

FAMILY SERVICES IN MENTAL HEALTH

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy for providing mental health services to Veterans' relatives and other eligible individuals in order to support the care of Veteran's diagnosed with an International Classification of Diseases (ICD)-10 mental health disorder. The goal of this directive is to ensure that all Veterans have access to these family mental health services, tailored to their specific circumstances, to promote recovery and optimal community functioning of the Veteran. It delineates the essential components of the Department of Veterans Affairs (VA) family services in mental health care to be implemented nationally.

2. SUMMARY OF MAJOR CHANGES: This directive describes VHA policy for involving the Veteran's relatives and other eligible individuals in the Veteran's care for Veterans diagnosed with an ICD-10 mental health disorder, as well as the benefits of involving these individuals in Veteran mental health care, and strategies for doing so. It has been updated to reflect the administrative responsibilities of VA personnel in ensuring all Veterans receiving VHA mental health care have access to family services.

3. RELATED ISSUES: VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008; VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, dated July 1, 2011; VHA Handbook 1163.01, Psychosocial Recovery and Rehabilitation Services, dated July 1, 2011; VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011, VHA Handbook 1163.03, Psychosocial Rehabilitation and Recovery Centers (PRRC), dated July 1, 2011, and VHA Handbook 1163.05, Psychosocial Rehabilitation and Recovery Services Peer Support, dated July 1, 2011.

4. RESPONSIBLE OFFICE: VA Office of Mental Health and Suicide Prevention (10NC5) is responsible for the contents of this directive. Questions may be referred to the National Mental Health Director for Family Services, Women's Mental Health and Military Sexual Trauma at 202-340-4192.

5. RESCISSIONS: VHA Handbook 1163.04, Psychosocial Rehabilitation Family Services, dated July 1, 2011 is rescinded.

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 This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

June 17, 2019

VHA DIRECTIVE 1163.04

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

/s/ Renee Oshinski
Acting Deputy Under Secretary for Health
for Operations and Management

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

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DESCRIPTION OF VA FAMILY SERVICES IN MENTAL HEALTH.....A-1

FAMILY SERVICES IN MENTAL HEALTH

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for providing services to eligible family members of Veterans' as defined in 38 United States Code (U.S.C.) 1782 in support of the Veteran's mental health care for International Classification of Diseases (ICD)-10 diagnoses. Family services to support VHA mental health treatment are available to eligible Veterans. VA must provide family service to Veterans with a service-connected disability, and may provide these services to Veterans with a non service-connected injury. Eligible family members are members of the immediate family or the legal guardian of a Veteran; a family caregiver of an eligible Veteran or a caregiver of a covered Veteran (as those terms are defined in 38 U.S.C. 1720G); or an individual who certifies an intention to live in the Veteran's household.

AUTHORITY: Title 38 U.S.C. 1782. **NOTE:** *This policy only addresses the mental health care of Veterans' relatives members and other eligible individuals as it pertains to the Veteran's mental health goals.*

2. BACKGROUND

Scientific research consistently demonstrates that individuals diagnosed with mental health disorders, such as schizophrenia, schizoaffective disorder, posttraumatic stress disorder, anxiety disorders, bipolar illness, or depression, experience improved outcomes when families are active participants in their clinical care. The Substance Abuse and Mental Health Services Administration (SAMHSA) delineates having relationships and social networks that provide support, friendship, love, and hope as a key dimension of a life in recovery. In order to provide this support to Veterans, VA is authorized by statute 38 U.S.C. 1782, to provide certain mental health services to a Veteran's eligible family members. These services include consultation, professional counseling, marriage and family counseling, training, and mental health services as are necessary in connection with the Veteran's treatment for an ICD-10 mental health diagnosis. VA Family Services also partners with other agencies committed to addressing the needs of Veterans and their families, such as the National Alliance on Mental Illness (NAMI).

3. DEFINITIONS

a. **Collateral.** For the purposes of this policy, a collateral is an eligible family member who is seen by a professional member of the VA medical facility's staff either within the VA medical facility or at a site away from the VA medical facility for reasons relating to the Veteran's clinical care. The purpose of this clinical contact must be an integral part of the Veteran's treatment plan and demonstrate the role of the person in assisting the Veteran to achieve a specific treatment goal or goals.

b. **Shared Decision-Making.** Shared decision-making is an approach where clinicians and patients share the best available evidence when faced with the task of

making decisions, and where patients are supported to consider options, to achieve informed preferences.

4. POLICY

It is VHA policy to create a strong recovery environment for the Veteran by providing a continuum of mental health services to the Veteran diagnosed with an ICD-10 mental health diagnosis and the Veteran's eligible family members, tailored to the Veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences. The continuum includes, at a minimum, several distinct interventions, including family education, Veteran-centered brief family consultation, and marital and family counseling, including family psychoeducation. **NOTE:** *This continuum of mental health services is offered to the Veteran and their eligible family members as a component of the clinical care provided to Veterans. See paragraph 6.e. and Appendix A below for specific information regarding these mental health services.*

5. RESPONSIBILITIES

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

b. **Deputy Under Secretary of Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management is responsible for:

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

(2) Ensuring that each VISN Director has the resources required to support the execution of this directive in all the VA medical facilities within that VISN.

(3) Confirming that each VISN has and utilizes on an ongoing basis a means for ensuring the terms of this directive are fulfilled in all the VA medical facilities of the VISN.

c. **Director, Office of Mental Health and Suicide Prevention, Family Services Section.** The Director, Office of Mental Health and Suicide Prevention (OMHSP), Family Services Section is responsible for:

(1) Developing national policy and procedures for family services that are consistent with Federal law, the evidence-based, best, and promising practices literature, VHA's mission, goals, and objectives, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, and other authorizing documents as may be issued.

(2) Providing consultation and guidance to VISNs and their VA medical facilities in the development and execution of family services clinical programs.

(3) Providing subject matter experts for ad hoc consultation and guidance in specific family services program areas.

(4) In conjunction with VA Employee Education System (EES), developing and providing VA health provider training in effective strategies to engage Veterans and their collaterals in care and provide comprehensive evidence-based couple and family interventions to reduce relationship distress and support recovery from ICD-10 mental health disorders. These trainings should meet the evolving clinical needs of the Veterans served, and collate data on trainee participation and completion for program evaluation purposes.

d. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that evidence-based family services are accessible to all eligible Veterans and their collaterals by providing the services at or through their facilities.

(2) Ensuring that VA medical facilities within the VISN operate family services in compliance with relevant law, policy, and procedures.

e. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring all eligible family members have access to high-quality family services as appropriate to the Veterans' treatment plan to support the Veterans' recovery.

(2) Ensuring that mental health providers with competency and time to provide the family services in support of the Veteran's care for an ICD-10 mental health disorder, as outlined in this directive, are available to all eligible family members, either at the VA medical facility or through VA funded community care.

(3) Ensuring the VA medical facility provides family services during off hours (e.g., evening and weekends) when collaterals may be more available.

(4) Ensuring that Veterans have ongoing input into the operational plan and evaluation of the family services continuum of care through their participation in Veterans Mental Health Councils (VMHC). **NOTE:** *VMHCs are described in VHA Handbook 1160.01.*

f. **VA Facility Mental Health Leader.** The VA medical facility Mental Health Leader (e.g., Mental Health Service Line Chief, Associate Chief of Staff–Mental Health, Associate Chief Nurse for Mental Health) is responsible for:

(1) Ensuring there are mental health providers with the expertise at the VA medical facility to provide the full continuum of family services to Veterans and all collaterals in support of Veteran's care for an ICD-10 mental health disorder as described in this directive. If there are no VA mental health providers with the expertise or time to provide the service, then community care for eligible Veterans must be arranged.

(2) Ensuring that all Veterans receiving treatment for an ICD-10 mental health disorder at the VA medical facility are queried to discuss the need, benefits, and risks of

family involvement in care, using a shared-decision making process. This query is to be made and documented in the Veteran's medical record by the provider responsible for writing the Veteran's treatment plan. These queries must be made at the following times:

(a) The development of the initial treatment plan.

(b) Annual treatment plan review.

(c) At times of significant change in the treatment plan due to an improvement or worsening of symptoms or functioning.

(d) As early as possible in an inpatient or residential program stay, to permit the possibility of establishing a relationship with the VA and the collateral during a period where motivation may be highest.

(e) At the resumption of outpatient treatment after a discharge from a residential or inpatient mental health unit.

(3) If the Veteran desires that eligible family members are involved in their care, ensuring that these opportunities are available.

(4) Ensuring the VA mental health providers with expertise in providing family services have sufficient time in their schedules to provide Veterans and their collaterals with the services specified in this directive, or, if providers do not have sufficient time, through referral to community care, to the extent the Veteran is eligible.

(5) Ensuring that family services providers at the VA medical facility are knowledgeable about local community care resources so that they can provide appropriate referrals to collaterals who may need more direct services not subsumed under the Veteran's treatment care plan.

g. VA Provider Who Develops and Updates Mental Health Treatment Plans.

The VA provider who develops and updates mental health treatment plans is responsible for:

(1) Querying all Veterans for whom they develop treatment plans about their interest in having their eligible family members involved in their care, and documenting the Veteran's response in the medical record. The discussion with the Veteran must include a review, using a shared decision-making process, of both benefits and risks of involvement of eligible family members and offer opportunities to involve eligible family members in care if the Veteran desires this. These opportunities must be consistent with the family services continuum of care, specified in paragraph 6.e. and the Appendix below. These queries must be made at the time points specified in paragraph 5.f.(2) above.

(2) Becoming knowledgeable about local community care mental health service resources so they can provide appropriate referrals to collaterals of Veterans when they

need more intensive direct services not connected to the Veteran's mental health treatment plan. Increased contact with collaterals often makes VHA providers aware of potential mental health problems in other eligible family members which are outside the scope of VA treatment guidelines (e.g., children's school difficulties, partners' substance use problems).

6. PROVISION OF FAMILY SERVICES IN MENTAL HEALTH

a. **Annual Review for Desire for Family Service.** At a minimum, all Veterans diagnosed with mental health disorders in the ICD-10 must be approached by the VA provider responsible for developing and updating the Veteran's mental health treatment plan annually to discuss their preferences for and the benefits and risks of involving eligible family members in their care. Veterans may require assistance in determining whether and when eligible family member involvement in care may be in their best interest; Veterans and their eligible family members may benefit from guidance on how the relative's involvement in care may cause benefit or risk to the Veteran. Shared decision-making will be useful in this process. This conversation must occur at least annually, at a minimum, and must also occur at the time points specified in paragraph 5.f.(2) above.

b. **Screening.** Providers must screen for experience or use of aggression or violence during routine assessments for family, couple, or marital interventions. Screening must be conducted with all couple or family members in private, on an individual basis. If a Veteran or collateral screens positive, further evaluation and intervention is necessary as conjoint therapy may be contraindicated, depending on the recency and severity of any aggression revealed (see paragraph 7 below for information on available training on screening and addressing intimate partner violence (IPV) in the couples therapy context). For non-Veterans, an outside provider may need to continue the evaluation and intervention after initial risk of aggression is identified and appropriate referrals are made. Thus, it is suggested that VA providers have available a list of referrals; including the facility IPV Coordinator, community care and other community-based resources that may be appropriate.

c. **Confidentiality.** The provider must provide guidance to Veterans on handling information sharing with collaterals of the Veteran. Veterans must be informed about statutes and VA policies regarding sharing information with collaterals. Information about the Veteran's care can only be shared with next of kin, families, or others with a significant relationship in accordance with paragraph 23 of VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

d. **Treatment Planning for Family Service Needs.** The Veteran's treatment plan for an ICD-10 mental health diagnosis must identify at least one collateral whom the Veteran consents to be involved in the Veteran's care or the reason for the lack of a specification of such a contact (e.g., no other family members or Veteran preference). This information must be obtained and documented in the Veteran's medical record by the provider who is responsible for writing or updating the Veteran's mental health treatment plan. When the Veteran communicates family concerns relevant to their

mental health care, the treatment team must query the Veteran about addressing those concerns and attempt to engage the collateral to address those concerns if the Veteran consents. Family service needs are typically met through the provision of a continuum of family-based services, discussed under paragraph 6.e. and Appendix A.

e. **Continuum of Family Services.** Flexibility is a key principle when involving collaterals in mental health care in order to support the Veteran. Services must be tailored to the Veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences. A graduated continuum of services is necessary to meet these varying needs; expertise is required to deliver these services skillfully and often crosses mental health specialties.

(1) The full VA family services continuum ranges from family education to problem-focused brief Veteran-centered family consultation scheduled as needed, to marriage and family counseling, which may also include intensive Family Psychoeducation (FPE). **NOTE:** See Appendix A for more information about these services.

(2) Opportunities for family education, family consultation, and marriage and family counseling (which may also include FPE as appropriate to the VA medical facility), must be available for all Veterans diagnosed with an ICD-10 mental health disorder to the extent the Veteran is eligible. Family services must be provided on site, by telemental health or through referral to community care to the extent the Veteran is eligible. Some VA medical facilities may not have the expertise available for this service and will need to identify training opportunities to increase the knowledge base of its professional staff.

(3) Couples/marriage or family counseling services must be offered, as appropriate, regardless of Veteran sexual orientation.

7. TAILORING INTERVENTIONS TO THE NEEDS OF DIFFERENT FAMILY CONSTELLATIONS

The influence of the functional impairments accruing from mental illnesses can have a differential impact on the needs and experiences of the family, depending on whether relatives are from the Veteran's family of origin or are involved in a partnered relationship with the Veteran. All family interventions must be tailored to the specific needs of the Veteran and the Veteran's loved ones.

8. TRAINING

a. There are no formal training requirements associated with this directive. The following trainings are recommended for all mental health providers offering Veterans couple or family therapy or conducting screening for these services:

(1) High Conflict Couples in Conjoint Therapy Webinar Recording available on the VA Family Services SharePoint (<https://vaww.portal.va.gov/sites/OMHS/familyservices/default.aspx>). **NOTE:** This is an internal VA Web site that is not available to the public.

(2) Couples Therapy and Intimate Partner Violence TMS Item #33858.

(3) Couples Therapy with LGBT (Lesbian, Gay, Bisexual, Transgender) Veterans TMS Item #29533.

(4) Strategies for Dealing with Common Issues when Working with Veteran Parents Webinar. Recording available on the VA Family Services SharePoint (<https://vaww.portal.va.gov/sites/OMHS/familyservices/default.aspx>). **NOTE:** *This is an internal VA Web site that is not available to the public.*

b. VA Family Services typically offers at least yearly mental health provider training with ongoing case consultation in evidence-based family interventions, including integrative behavioral couples therapy (IBCT) and cognitive-behavioral conjoint therapy (CBCT) for post-traumatic stress disorder (PTSD). Acceptance is competitive and submissions are organized through local evidence-based practice coordinators.

9. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

10. REFERENCES

a. 38 U.S.C. 1782.

b. 38 U.S.C. 7332.

c. VA Privacy Act System of Record 24VA19.

d. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

e. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, as amended November 16, 2015.

f. VA FORM 10-5345 Request for and Authorization to Release Health Information available at <https://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf>.

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h. Pitschel-Walz G, Leucht S, Bauml J, Kissling W, Engel RR. "The effect of family interventions on relapse and rehospitalization in schizophrenia: a meta-analysis." *Schizophr Bull.* 2001; 21:73–92.

DESCRIPTION OF VA FAMILY SERVICES IN MENTAL HEALTH

1. FAMILY EDUCATION

Family education involves providing Veterans' collateral with the factual information about a Veteran's mental illness so the collateral can partner with the treatment team to support the Veteran's recovery. Family illness education should include, at a minimum, discussion of symptoms, prognosis, etiology, potential effective treatments, potential for recovery, strategies for identifying and managing sources of stress, and factors associated with good outcomes. Family education may be offered through written and video materials, or by trained family peer members (e.g., the National Alliance on Mental Illness ((NAMI) Family to Family and Homefront programs), in workshops or regularly scheduled meetings conducted by professionals (e.g., the Support and Family Education (SAFE) program), or in individual meetings with a mental health provider. The Veteran may or may not be present.

2. VETERAN-CENTERED BRIEF FAMILY CONSULTATION

Veteran-Centered Brief Family Consultation (VCBFC) consists of the family, including the Veteran, meeting with a trained mental health provider as needed to resolve specific issues related to the Veteran's treatment or recovery. The intervention is usually brief with 1-5 sessions typically scheduled for each course of consultation; it is comprised of engagement, assessment, and problem resolution or triage to more long-term appropriate intervention. A course of consultation may be provided on an as needed or intermittent basis.

3. MARRIAGE AND FAMILY COUNSELING

Conjoint marriage and family counseling involves the Veteran and a spouse (or conjugal-like partner) or other collaterals meeting in multiple sessions with a mental health provider to resolve conflicts and learn new skills and attitudes to increase relationship satisfaction and improve relationship functioning. Participation can be helpful in reducing Veteran relationship discord as well as in supporting recovery from disorders such as post-traumatic stress disorder or depression. Conjugal partners often benefit from couples' therapy interventions which promote intimacy, empathy, and reciprocal positive regard in the relationship; this relationship support can serve as a foundation for recovery from physical and mental health disorders.

4. FAMILY PSYCHOEDUCATION

Family Psychoeducation (FPE) is an evidence-based practice model of family counseling/therapy for serious mental illnesses, such as such as schizophrenia, schizoaffective disorder, bipolar illness, and severe depression. It is a collection of manualized interventions to equip families with the skills and attitudes which have been shown to reduce relapse. Every FPE intervention shares a number of essential components including careful assessment, provision of illness education, problem-solving, and an emphasis on improving current functioning. Interventions can be

offered individually or in a group, and can be offered in the home or the clinic. Reductions in relapses have been associated with a minimum of 9 months of intervention, with most programs recommending longer (1-2 years) treatment. The treatment is typically offered on a declining contact basis, beginning with weekly or biweekly sessions and then reducing to less frequent sessions over time. With the exception of initial individual assessment sessions attended separately by each participant, Veterans typically attend FPE conjointly with their collaterals, unless the Veteran prefers not to attend. Collaterals are encouraged to accommodate the Veteran’s illness-related functional limitations while supporting gradual (re)acquisition of community living and interpersonal skills in FPE. These programs often successfully meet the needs of families of origin and other extended family members, who may not be appropriate for couples’ therapy interventions.

5. DOCUMENTATION AND/OR CODING

At the time of this writing, there were no approved Stop Codes specifically for family services. Family services are tracked by Current Procedural Terminology (CPT) codes. The following are appropriate CPT codes for family services. It is imperative that VA providers use the appropriate CPT code when conducting family psychotherapy.

a. Mental Health CPT Codes

(1) 90846 – Family psychotherapy without patient present.

(2) 90847 – Family psychotherapy with patient present. **NOTE:** *The below chart indicates specific code guidance based on the length of the family psychotherapy session.*

Family Therapy	Code As	Code Description
0-25 minutes	Not Reported	-
26-79 minutes	90847	50 minutes
80-154 minutes	90847 +99354	50 minutes Prolonged Services
155-184	90847 +99354 +99355	50 minutes Prolonged Services Prolonged Services, each additional 30 minutes

(3) 90849 – Multiple-family group psychotherapy.

(4) 90887 – Education/advising collaterals how to assist patient.

b. Health and Behavior CPT Codes (focus on patients whose primary diagnosis is medical in nature):

(1) 96154 – Intervention services to family with patient present.

(2) 96155 – Intervention services to family without patient present.

6. DOCUMENTATION OF SERVICES TO RELATIVES AS PART OF FAMILY SERVICES

a. A collateral can be seen by a professional member of the VA medical facility's staff either within the VA medical facility or at a site away from the VA medical facility for reasons relating to the Veteran's clinical care. The purpose of this clinical contact must be an integral part of the Veteran's treatment plan; it must be documented by the treating provider in the Veteran's treatment plan and progress notes in such a way as to demonstrate the role of the collateral in assisting the Veteran to achieve a specific treatment goal or goals. Examples of appropriate designation of a collateral visit include: initial and follow-up contacts for a person assisting a Veteran; participation of a family member in outpatient family psychotherapy; continuing education and follow through with a primary care giver such as a residential care sponsor.

b. In interactions with VA mental health providers as part of supporting the Veteran's treatment plan, the collateral may indicate a personal problem or concern (e.g., suicidality, homicidality, presence of intimate partner violence) that is serious enough that it warrants its own documentation, distinct from the Veteran's medical record, in the judgment of that provider. In such a case, a note must be entered within a separate medical record established for the collateral by the provider receiving the information. This requires the collateral patient to be registered in Veterans Health Information Systems and Technology Architecture (VistA).