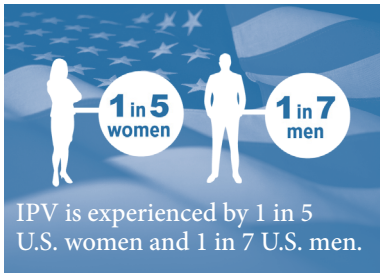
Five Keys to Successfully Implementing IPV Assistance at the Department of Veterans Affairs

Understanding of the Context

Intimate partner violence (IPV) is a public health concern that millions of people across the United States have experienced and is of particular concern among Veterans. The Centers for Disease Control and Prevention (CDC) describes IPV as "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner).[1] The 2011 National Intimate Partner and Sexual Violence Survey revealed that annually over 10 million, men and women, in the United States experienced IPV.[2] Though data has shown that nearly 1 in 5 of all women in the United States will experience IPV in their lifetime, women Veterans are more likely to experience IPV, with nearly 1 in 3 experiencing IPV in their lifetime.[3]

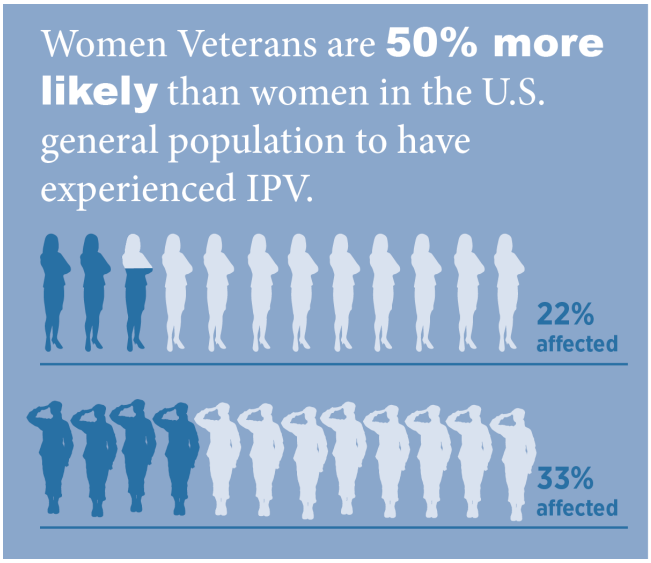


Research has shown that experiencing IPV increases risk of developing co-morbidities, including high rates of depression, substance use, and chronic mental illness.[4,5] Adverse outcomes among those who have experienced IPV are higher among women Veterans. For example, one study revealed that women Veterans who experienced IPV also experienced increased heart health risk factors compared to other populations.[6]

The United States Preventive Service Task Force has recently recommended routine screening of IPV in women of childbearing age in primary care settings.[7] Though men, including male Veterans, are also at risk of experiencing IPV, they are less likely to be screened for experience of IPV and are less likely to seek care following IPV experience, which further highlights the need to screen both male and female patients.[8]

Coupled with concerns about Veterans who experience IPV comes concerns about those who use it. History of military combat and post traumatic stress disorder (PTSD) among Veterans have both been linked to increased risk of using IPV, along with other experiences related to military service and childhood trauma.[9]

Though agencies and organizations are beginning to screen more routinely for both experience and use of IPV, surveillance data has shown that this implementation is not yet widespread, perhaps due to barriers encountered due to confidentiality restrictions, capacity constraints to train staff on proper screening techniques and tools, as well as lack of consistent reporting for recommended IPV screening measures.[10] Fortunately, effective intervention as a follow-up to IPV screening has shown to reduce further risk of experiencing IPV, physical or mental health concerns, or mortality due to IPV-related causes.[11] However,



Adverse Health Outcomes Associated with IPV	
Health Disorders	Bladder and kidney infections, circulatory conditions, central nervous system disorders, gastrointestinal disorders, and migraines and headaches
Gynecological Disorders	Pregnancy difficulties including low birth weight babies, perinatal deaths and unintended pregnancy
Psychological Conditions	Anxiety, depression, suicidal behavior, low self-esteem, and sleep disturbances
Social Conditions	Homelessness, isolation from social networks, and restricted access to services
Risk Behaviors	High-risk sexual behavior, use of harmful substances, and unhealthy diet-related behaviors

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (2015). Intimate Partner Violence: Consequences. Retrieved from: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/consequences.html

existing interventions with those who use IPV are known to be less effective among military Veterans, calling for further research and implementation of effective practices specifically developed for this population.[12]

Addressing IPV Among Veterans: The National IPV Assistance Program

These findings point to opportunities for healthcare systems like the Veterans Health Administration (VHA) to integrate disease management approaches that promote help-seeking behavior among all Veterans; improve the health and safety of Veterans and their partners, and ensure a safe environment at VA Medical Centers (VAMCs) across the country; evaluate best practices in implementation; and contribute to a national strategy for addressing IPV.

Recognizing that effective interventions for domestic and intimate partner violence (DV/IPV) are vital to increasing the safety and health of Veterans, the VHA is launching a National IPV Assistance Program. The program, which builds on 14 recommendations made by a DV/IPV task force chartered in 2012, seeks to make assistance available to all Veterans and VA employees who are experiencing such violence as well as to Veterans currently using IPV or at risk to use IPV.

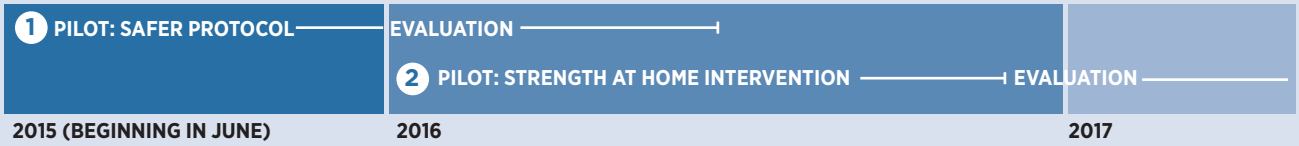
VHA is in the process of putting in place accountabilities for IPV assistance, assigning a National IPV Program Manager, a DV/IPV steering committee and workgroups, a point of contact at each VISN (Veterans Integrated Service Network), and a local Domestic Violence Coordinator (DVC) at each VAMC. Delivery of IPV services will be accomplished through referrals to community-based providers. The program has developed the SAFER protocol—encompassing screening with the E-HITS tool, counseling and educating, and providing referrals and flexible documentation options—that has been piloted and evaluated at six VAMCs as part of the first phase of program implementation. In addition, the Strength at Home intervention is currently being piloted in the second phase of program implementation, and evaluations are being conducted to assess its effectiveness in reducing the risks of IPV.

Assessing Needs for a National Rollout

The rollout strategy for the National IPV Assistance Program will be determined at the conclusion of the pilot phases, including the staffing and resources that will be required at VA headquarters as well as locally. This data-driven design process will be based on an in-depth assessment of the needs of VAMCs. A baseline survey tool is being distributed nationally to assess the VA enterprise needs, and health data are currently being aggregated and mined for insights to enhance this baseline assessment. In addition, the two pilot phases of the program will yield detailed needs analyses based on the challenges and gaps identified by the participating VAMCs.

One critical element of the national rollout will be the appointment of a DVC at each VAMC, as recommended by the DV/IPV task force. DVCs have been assigned at the six pilot locations, playing central roles throughout the pilot implementations and evaluations.

Two Pilot Phases of National IPV Assistance Program



The National IPV Assistance Program is being developed through an evidence-based process that includes two pilot phases. In phase 1, six VAMCs served as pilot sites in implementing the SAFER protocol, with local leadership provided by an onsite Domestic Violence Coordinator at each participating VAMC. The results of this pilot are currently under evaluation. In phase 2, the Strength at Home intervention is being piloted at VAMCs and three additional sites.

Unexpectedly, an additional 70 VAMCs have moved proactively to appoint a DVC ahead of the national program rollout, evidencing their strong interest in supporting Veterans' IPV needs. Indeed, a few VAMCs have devoted a staff member to the DVC role on a full-time basis. With these voluntary actions, close to half of the VAMCs now have a DVC in place. Alongside any other staffing and resource requirements to be defined, the appointment of DVCs in the remaining locations will be instrumental in a successful national rollout.

Stepping Up to the Challenges

The decentralized structure being created across VHA will enable flexible responses to the needs of individual Veterans experiencing IPV, giving them a choice about what, when, to whom, and how to disclose, and providing them with access to tailored support available through VA and community resources. Support will also be made available to Veterans who use IPV, again through a combination of VA and community resources.

However, the decentralized nature of the program also introduces challenges:

- **Challenge 1: Ensuring consistent and satisfactory Veteran experiences**
  Each VAMC will be expected to identify, closely coordinate with, and train a broad array of resources and partners unique to that specific community; to provide educational materials to Veterans and employees; to develop procedures for determining and referring to the most appropriate mix of resources for the individual Veteran seeking assistance; and to appropriately follow up and evaluate the services provided and the satisfaction of the Veteran. Partnering with the Domestic Violence Hotline will greatly assist DVCs in identifying and referring out to appropriate community-based resources. Yet setting standards of care and ensuring consistency in screening, referral protocols, and service delivery to ensure satisfactory Veterans' experiences will be complicated given the wide variations in available resources from community to community.
- **Challenge 2: Ensuring up-to-date best practices across the VA system**
  As the national spotlight focuses on IPV with increasing intensity, the field is rapidly evolving. Heightened national awareness is spurring significant new research on IPV prevention, detection, and intervention, as well as increased investment in public education campaigns. Furthermore, provisions in the Affordable Care Act are emphasizing the central roles of health care providers in IPV screening and counseling, which, in turn, is increasing the availability of high-quality data on the prevalence, detection, and treatment of IPV. In this environment, best practices are continually being evaluated and improved. Through its National IPV Assistance Program, VA intends to create communities of practice to keep pace with current knowledge and to diffuse this knowledge across its health care delivery system. These communities of practice will bring together multidisciplinary expertise from across VA—representing mental health, social work, women's health, primary care, emergency care, and justice—as well as leading advocacy

groups, nongovernmental organizations, and related Federal programs, encompassing practitioners and researchers. The challenges of productively and systematically convening these communities of busy professionals, facilitating them in identifying and framing best practices, and documenting and diffusing the resulting knowledge base will not be trivial.

Realizing the Opportunity

Looking beyond the challenges, VA has an extraordinary opportunity to become a national leader and convener on effective IPV services, particularly given its strong research capabilities and access to rich data on diverse Veteran populations. Indeed, VA is well positioned to evaluate the effectiveness of screening and intervention protocols based on gender and cultural differences, as well as age and other demographics; and to develop insights into the interrelationships among IPV, post-traumatic stress disorder, homelessness, and military sexual trauma. VA also can raise the standard for coordination of care, by demonstrating Veteran-centric delivery of IPV services across mental health care, primary care, social work, and emergency care. Partnerships with other Federal agencies could be leveraged as well. Engaging the Department of Defense, Military Health System, in collaborative research and data sharing, for example, would further the understanding of vulnerabilities to IPV within the active duty military and enable identification of effective strategies for IPV prevention, detection, and treatment both during military service and at the time of separation.

Challenges & Opportunities

- Ensuring consistent and satisfactory Veteran experiences
- Ensuring up-to-date best practices across the VA system
- Positioning VA as a leader in Veteran-centric IPV services

Five Success Factors

Given these challenges and opportunities, five success factors will be essential in achieving the greatest possible benefits and impacts from VA's IPV assistance program:

1. **Support for communities of practice in articulating and documenting best practices in IPV services and diffusing current knowledge throughout the VHA system**

   The IPV program has formed productive partnerships at the national level with leading advocacy groups, nongovernmental organizations, and related Federal programs, encompassing a wide range of subject-matter experts and researchers. This network of expertise has been tapped in developing and evaluating the SAFER protocol for screening, counseling, and referrals.

   As the state of IPV knowledge and best practices continues to evolve—along with the landscape of programs, organizations, resources, and research across the nation—the relationships established to date by the IPV program will become a valuable foundation for ongoing communities of practice. These communities of practice will ensure that VA has access to current knowledge to inform its IPV education, outreach, detection, and interventions for the Veteran and VA employee populations.

   One strategy to gain the greatest possible benefit of these communities of practice is to provide skilled facilitation and documentation support. This support will enable these multidisciplinary experts to effectively share their diverse bodies of knowledge, experience, and research, and to reach consensus in identifying and framing best practices. Such support also will accelerate the diffusion of best practices through the VHA system, ensuring that best practices are effectively translated into policy

Five Success Factors

- ✔ Support for communities of practice in articulating and documenting best practices in IPV services and diffusing current knowledge throughout the VHA system
- ✔ Support for VAMCs in integrating standards of care and ensuring consistency in screening, referral protocols, and service delivery
- ✔ Support for DVCs and other VAMC staff in cultivating, maintaining, and continually improving strong partnerships at the local level
- ✔ Strategic communication and educational campaigns at the national and local levels
- ✔ Positioning of VA as a national leader and contributor to the development of best practices in IPV services for Veterans and their families

recommendations for consideration by leadership and into actionable tools, training, and communication for use at the local level. Policies and training to ensure staff and patient safety—aligned with VA disruptive behavior prevention and response initiatives—would be a vital area of focus.

2. **Support for VAMCs in integrating standards of care and ensuring consistency in screening, referral protocols, and service delivery**

   VA is undergoing a massive reorientation to focus on Veteran needs and to empower and assist employees in delivering excellent customer service to improve the Veteran experience. Aligned closely with this reorientation, the National IPV Assistance Program can play a critical role in ensuring that a Veteran experiencing IPV is able to get high-quality, culturally competent, and stigma-free services no matter where they access services.

   Translating the work of the communities of practice into actionable tools for use at the local level will be critical in supporting the VAMCs and the DVCs. Equally important will be VAMC-level data collection and evaluation to ensure that services across VHA meet a consistent standard.

   Data collection could be accomplished through field surveys, telephone interviews with DVCs and community providers, or other methods. One relevant model would be the qualitative and quantitative data collection efforts conducted by the VHA Office of Women's Health Services (WHS). Surveys are done by WHS at the national, VISN, and VAMC levels and onsite evaluations are performed at each VAMC, entailing interviews with Women Veterans Program Managers (WVPMs) and relevant staff across a range of health-related and social services. This multidisciplinary model is used by WHS to evaluate how well each VAMC is meeting standards of care delivery. A similar approach could be used to evaluate the use of IPV awareness and treatment protocols at the VAMCs and to ensure that VAMCs and DVCs are receiving the support they need, including training and communications materials. Evaluations could include an in-depth review of protocols and processes for patient screening, consultation, treatment, and of elements such as call center scripts and emergency department intake forms.

3. **Support for DVCs and other VAMC staff in cultivating, maintaining, and continually improving strong partnerships at the local level**

   The communities of practice at the national level can be leveraged to assist VAMCs in creating and cultivating local networks of IPV resources. Partnering with the Domestic Violence Hotline, for example, will give DVCs important insights into the resources in their communities. However, national alliances can go only so far in supporting local-level implementation. DVCs will be responsible for understanding community resources in depth, and for building and fostering collaborative professional relationships, providing training,

communicating VA policies and standards, and conducting evaluations of Veteran satisfaction and program effectiveness.

Furthermore, DVCs will need a thorough understanding of VA's resources in such areas as social work, mental health, primary care, and emergency care, which may require them to develop new networks and collaborations with VA colleagues. Finally, they will also need methodologies for determining the best approach for referring individual Veterans to community and local VA resources and for following up on effectiveness.

One potential strategy for building the capacity of the DVCs to maximize existing VA and community resources could be to adapt the technical support model for the VA's Community Employment Coordinators (CECs). Like DVCs, CECs are "champions" within the VAMC structure at the direct service level who coordinate and maximize resources across the service continuum (both within VA and in the community). Serving as liaisons, advocates, and technical advisors, CECs play a critical role in encouraging local stakeholders (e.g., VAMCs, VHA, VBA, State, and private employment entities) to work together to employ homeless Veterans while reducing redundancies in services.

The CECs benefit from technical support on how to effectively carry out their roles and responsibilities and educate Veterans and their families. Similar technical support would assist the DVCs and other VAMC staff responsible for implementing the National IPV Assistance Program. Technical support could include toolkits with current information, protocols, and regulation; site visits and site-specific action and implementation plans to assess and maximize resources and external and internal relationships; and individualized training and consultation to build DVC capacity to foster productive relationships with community groups and VA colleagues and to satisfy standards and policies set by VA for delivery of IPV services.

4. **Strategic communication and educational campaigns at the national and local levels**

   Skillfully targeted communication and education will be vital to the success of the National IPV Assistance Program. It is recommended that in collaboration with the Office of Public Affairs, strategic communication plans be developed that establish clear goals and priorities for tailored outreach, leveraging owned media (social media, web, other internal), earned media, and outreach partnerships with local and national stakeholders to engage with important audiences. Plans would include outreach strategies for leveraging key national observations, including Sexual Assault Awareness Month and Domestic Violence Awareness Month.

   Several key audiences will require education about IPV and the assistance offered by VA, including Veterans, their families, and caregivers, as well as community influencers, VSOs, and other outreach partners at the national and local levels. Similarly, VA employees will be a key audience for educational campaigns about IPV and the services available to them. Other audiences will require communication and education about their responsibilities in implementing IVP assistance. These audiences include VA employees as well as community providers. VA healthcare, mental health, and social work professionals will require up-to-date information about IPV and the expectations for their roles in detection and intervention, while community providers will require ongoing communication about applicable VA standards and procedures. A final set of audiences are those who will require ongoing briefings on the program itself and on key metrics, including Congressional staffers, VA leadership, national stakeholder organizations, and Regional, VISN, and VAMC leadership.

   By conducting research on the attitudes and information needs of these diverse audiences, developing strategic communication plans, and maintaining productive two-way exchanges and tailored messaging, VHA will be equipped to successfully engage all key constituencies in the shared mission of improving the health and safety of Veterans.

5. **Positioning of VA as a national leader and contributor to the development of best practices in IPV services for Veterans and their families**

   Utilizing its communities of practice, along with its research expertise and unparalleled access to data on Veterans' health, VA is ideally positioned to break new ground in IPV prevention, detection, and intervention. The communities of practice will enable VA to stay current on the national landscape of best practices across the IPV field. In turn, insights gained by VA into effective interventions by gender, age, health status, and other factors through the National IPV Assistance Program can inform improvements in practices for non-Veteran as well as Veteran populations. VA can become a testing ground in addressing such areas as the challenges of documenting IPV, effectively screening men experiencing IPV, and supporting Veterans using or at risk of using IPV. In short, VA can become proactively engaged in two-way learning and in piloting and evaluating new approaches to IPV services.

   For example, VA could pilot and evaluate an IPV stigma reduction initiative. Not only do individuals experiencing IPV face public stigma, perceived stigma, and self-stigma, they may also face structural stigma related to military culture, mental illness, substance use disorder, housing status, race, ethnicity, sexual orientation, and gender identity. Research indicates that all of these stigmas can affect access to care and quality of care for the individual experiencing IPV. Effective stigma reduction requires ongoing programming rather than a one-time campaign and is most effective when it is targeted, local, credible, and continuous. An IPV stigma reduction initiative within the VA could feature the inclusion of stigma reduction content in all IPV trainings; the inclusion of best practices for stigma reduction interventions and recommendations for sustained stigma reduction efforts in educational toolkits and stakeholder outreach; and on-site stigma assessment and action planning technical assistance with staff and administrators with ongoing, virtual follow-up.

   Positioning VA as a leader in Veteran-centric IPV services can be accomplished through a mix of strategies, including convening of national meetings, workshops, and webinars by VA; participation by VA subject-matter experts and leadership in national conferences through presentations, publications, and exhibits; developing of journal publications and white papers; and collaboration with the Office of Public Affairs in planning and implementing earned media strategies.

Summary

The prevalence and far-reaching impacts of IPV in Veteran populations make effective interventions a pressing concern. As national attention to IPV continues to intensify, VHA is responding proactively with a National IPV Assistance Program that utilizes proven protocols for detection and refers Veterans to services available in local communities. This decentralized approach holds promise for providing each Veteran with timely access to a mix of services—within and outside of VA—tailored to his or her specific needs. The approach will require strategic communication and program evaluation support to ensure that VHA practices stay aligned with best practices in the rapidly evolving IPV field, and to provide for consistent and satisfactory Veteran experiences despite the wide variations in community resources available across the nation.

Endnotes

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