

PSYCHOSOCIAL REHABILITATION FAMILY SERVICES

1. PURPOSE. This Veterans Health Administration (VHA) Handbook outlines the procedures for providing family and couples therapy for Veterans and their family members in accordance with the Department of Veterans Affairs policy and Federal regulations.

2. SUMMARY OF CHANGES. This is a new VHA Handbook.

3. RELATED ISSUES. VHA Handbook 1160.01, VHA Directive 1163, and VHA Handbooks in the 1163 series.

4. RESPONSIBLE OFFICE. The Office of Mental Health Services (116) in the Office of Patient Care Services is responsible for the contents of this Handbook. Questions may be referred to the National Mental Health Director for Psychosocial Rehabilitation and Recovery Services (352) 376-1611 ext. 4642.

5. RESCISSIONS. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on/or before the last working day of July 2016.

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PSYCHOSOCIAL REHABILITATION FAMILY SERVICES

1. PURPOSE. The purpose of the Veterans Health Administration (VHA) Handbook is to outline the procedures for providing family and couples therapy services to Veterans and their family members in accordance with the Department of Veterans Affairs (VA) policy and Federal regulations.

2. BACKGROUND

a. Partnering with families in mental health care is a key feature of the President's New Freedom Commission on Mental Health, and is essential to the transformation of VA Mental Health services. Research consistently demonstrates that Veterans with serious mental health disorders, such as schizophrenia, schizoaffective disorder, bipolar illness, or depression, experience improved outcomes when families are active participants in their clinical care.

b. According to title 38 United States Code (U.S.C.), § 1782, eligible individuals may be provided consultation, professional counseling, marriage and family counseling, training, and mental health services as necessary in connection with the Veteran's treatment. Eligible individuals who may be provided counseling, training, and mental health services are the members of the immediate family or the legal guardian of a Veteran, or the individual in whose household such Veteran certifies an intention to live.

3. SCOPE

Each VHA medical facility has mental health clinicians with the requisite training to provide the assessments and interventions outlined in this Handbook. In addition to providing direct service, these family experts need to provide consultation to other clinicians at the facility. The medical facility must have provisions for providing services during off hours (evening and weekends) when family members may be more available. Clinicians at the medical facility need to develop knowledge of non-VA mental health service resources in the immediate area. **NOTE:** *Increased contact with family members often renders VA clinicians cognizant of potential mental health problems in other family members which are outside the scope of VA treatment guidelines (e.g., children's school difficulties, partners' substance use problems).*

4. MISSION

VA has made a commitment to evidence-based practices, Veteran and family-driven care, and a recovery-oriented mental health system where those with mental illnesses have the essential services and supports necessary to fully live, work, learn, and participate in the community.

5. VISION

VHA will offer providers, Veterans and their families the tools to overcome system, clinician, Veteran and family barriers to optimizing the participation of families in the mental health care of Veterans.

6. GOALS

VHA will assure that:

- a. The clinical need for services to families is discussed with all Veterans at least yearly and at the time of every discharge from an inpatient mental health unit;
- b. The identified family service needs are incorporated into the overall plan of care; and
- c. Every medical center provides a continuum of recovery-oriented services to Veterans and their families to the extent they are eligible in order to meet objectives specified in the plan of care.

7. PROGRAM ELEMENTS

a. **Yearly Review For Family Service.** At a minimum, Veterans with serious mental illnesses need to be approached by their treatment teams yearly, and at the time of each discharge from an inpatient mental health unit to discuss the need and benefits of family involvement in care. Veterans may require guidance to consider whether and when family involvement in care may be in their best interest, and both Veterans and families may need special attention and education in order for them to develop a trusting relationship with VA, and an appreciation for why the family's involvement in care can benefit the Veteran.

b. **Confidentiality.** Veterans must be informed about confidentiality in order to discuss specific topics with the family (e.g., recommended treatment and options for recovery-oriented services). The best way to handle sharing of information is to obtain the Veteran's written authorization or oral consent if the family member is in the presence of the Veteran. VA policy (Department of Veterans Affairs Privacy Act System of Record 24VA19) permits sharing of pertinent information (excluding information protected by 38 U.S.C. 7332 relating to sickle cell anemia, drug/alcohol abuse and in most situations Human Immunodeficiency Virus (HIV)) with family members, even if permission from the Veteran is not obtained under two conditions:

- (1) The caregiver/family member is involved in the Veteran's personal care; and
- (2) The clinician deems it would be in the best interest of the Veteran to share the information with the caregiver.

c. **Treatment Planning for Family Service Needs.** The plan of care must identify at least one family contact or the reason for the lack of a contact (e.g., absence of a family and Veteran preference). When family needs are articulated, the treatment team must collaborate with the Veteran and their supporters to see how these needs can be met. Regardless of how they are identified, family service needs will typically be met through the provision of a continuum of family-based services.

d. **Continuum of Family Services.** Consistent with a recovery philosophy, flexibility is a key principle when involving families in care. 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 crosses mental health specialties.

(1) The full continuum ranges from family engagement; education and family access to the treatment team; family involvement in treatment planning; on-going, low intensity, problem-focused family consultation; and intensive family psychoeducation (FPE).

(2) Opportunities for family consultation and family education or FPE must be available for all Veterans with serious mental illness either on-site, by telemental health, contract, or through non-VA fee-basis care to the extent the Veteran and family are eligible. Some facilities may not have the expertise available for this service and will need to take advantage of the available Office of Mental Health Services training opportunities to increase the knowledge base of its trained professional staff.

e. Guidelines for Family Education. Family education is a set of techniques to provide families with the factual information necessary to partner with the treatment team to support the Veteran's recovery. Typical topics include symptoms, prognosis, likely treatments, identifying and managing sources of stress, and factors associated with good outcomes. Family education may be offered through written and video materials, one day workshops and/or regularly scheduled meetings conducted over time by professionals (e.g., the Support and Family Education (SAFE) program) or by trained family members (e.g., the National Alliance on Mental Illness (NAMI) Family to Family program). The Veteran may or may not be present.

f. Guidelines for Family Consultation. Family consultation involves the family meeting with a trained mental health professional as needed to resolve specific issues related to the Veterans' treatment or recovery. The intervention is brief; typically 1-5 sessions are scheduled for each consultation. Consultations may be provided on an as needed or intermittent basis. If more intensive ongoing effort is required, the family can be referred for FPE to the extent the Veteran and family members are eligible.

g. Guidelines for FPE. FPE is an evidence-based practice model of family counseling/therapy. It is a collection of manualized interventions to equip families with the skills and attitudes which have been shown to reduce relapse. FPE interventions share a number of components including careful assessment, provision of 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 nine 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. Veterans are typically present during the FPE sessions.

h. Tailoring Interventions to the Needs of Different Family Constellations. The influence of the functional impairments accruing from serious 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 conjugal-like relationship with the Veteran that meets the eligibility criteria for marriage/family counseling.

(1) Compared to those eligible conjugal-like relationships, immediate family members from families of origin (parents, siblings) often have greater latitude to accommodate the impaired role functioning accruing from the mental illness since the family members' welfare is typically not directly dependent on Veteran's adequate role adjustment. Participation in standard FPE programs, which encourages accommodation to the functional limitations imposed by the illness and support for gradual (re)acquisition of instrumental and interpersonal skills, often successfully meets the needs of families of origin.

(2) Families in which Veterans are part of a conjugal or conjugal-like relationship confront different challenges. The welfare of these family units is often directly related to the capacity of Veterans to meet the emotional and instrumental needs of others in the family (typically, partners and children). In these eligible families, standard FPE interventions may not fully meet immediate family needs, and family members often benefit from augmentation with interventions adopted from traditional couple's therapy to promote intimacy, empathy, and reciprocal positive regard in the couple as a foundation for the subsequent FPE work. Furthermore, couples may need more focused attention to address the larger family needs that Veteran's functional impairments may preclude them from meeting (e.g., supervision of children, providing adequate financial support for the family).

i. 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 CPT codes. The following are appropriate Current Procedural Terminology (CPT) codes for family services.

(1) Mental Health CPT Codes:

- (a) 90846 – Family psychotherapy without patient present
- (b) 90847 – Family psychotherapy with patient present
- (c) 90849 – Multiple-family group psychotherapy
- (d) 90887 – Education/advising family how to assist patient
- (e) 90899 – Unlisted psychiatric services

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

- (a) 96154 – Intervention services to family with patient present
- (b) 96155 – Intervention services to family without patient present

j. Collateral Services. Collateral services are services provided to the person other than the Veteran as a part of the Veteran's care.

(1) Collateral services provided directly to the collateral (e.g., the spouse) separate from the Veteran must be reported separately for the collateral (e.g., stress reduction skills; VHA Directive 2006-026 Patient Care Data Capture).

(2) On occasion the collateral may have an appointment on their own, outside of the care being delivered to Veteran. This visit requires a note to be entered within the collateral's own record in CPRS. This requires the collateral patient to be registered in Veterans Health Information Systems and Technology Architecture (VISTA). Contact the facility enrollment staff prior to the scheduled appointment to ensure accurate documentation.

k. Sharing Information with Caregivers. All sharing of information with caregivers must be done in accord with Office of Health Data and Informatics, VHA Privacy Office, Privacy Fact Sheet, May 2009, Volume 09, No. 07, "Sharing Information with Caregivers" <http://vaww.vhaco.va.gov/privacy/Communications/FactSheetVol09No7.doc>. **NOTE:** *This is an internal VA Web site not available to the public.*

(1) VA policy permits sharing of pertinent information (excluding information protected by title 38 U.S.C. 7332 relating to sickle cell anemia, drug/alcohol abuse, and in most situations HIV) with caregivers, even if permission from Veterans is not obtained, if two conditions are met:

(a) The caregiver is involved in the Veteran's personal care, and

(b) The clinician deems it would be in the best interest of the Veteran to share the information with the caregiver.

(2) Sharing information with the caregiver in the presence of the Veteran is preferred, and requires the provider to ask the Veteran's permission to discuss the information with the caregiver present. The above guidance only applies to discussions outside the presence of Veterans.

(3) If pertinent information involves a discussion of the Veteran's sickle cell anemia, drug/alcohol abuse, or HIV, discussions need to be held with the Privacy Officer or Office of General Counsel.

(4) Additional issues related to the special circumstance of informing caregivers about support/educational groups when their participation would be expected to benefit Veterans include:

(a) If the clinician is certain the individual is the caregiver, and believes that their participation would be in the best interest of the Veteran, the clinician can invite the caregiver to attend support/educational groups. Though not required, it usually is optimal for the clinician to indicate to the Veteran that this is being done.

(b) If the clinician is not certain that the individual is involved in the care of Veterans, an invitation is not automatically extended. The clinician must ascertain that the individual is involved in a Veteran's care and that the caregiver's participation would be in the best interest of the Veteran.