guidance.

(b) Ensuring that IPVAP follows a person-centered, trauma-informed, recovery-oriented approach for Veterans, their eligible intimate partners and eligible VA employees who are impacted by IPV.

(c) Completing required national IPVAP training as specified in paragraph 3 of this directive.

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

(e) Including their contact information on the Directory of Intimate Partner Violence Assistance Program Coordinators at https://www.socialwork.va.gov/IPV/Coordinators.asp and reporting any changes immediately to the National IPVAP Program Manager.

(f) Ensuring that contact information for the IPVAP is clearly posted in prominent locations throughout the facility. Examples of prominent locations include main entrance(s), Emergency Departments, Women's Health Clinics, restrooms, VA medical facility websites and listing the IPVAP-C in other program or service directories.

(3) Providing IPV and IPV-related awareness and education, including:

(a) Ongoing efforts to raise awareness, through strategic facility and community-wide campaigns including, at a minimum, the organization of and participation in annual Domestic Violence Awareness Month and other related events.

(b) Facilitating awareness of IPVAP-related training for all staff as identified in paragraph 3 of this directive.

(c) Providing clinical consultation to facilitate trauma-informed service delivery approaches to mitigate risk. This may include direct follow-up, documentation, safety planning, clinical assessment or guiding facility employees on options for responding to positive screenings. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(4) Monitoring and reporting compliance with IPV screening and identification protocols in accordance with the IPVAP Screening and Assessment Guidance. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.* This includes:

(a) Implementing local procedures for IPV screening.

(b) Ensuring that Veterans, eligible intimate partners or eligible VA employees who disclose experiencing IPV (via screening, self-report, case finding or other means) are assessed for risk during the same episode of care in which the disclosure is made unless the Veteran declines the risk assessment.

(c) Ensuring that Veterans who are identified as using or at risk of using IPV (via screening, self-report, case finding or other means) are offered appropriate evidenced based interventions.

(d) Supporting processes to address positive RHS screenings.

(5) Developing and maintaining a community of practice to assist in the coordination of support services including:

(a) Establishing relationships with internal stakeholders. Key internal stakeholders include, but are not limited to, Suicide Prevention Program, Veterans Justice Outreach, VA Police, Women's Health, Family Services, Readjustment Counseling Services (Vet Centers), Caregiver Support Program, Military2VA Program, Social Work Services, Homeless Veteran Programs, Mental Health, Emergency Department, Urgent Care, Primary Care, Employee Occupational Health, Workplace Violence Prevention Program (WVPP), LGBTQ+ Veteran Care Coordinators and Employee Assistance Program (EAP).

(b) Establishing relationships with external stakeholders. Key external state and local stakeholders include, but are not limited to, domestic violence, IPV and sexual assault coalitions; law enforcement and other legal systems; Veterans Service Organizations; tribal governmental entities; and emergency shelters.

(c) Developing and maintaining a list of local IPV-related community agencies and resources and ensuring this list is available to facility providers and other staff.

(d) Serving on the Disruptive Behavior Committee, Employee Threat Assessment Team, and Sexual Assault Response Teams to provide consultation as needed. ***NOTE:*** *Involvement must be at a minimum as an ad hoc member.*

(6) Providing and coordinating interventions, including:

(a) Developing, coordinating and implementing evidenced-based interventions. Interventions offered may include referrals to existing VA services, community resources or the implementation of new programs to meet identified needs of this population.

(b) Facilitating referrals to external organizations to address IPV and related issues.

(c) Collaborating with Employee Occupational Health, WVPP and EAP to develop procedures to provide resources for VA employees, including developing local protocols in accordance with the IPVAP Serving VA Employees Toolkit. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(d) Responding to consults and referrals for Veterans who experience or use IPV.

(7) Completing the annual IPVAP PIE, reporting data and completing other reports required or requested by the national program office.

(8) Utilizing nationally created data sources and developing local methods to collect and review data regarding IPV screening, referrals and services rendered within the VA medical facility to identify needs and opportunities for program improvement.

(9) Reporting adherence to national and local procedures for referral, documentation and safety planning, including findings to facility leadership and providing feedback to providers as appropriate.

(10) Assisting with VHA national IPVAP evaluation efforts as requested.

k. **VA Licensed Practitioners.** VA Licensed Practitioners are responsible for:

(1) Screening, assessing and safety planning in accordance with licensure, position, credentialing and scope of practice as delineated by IPVAP Screening and Assessment Guidance. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(2) Using trauma-informed approaches to service delivery and documentation guidelines to mitigate risk in accordance with the IPVAP Trauma-Informed

Documentation Guidance. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(3) Completing required national IPVAP training as specified in paragraph 3 of this directive.

(4) Providing universal education and resources to Veterans.

3. TRAINING

a. The following training is required:

(1) IPVAP-Cs (including back-up or interim Coordinators) are required to complete the following training within 90 calendar days of appointment:

(a) Core Training Course for Intimate Partner Violence Assistance Program which covers general program orientation, screening, assessment, documentation and program evaluation (VA 131008706).

(b) Intimate Partner Violence Risk & Lethality Assessment: Implications for Women's Safety. This course leads to certification in use of the Danger Assessment (VA 41233).

(2) IPVAP-Cs are also required to complete all five orientation calls via Microsoft Teams meetings within the first six months of appointment provided by the national IPVAP. Invitations are available from vhaipvapvacoteam@va.gov.

(3) All VA Licensed Practitioners who provide specific IPV-related interventions are required to complete the corresponding training as specified in the IPVAP Training Tip Sheet. Health profession trainees are not required to participate in IPVAP trainings. See https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e =38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

b. The following training is recommended:

(1) All employees are highly recommended to complete the following:

(a) Intimate Partner Violence Assistance Program Overview (VA 131001788). This training may also be provided in New Employee Orientation by the IPVAP-C.

(b) Understanding Human Trafficking (NFED 4628321).

(2) All VA covered professionals are highly recommended to complete the following skills-based training(s) based upon the employee’s role and responsibilities within the organization:

(a) Document IPV-related information in the electronic health record: VHA IPVAP: Trauma-informed Documentation Practices (SharePoint Video), at http://site-360277.bcvp0rtal.com/detail/videos/video-playlist/video/6157511618001/ipvap-training:-trauma-informed-documentation-practices-march-2019?autoStart=true&page=2.

(b) Conduct the RHS Screen: Relationship Health and Safety Clinical Reminder Training for New Screeners (TMS VA 131007439).

(c) Conduct RHS Assessment: Relationship Health and Safety Assessment Note Training (SharePoint Video), at https://dvagov.sharepoint.com/:v:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Training%20and%20Education/Office%20Hours%20Recordings%20by%20Topic/Relationship%20Health%20and%20Safety%20Assessment%20Note/IPVAP%20Coordinator%20Support%20Office%20Hour.%20.%20.%20-%20Thursday,%20April%202,%202020%2012.31.44%20PM.mp4?csf=1&web=1&e=VqUndw.

(d) Conduct RHS Safety Planning: IPVAP Safety Plan Training: A Live Demonstration of Trauma-Informed Safety Planning (TMS VA 131006026).

4. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

5. BACKGROUND

a. On September 28, 2022, the Office of Inspector General (OIG) published the Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance report. The recommendations include ensuring that protocols are developed at all VA medical facilities, that VA medical facilities have sufficient staffing to implement IPVAP and that roles are clearly defined, that standardized IPV staff training is developed, and screening requirements are followed. Revisions to this directive take these recommendations into account and further strengthens the VA commitment to serving Veterans, their eligible intimate partners and eligible VA employees impacted by IPV and IPV-related issues as authorized by law and by VHA policy.

b. VHA is committed to ensuring Veterans, their eligible intimate partners and eligible VHA employees who are directly impacted by all forms of IPV and related issues are served with dignity and respect. The IPVAP is specifically committed to promoting safe, healthy relationships by providing a comprehensive network of services to include education, prevention, screening, assessment and intervention.

c. Research suggests Veterans may experience unique stressors that can increase risk for using and/or experiencing IPV. In addition, IPV is linked with several other

issues of concern such as exploitation, sexual assault, homelessness, human trafficking, suicide and homicide as well as related to physical and mental health concerns. VA recognizes IPV can happen to anyone, any gender and any age, and that some demographic groups can be at higher risk.

6. DEFINITIONS

a. **Domestic Violence.** Domestic violence is any violence (physical or 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. **Intimate Partner.** Intimate partner refers to any person with whom one has, or once had, a close personal relationship that may be characterized by emotional connectedness, regular contact, ongoing physical or sexual contact, identity as a couple and familiarity and knowledge about each other's lives. Cohabitation or a sexual relationship is not required.

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

d. **Person-centered**. Person-centered language respects the dignity of individuals by refraining from assigning labels, focusing instead on naming the behavior to be changed. For example:

(1) A Veteran or partner who is traditionally referred to as *victim or survivor of IPV*, would be referred to as a Veteran or partner who *experiences IPV*.

(2) A Veteran or partner who is traditionally referred to as *batterer, abuser or perpetrator* would be referred to as a Veteran or partner who *uses IPV*.

e. **Recovery-oriented.** A recovery-oriented 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. **Relationship Health and Safety screening.** RHS screening is a method to identify individuals who are experiencing relationship conflict or IPV risk.

g. **Sexual Assault.** Sexual assault is any of various behaviors, including but not limited to, a completed nonconsensual sex act (e.g., rape, sodomy, child molestation), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal harassment). Sexual assault includes any sexual act or behavior that is perpetrated when someone does not or cannot consent.

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

i. **VA Covered Professional**. VA covered professionals are VHA employees or contractors who are allopathic and osteopathic physicians; dentists; hospital personnel and administrators; registered nurses; licensed practice/vocational nurses; certified nurse practitioners; certified registered nurse anesthetists; certified nurse midwives; certified clinical nurse specialists; physician assistants; health care practitioners; chiropractors; pharmacists; optometrists; podiatrists; emergency medical technicians; ambulance drivers; medical examiners; alcohol or drug treatment personnel; persons performing a healing role or practicing the healing arts; psychologists, psychiatrists and mental health professionals; social workers; licensed or unlicensed marriage, family and individual counselors; and childcare workers and administrators. ***NOTE****: For the purpose of this directive, health profession trainees are not considered VA covered professionals.*

j. **VA Licensed Practitioner**: An individual who is licensed and qualified to direct or provide care, treatment and services in accordance with state law and regulation, applicable federal law and regulation and organizational policy.

k. **VA Employee.** For purposes of this directive, in accordance with VA Handbook 5019, Employee Occupational Health Service, Part VII: Domestic Violence, Sexual Assault and Stalking in the Workplace, dated January 23, 2015, an employee is any person appointed by VA. This does not include employees of private contractors hired by VA. For purposes of this directive, the term employee includes detailees and 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*.

7. REFERENCES

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

b. VHA Directive 1115(1), Military Sexual Trauma (MST) Program, dated May 8, 2018.

c. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

d. VHA Directive 1199(2), Reporting Abuse and Neglect, dated November 28, 2017.

e. VHA Directive 1330.01(7), Healthcare Services for Women Veterans, dated February 15, 2017.

f. VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022.

g. IPVAP Trauma-Informed Documentation Guidance: https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

h. IPVAP Screening and Assessment Guidance: https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

i. IPVAP Serving VA Employees Toolkit: https://dvagov.sharepoint.com/:f:/r/sites/vhavha-ipv-assistance-program/Shared%20Documents/Directive%201198?csf=1&web=1&e=38oyKY. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

j. VA Office of Inspector General (OIG) Report #21-00797-248, Veterans Health Administration: Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance, dated September 28, 2022. Available at https://www.va.gov/oig/pubs/VAOIG-21-00797-248.pdf.

g. U.S. Preventive Services Task Force Final Recommendations for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening [in health care settings]. Retrieved August 24, 2017 from https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening. ***NOTE:*** *This linked website is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*