VISN 9 – Universal Screening of Intimate Partner Violence and Relationship Health with Veterans Experiencing Homelessness
An Innovative Practice in VHA Homeless Program Operations

White Paper

U.S. Department of Veterans Affairs

Developed by
VHA National Homeless Programs Office

INTRODUCTION

The VHA Homeless Programs Office identifies and disseminates innovative practices in homeless program operations. Veterans Integrated Service Network (VISN) 9 has been identified as a region with an innovative practice for piloting universal screening of intimate partner violence (IPV) and relationship health with Veterans engaged in VHA specialty homeless programs.

PRACTICE OVERVIEW

Universal IPV screening is essential to ensure that Veterans experiencing homelessness and housing instability receive access to needed education and services.

IPV is defined as any violent behavior that includes, but is not limited to, physical or sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner. These behaviors occur on a continuum of frequency and severity ranging from one episode, that may or may 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.[1] In the United States, about 1 in 4 women and 1 in 10 men report experiencing (i.e. being a victim or survivor of) IPV[2]. VA is committed to ensuring that Veterans and their partners who are directly impacted, whether experiencing or using IPV, are provided with a comprehensive network of services while being treated with dignity and respect. These services are primarily delivered through VHA's Intimate Partner Violence Assistance Program (IPVAP). To help identify Veterans in need of IPV services and assess the potential risk for serious injury or lethal harm, local VA Medical Centers (VAMC) and Outpatient Clinics are encouraged conduct universal IPV screenings for all Veteran served. This screening primarily focuses on those who experience IPV. However, as some Veterans engage in bi-directional forms of IPV, both experiencing and using in the context of their intimate relationships, the screening often leads to a discussion of Veterans' own behaviors and focuses on developing healthy relationships. Those Veterans who endorse experiencing IPV are then assessed for risk and offered safety planning during the same episode of care. Regardless of screening outcome, all Veterans are offered information and resources such as the National Domestic Violence Hotline contact information, the local IPVAP Coordinator contact information, and general information on safe and healthy relationships.

---

[1] VHA Directive 1198: Intimate Partner Violence Assistance Program, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8192.
[2] Preventing Intimate Partner Violence, https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

VHA's goal is to screen all Veterans for IPV, with special attention paid to all at-risk populations. Unfortunately, there is limited visibility into the prevalence of IPV among Veterans accessing VHA specialty homeless services. During a VISN-wide IPV Summit in November 2019, the VISN 9 Network Homeless Coordinator (NHC) recognized an opportunity to better serve Veterans experiencing both IPV and homelessness. Meeting with the VISN 9 IPVAP Coordinators and the National IPVAP Manager, she proposed conducting a universal IPV screening pilot across all VISN 9 homeless programs. This NHC also happened to be the VISN IPV Champion and was uniquely situated to improve collaboration between the facility-level IPVAP Coordinators and homeless program staff.

The planned pilot would take place during the months of January, February, and March of 2020. The NHC and team decided to screen all new and existing Veterans participating in the Housing and Urban Development-VA Supportive Housing (HUD-VASH), VA Homeless Providers Grant and Per Diem (GPD), Health Care for Homeless Veterans (HCHV) Contract Residential Services (CRS), and HCHV Case Management programs. Some Veterans were excluded, such as those participating in Veterans Justice programs over concerns that assessment information could be used as evidence during criminal proceedings. Veterans who were already enrolled in HUD-VASH for at least one year, as these Veterans were less likely to be unstably housed or housing insecure, or Veterans who already received the IPV Screen in the last year were also excluded, unless other factors indicated a need for screening.

Following the Summit, the NHC met with each of the five homeless program managers throughout VISN 9 to talk through the high-level goals for the pilot and obtain buy in. In her discussions, she encountered understandable and anticipated concerns regarding adding tasks to homeless program staff and the impact an additional screener would have on productivity and time available for other patient care related activities. Interestingly, the most significant concern was on using the official IPVAP Screening Clinical Reminder, called the "Relationship Health and Safety Screen" (RHSS), to document the screens in the Veterans electronic health record (EHR). VHA's Clinical Reminder system assists with clinical decision-making and improves documentation and follow-up, by allowing providers accessing EHRs to easily view when certain tests or evaluations were performed and to track and document when care has been delivered.[3] As the majority of the work done by homeless program providers throughout VA is field based and without immediate access to the

[3]VISTA Clinical Reminders User Manual: https://www.va.gov/vdl/documents/Clinical/CPRS-Clinical_Reminders/pxrm_2_6_um.pdf

EHR, these staff generally do not complete clinical reminders. Program managers expressed concerns that completing the RRHS would open the door for homeless program staff to be required to complete other reminders. The NHC made a commitment to only require RRHS for the duration of the pilot. Facilities could later reevaluate the RRHS's value and effectiveness.

Once commitment and buy-in was secured among the homeless program managers, all homeless program staff underwent one of three levels of IPV Screening Training during the month in December 2019. Level 1 training consisted of general information about IPV and the IPVAP. Level 2 training was targeted to clinicians who would administer the RRHS. Level 3 was the most intensive and was targeted to Champions who would complete further assessments and develop safety plans. IPVAP strongly encourages that training be matched to the specific and unique needs of the staff trained at each level. Training also included instruction on conducting trauma-informed screening, overviews of screening resources, and walkthroughs of the actual RRHS in the EHR using test patients. Local IPVAP Coordinators were available to help refresh or retrain staff as well as serve as consultants. Critical to Level 2 and 3 training was ensuring that screenings took place in a safe environment such that the administration of the RRHS did not increase any risk of violence.

"The key to making this pilot a success was to make sure that the partnerships with homeless programs and our IPVAP Coordinators were strong and ongoing. All of our staff completing the screens were more comfortable when they knew that they didn't have to be the experts on all the resources or referral opportunities available. Having the IPVAP Coordinators as lifelines was invaluable."

Erin Silanskis, LCSW
Network Homeless Coordinator
VISN 9

The VISN 9 Relationship Health and Housing Instability Pilot (RHHIP), began in full during the first business days of January 2020. Staff had discretion to administer the screen during face-to-face encounters, in the home or in the office, or via telephone. Information on the screening protocol including procedures on environmental safety checks, consent to screen, primary and secondary screening questions, and guidance on safety planning and referral options are available in Appendix A of this white paper. Since most staff did not have access to the EHR while in the community, they simply used the screening protocol in a worksheet format to make notes for documentation in the EHR upon return to the office. Although activities went smoothly during January and February, the pilot essentially shut down in mid-March 2020 due to the start of the COVID-19 National Emergency. Two weeks later on March 31, 2020 the VHA National Homeless Program Office issued official guidance to avoid all routine or non-urgent face-to-face visits. From April to June, homeless program operations across all VHA shifted to crisis management, ensuring that Veterans could appropriately socially isolate while continuing to receive care in ways consistent with Centers for Disease Control (CDC) guidance. Although some sites

continued to administer the RRHS Screen, the status of the pilot was not revisited until early July 2020 once all sites fully converted to, and were active with, telehealth capability.

In mid-July 2020, the VISN 9 NHC and National IPVAP Program Manager reconnected and reviewed the data collected during the pilot. **Of the 577 total Veterans screened, 514 (or 89 percent) were male and 63 (or 11 percent) were female. A total of 91 Veterans screened positive for the primary screen that focused on screaming, insults, threats, physical harm, and unwanted sexual contact. Of those that screened positive for the primary screen, 74 (or 81 percent) were male and 17 (or 19 percent) were female. All Veterans who screened positive for the primary screen were administered the secondary screen immediately after. A total of 30 Veterans screened positive for the secondary screen following the primary screen. This included 20 (or 67 percent) male Veterans and 10 (or 33 percent) female Veterans.**

Category	VISN-wide
Total Screened	**577**
Males Screened	514
Females Screened	63
Total Primary Positive	**91**
Males Primary Positive	74
Females Primary Positive	17
Total Secondary Positive	**30**
Males Positive Male	20
Females Positive Female	10

FIGURE 1: SUMMARY OF SCREEN RESULTS BY GENDER

Notably, while women Veterans who screened positive for past-year IPV had up to four times the odds of experiencing housing instability, there is little research on the impact of IPV for male Veterans and homelessness.[4] The National IPVAP Program Manager noted that, although many Veterans did not endorse IPV, the benefit of having the conversation and providing universal education and intervention regardless of screening outcome could allow for Veterans to feel safe to endorse IPV and seek help at a later date.

VISN 9 NHC offered some considerations for sites interested in administering RHSSs for all Veterans accessing VHA homeless services. While most staff felt comfortable with completing the RHSS, this is largely in part due to effective training and ongoing support by supervisors and local IPVAP Coordinators. Developing strong, open relationships with facility-level IPVAP Coordinators was key so that homeless program staff did not need to become experts on all the resources or referral opportunities available to Veterans who endorse IPV. Additionally, since discussions focusing on the content from the secondary screen can be discomforting for staff due to the potential for lethality, it is critical that staff offer Veterans immediate safety planning and

[4] Montgomery AE, Sorrentino AE, Cusack MC, et al. Recent Intimate Partner Violence and Housing Instability Among Women Veterans. *Am J Prev Med*. 2018;54(4):584-590. doi:10.1016/j.amepre.2018.01.020

same day referral to the IPVAP Coordinator, Champion, or suicide prevention services for a more thorough assessment. To help address staff concerns and fears, the IPVAP Coordinators were available to meet with homeless program staff once a week to debrief and talk through their experiences.

CONCLUSION

Information gathered during the VISN 9 RHHIP hints at an underserved need for IPV services in VHA specialty homeless programs. All Veterans who have experienced homelessness are at greater risk for negative health outcomes, and providing effective whole health care demands that relationship health and safety be included in treatment planning and service delivery. We would like to thank the dedicated homeless program and IPAVP staff throughout VISN 9 and the National IPVAP team for sharing their practice with us.

For more information, please contact Erin Silanskis, VISN 9 NHC, at Erin.Silanskis@va.gov and LeAnn Bruce, Ph.D., National IPVAP Manager, at LeAnn.Bruce@va.gov.

APPENDIX A: RELATIONSHIP HEALTH AND SAFETY SCREEN PROTOCOL

STEP 1: ENVIRONMENTAL CHECK

Determine if the conditions are safe and appropriate for screening. Do not screen if a child older than age 2 years is present or another adult is present (e.g., do not ask about intimate partner violence in front of the partner). If safe and appropriate, go to Step 2; otherwise do not screen.

STEP 2: CONSENT TO SCREENING AND DOCUMENTATION

Discuss limits of confidentiality and purpose of screening. Verify that it is safe to document in the electronic health record (e.g., the partner will not have access or access will not increase risk).

- If the individual consents to answer the screening questions – Go to Step 3
- The individual declines to answer the screening questions – Go to Step 6

Regardless if the screening is conducted or only resources are given, document as much detail as the Veteran is comfortable with in accordance with the IPVAP Documentation Toolkit.

STEP 3: PRIMARY SCREEN

Ask: In the past 12 months, how often did a current or former intimate partner (e.g., boyfriend, girlfriend, husband, wife, sexual partner):

Scream or curse at you	never	rarely	sometimes	often	frequently
Insult or talk down to you	never	rarely	sometimes	often	frequently
Threaten you with harm	never	rarely	sometimes	often	frequently
Physically hurt you	never	rarely	sometimes	often	frequently
Force or pressure you to have sexual contact against your will, or when you were unable to say no	never	rarely	sometimes	often	frequently

Next Steps after Primary Screen:

- If any form of IPV is endorsed (any grey box selected) – Go to Step 4
- If all forms of IPV are denied (answered never to all 5 items above) – Skip to Step 6

STEP 4: SECONDARY RISK ASSESSMENT

Ask:

Has the IPV behavior increased in frequency/severity in the past 6 months?	No	Yes
Has your partner ever choked or strangled you?	No	Yes
Do you believe your partner may kill you?	No	Yes

Next Steps after Secondary Risk Assessment:

- If any item is endorsed (any grey box selected) – Go to Step 5
- If all items are denied (all no) – Skip to Step 6

STEP 5: FURTHER ASSESSMENT AND SAFETY PLANNING

Encouraging the Veteran to accept further assessment and safety planning is required. You must do at least one of the options shown here. In addition, you may include any options listed in Step 6.

- Warm handoff (a physical transfer between providers; a call or co-sign is not a warm handoff) to the Intimate Partner Violence Assistance Program Coordinator for further assessment, safety planning, and additional services as needed.
- Warm handoff to an IPVAP Champion (i.e., a designated social worker, psychologist, or other licensed independent provider) who has been trained in how to respond to IPV in accordance with IPVAP guidelines and who agrees to complete further assessment and safety planning upon receiving the warm handoff.
- If the screener is a trained designated IPVAP Champion, that LIP can complete further assessment and safety planning within the same encounter (e.g., no transfer of provider or setting needed).
- If the Veteran declines the above options, follow IPVAP documentation guidelines and proceed to Step 6.

STEP 6: UNIVERSAL EDUCATION AND INTERVENTION

Any of the following options can be used in the context of positive or negative screenings. Many times, a person may screen negative for past year IPV but still need services. Other times, an individual may not need services now but could in the future. Use any or all that are deemed appropriate. Additional assessment and safety planning (as shown in Step 5 is also an option but is not required when the secondary risk assessment is negative). It is also okay, in the context of a negative screening, to just let the person know you are available if needed in the future.

- Provide a brochure or fact sheet on IPV such as can be found on the IPVAP SharePoint or other sources recommended by the IPVAP or local IPVAP Coordinator.
- Provide the National Domestic Violence Hotline number 1-800-799-SAFE (7233) and/or the web address www.thehotline.org.
- Provide contact information for your state domestic violence coalition. Find your state at www.ncadv.org.
- Provide information on shelters. A list is available at www.domesticshelters.org.
- Provide guidance on safety planning. Materials available for use include safety planning worksheets found on the IPVAP SharePoint, a safety planning guide and pocket cards.
- Provide education about relationship heath, such as by discussing a military power and control wheel and/or a relationship equality wheel.
- Place a referral or consult to the Intimate Partner Violence Assistance Program Coordinator, a co-located or clinic-affiliated IPVAP Champion, or give their contact information to the Veteran.
- Make a referral for services within VA or in the community (e.g., financial or legal support).
- Make a referral for psychotherapy if there are mental health symptoms, not just due to IPV history.