

VHA PROGRAMS FOR VETERANS WITH SUBSTANCE USE DISORDERS

1. SUMMARY OF MAJOR CHANGES: Major changes are as follows:

a. **Amendment dated March 7, 2025**, updates “gender-specific” to “sex-specific” to comply with EO 14168.

b. Amendment dated July 25, 2024 updates:

(1) Paragraph 2.k.(4): Delineates responsibility for ensuring annual completion of the Directive Implementation Support Tool.

(2) Paragraph 2.n.(2): Requires updating the SUD treatment locator as services and contact information changes.

(3) Appendix B, Paragraph 1.c.: Outlines expectations for annual completion of the Directive Implementation Support Tool.

(4) Appendix B, Paragraph 1.d.: Outlines requirements for updates to the SUD treatment locator.

(5) Appendix B, Paragraph 1.g.: Details requirements for documentation of Contingency Management rewarding abstinence.

c. As published December 8, 2022 updated:

(1) Paragraphs 2.m.-2.p.: Delineated responsibilities for the roles of Department of Veterans Affairs (VA) medical facility Program Director, Substance Use Disorder (SUD); SUD-Posttraumatic Stress Disorder (PTSD) Specialist and VA health care provider.

d. Paragraph 3: Updated guidance on training of SUD treatment staff and program managers.

e. Appendix A: Updated general principles for the provision of SUD treatment in the Veterans Health Administration (VHA).

f. Appendix C: Detailed expectations for monitoring for substance use to include requirements for urine toxicology screening.

g. Appendix D: Updated requirements for increasing access to and removing barriers to prescribing medications for treatment of opioid use disorder (OUD).

h. Appendix F: Detailed overdose prevention guidance.

2. RELATED ISSUES: VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021; VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019; VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), dated November 16, 2017; VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019; and VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023.

3. POLICY OWNER: The Office of Mental Health (11OMH) is responsible for the content of this directive. Questions may be addressed to VHA11 Mental Health Actions: VHA11MentalHealthActions@va.gov.

4. RECISSIONS: VHA Handbook 1160.04, VHA Programs for Veterans with Substance use Disorders (SUD), dated March 7, 2012, is rescinded. The following notices and memoranda also are rescinded:

a. VHA Notice 2022-02, Buprenorphine Prescribing for Opioid Use Disorder, dated February 28, 2022.

b. VHA Memorandum 2013-09-01, Urine Toxicology Screening, dated September 5, 2013.

c. VHA Memorandum 2014-11-01, Information Bulletin: Clarification of Urine Toxicology Screening Guidelines, dated November 6, 2013.

d. VHA Memorandum 2019-10-02, Same Day Substance Use Disorder (SUD) Access Capability Survey, dated October 2, 2018.

5. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of December 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: The directive is effective upon publication.

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

/s/ Erica M. Scavella, MD, FACE, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

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

December 8, 2022

VHA DIRECTIVE 1160.04(2)

DISTRIBUTION: Emailed to the VHA Publications Distribution List on December 14, 2022.

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VHA PROGRAMS FOR VETERANS WITH SUBSTANCE USE DISORDERS

1. POLICY

It is Veterans Health Administration (VHA) policy that all eligible Veterans who require or request treatment for substance use disorders (SUD) have timely access to the full continuum of SUD treatment services, including prevention, screening, brief intervention, medications and intensive specialty SUD treatment when indicated.

AUTHORITY: 38 U.S.C. § 1720A and 38 C.F.R. §§ 17.38, 17.80-17.83.

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 Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the Office of Mental Health (OMH) with implementation and oversight of this directive.

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

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

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

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

d. **Executive Director, Office of Mental Health.** The Executive Director, OMH is responsible for:

(1) Delegating responsibility within OMH to develop and implement policy regarding the treatment of SUD.

(2) Providing oversight to the SUD section within OMH and the Program Evaluation and Resource Center (PERC) through regular meetings with OMH executive leadership.

e. **National Mental Health Director, Substance Use Disorders.** The National Mental Health Director, SUD, is responsible for:

(1) Supporting implementation of the requirements of this directive and ensuring national policy and procedures for SUD services align with current practice standards.

(2) Maintaining communication, including consultation and guidance, with VISN and VA medical facility SUD leadership and frontline staff to support the provision of evidence-based treatment for SUD.

(3) Providing national program evaluation of VHA SUD services in collaboration with the PERC Director and Directors, Centers of Excellence in Substance Addiction Treatment and Education (CESATEs).

(4) Supporting the implementation of this directive and other SUD-related policy referenced in this directive to ensure operational practices and clinical services remain consistent with current practice standards.

(5) Providing subject matter expertise to OMH Quality Improvement and Implementation Consultants and VISN Chief Mental Health Officers to support the oversight of SUD clinical services provided in VA medical facilities within the VISN.

(6) Responding to inquiries from internal and external stakeholders through established processes for communication with support from PERC.

(7) Serving as a liaison for SUD-related concerns with Federal and non-Federal partners, including but not limited to the Department of Defense (DoD), Office of National Drug Control Policy, Indian Health Service and the Department of Health and Human Services.

(8) Providing technical assistance to VA medical facility Directors requesting local modifications or exceptions to the clinical requirements of this directive. See VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024, for additional information.

(9) Developing, executing and modifying when indicated, performance metrics to monitor provision of SUD services and the implementation of this directive in collaboration with the PERC Director.

(10) Consulting Directors, CESATE regarding evidence-based SUD prevention and treatment strategies to enhance delivery of care to ensure implementation of current practice standards.

f. **Program Evaluation and Resource Center Director.** The PERC Director is responsible for:

(1) Providing national program evaluation of VHA SUD services in collaboration with the National Mental Health Director, SUD and the Directors, CESATE.

(2) Developing, executing and modifying when indicated, performance metrics to monitor provision of SUD services and the implementation of this directive in collaboration with the National Mental Health Director, SUD.

(3) Providing data to support OMH responses to inquiries from internal and external stakeholders.

(4) Coordinating with the Substance Abuse and Mental Health Administration (SAMHSA) to collect information on the availability of SUD services across VHA in support of national integrated databases that inform VA and SAMHSA SUD program locators.

(5) In collaboration with the Directors, CESATE, monitoring performance and outcomes of SUD programs, including patient population outcome measures. Such measures assist in evaluating the quality, effectiveness and accessibility of treatment.

g. Director, Centers of Excellence in Substance Addiction Treatment and Education. The Director, CESATE is responsible for:

(1) Providing national program evaluation of VHA SUD services in collaboration with the PERC Director and the National Mental Health Director, SUD.

(2) Advising the National Mental Health Director, SUD on evidence-based SUD prevention and treatment strategies to enhance delivery of care or to ensure implementation of current practice standards.

(3) Assisting in the development and dissemination of VA-DoD Clinical Practice Guideline for the Management of Substance Use Disorders. **NOTE:** *VA-DoD Clinical Practice Guideline for the Management of SUD can be found at <http://www.healthquality.va.gov>.*

(4) In coordination with the OMH SUD section, developing, testing and facilitating implementation of evidence-based SUD treatment (e.g., Contingency Management, measurement-based care using the Brief Addiction Monitor, medications for opioid use disorder (M-OUD) and medication for alcohol use disorder).

(5) Providing subject matter expertise and consultation on SUD treatment to VA health care providers and policy makers (e.g., VA medical facility leaders, OMH leadership).

(6) Contributing to the training of current workforce and next generation of VA SUD experts. **NOTE:** *VHA Directive 1215, Standards for Veterans Health Administration Centers of Excellence, dated February 14, 2017, defines national policy for the operation of CESATE.*

(7) In collaboration with the PERC Director, monitoring performance and outcomes of SUD programs, including patient population outcome measures. Such measures assist in evaluating the quality, effectiveness and accessibility of treatment.

h. 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 leadership when barriers to compliance are identified.

(2) Ensuring sufficient capacity for access to appropriate health care services for Veterans with a SUD diagnosis to include the availability of Domiciliary (DOM) SUD services within the VISN. **NOTE:** *VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019, provides detailed information regarding access-to-care timeframes.*

(3) Designating a VISN SUD Representative to support the VISN Chief Mental Health Officer in providing oversight of and support for SUD services in the VISN. **NOTE:** *In some VISNs, the VISN Chief Mental Health Officer may be designated to serve as the VISN SUD Representative.*

(4) Adhering to requirements specified by VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016, prior to any significant changes in services, such as the termination, modification or initiation of new SUD programs or services.

(5) Reviewing and approving requests from VA medical facility Directors regarding modification or exception to clinical requirements of this directive. See VHA Notice 2022-01 for additional information.

i. **Veterans Integrated Services Network Chief Mental Health Officer.** The VISN Chief Mental Health Officer is responsible for overseeing the VISN SUD Representative.

j. **Veterans Integrated Services Network Substance Use Disorder Representative.** **NOTE:** *In some VISNs, the VISN Chief Mental Health Officer may be designated to serve as the VISN SUD Representative.* The VISN SUD Representative is responsible for:

(1) Coordinating SUD services across VA medical facilities in the VISN and, when necessary, between VISNs by assessing existing resources and current needs for SUD care in the VISN and working with the VISN Chief Mental Health Officer to communicate this information to the VISN leadership.

(2) Consulting with VA medical facility leadership, including VA medical facility Directors, Mental Health leadership and VA medical facility Program Directors, SUD in implementing this directive.

(3) Consulting with the National Mental Health Director, SUD about the impact of anticipated changes in policy on field-based SUD programs.

(4) Acting as a liaison between OMH, the VISN, VA medical facility leadership, VA medical facility Mental Health leadership, academic affiliates, pharmacy, primary care, women's health, medical specialty care and the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP).

(5) Communicating directives, guidance and resources with specific relevance to treatment of SUD to VA medical facilities in the VISN.

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

(1) Ensuring overall VA medical facility compliance with this directive and SUD treatment requirements specified by VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023. **NOTE:** *Every VA medical facility is required to have specialized outpatient SUD services. See Appendix B for the types of programs and services related to SUD.*

(2) Ensuring Veterans with a SUD diagnosis have access to the full continuum of mental health and medical services, including the availability of DOM SUD services within the VA medical facility consistent with timeframes and procedures specified in VHA Directive 1162.02 and minimizing barriers to engagement.

(3) Serving as or delegating the sponsor for the Opioid Treatment Program (OTP), if OTP is present at the VA medical facility, as required by 42 C.F.R. § 8.12. **NOTE:** *Additional details are provided in Appendix E.*

(4) Ensuring the completion of all mandated reporting, monitoring and accreditation requirements in conformance with timeframes established by the requesting office or stakeholder to include the annual completion of the Directive Implementation Support Tool. **NOTE:** *Additional details are provided in Appendix B.*

(5) Requesting technical assistance from the National Mental Health Director, SUD prior to submitting written requests to the VISN Director for local modifications or exceptions to the clinical requirements of this directive.

(6) Establishing a SUD program management structure that supports team-based, Veteran-centered care. **NOTE:** *When responsibility for care is shared between SUD program leadership and other direct supervisors, SUD program leadership must have substantial input into program operations and employee performance evaluations.*

(7) Ensuring barriers to buprenorphine prescribing for OUD are eliminated and the VA medical facility adheres to policy in this directive on buprenorphine prescribing. **NOTE:** *Additional details are provided in Appendix D.*

(8) Resourcing and facilitating the implementation of an interdisciplinary team (e.g., an overdose review team) to review very high risk Veterans as well as Veterans who have overdosed according to the most current national guidance (see <https://dvagov.sharepoint.com/sites/VHAPERC/STORM/SitePages/Start.aspx>). **NOTE:** *This is an internal VA website that is not available to the public. See Appendix F for additional information.*

(9) Ensuring the VA medical facility and Community-Based Outpatient Clinics (CBOCs) make routine urine drug screening and confirmatory testing available as specified in Appendix C, paragraph 3.

(10) Ensuring that Peer Support services are available to all Veterans receiving SUD care as specified in Appendix A, paragraph 1.

l. VA Medical Facility Chief of Staff or VA Medical Facility Associate Director, Patient Care Services. The VA medical facility Chief of Staff or Associate Director Patient Care Service is responsible for:

(1) Ensuring VA medical facility staff providing treatment for SUD have documented competencies in procedures for substance use monitoring (e.g., urine drug screening, use of breathalyzers) and in evidence-based pharmacotherapy and psychosocial interventions for SUD according to their credentials or scope of practice. **NOTE:** For additional information about substance use monitoring, see Appendix C, paragraph 4.

(2) Ensuring VA health care providers have access to and the ability to order urine drug testing and other laboratory testing for SUD care, as clinically indicated (see Appendix C).

(3) Ensuring VA health care providers prescribing buprenorphine have the appropriate Drug Enforcement Administration (DEA) x-waiver which is current, unrestricted and has been primary source verified in the electronic credentialing record.

(4) Ensuring all Veterans with OUD and stimulant use disorder are offered naloxone.

m. VA Medical Facility Associate Chief of Staff, Mental Health. The VA medical facility Associate Chief of Staff, Mental Health, is responsible for:

(1) Providing a continuum of SUD care that is consistent with current VA-DoD Clinical Practice Guideline for Management of SUD and utilizing a stepped-care approach to provide treatment in the least restrictive, clinically appropriate setting based on each Veteran's needs and preferences. **NOTE:** Stepped care is described in Appendix A.

(2) Facilitating collaborative care within and across health care teams beyond mental health (e.g., homeless program, pain management, infectious disease clinic, women's health teams, chaplain service) to promote a holistic approach to recovery.

(3) Designating a SUD-Posttraumatic Stress Disorder (PTSD) team or specialist to support the provision of concurrent, trauma-informed, integrated treatment for Veterans diagnosed with a co-occurring SUD and PTSD.

n. VA Medical Facility Program Director, Substance Use Disorders. The VA medical facility Program Director, SUD is responsible for:

(1) Ensuring available SUD services are consistent with recommended psychosocial and pharmacological SUD treatments specified by the VA-DoD Clinical Practice Guideline: <http://www.healthquality.va.gov/guidelines/MH/sud/>.

(2) Updating the SUD treatment locator when program services or points of contact change.

(3) Ensuring the implementation of an Intensive Outpatient Program (IOP) where appropriate as identified in this directive (see Appendix B).

(4) Designating or acting as an IOP manager who has primary responsibility for concurring in all IOP admissions and is responsible for program procedures and operations.

(5) Ensuring Veterans have the flexibility to move throughout the SUD continuum of care based on the individual needs and preferences of the Veteran by promoting a Veteran-centered, shared decision-making (SDM) approach. **NOTE:** *The SUD continuum of care is described in Appendix A.*

(6) Implementing measurement-based care as a tool to systematically individualize treatment based on recurring assessment of Veteran needs.

(7) Improving SUD care through participation in VA medical facility and national quality improvement initiatives.

(8) Working with VA medical facility women's health and women's mental health champions to ensure availability of substance use treatment tailored to women Veterans' needs, including preconception, pregnancy and postpartum care.

(9) Keeping specialty SUD and other clinical staff informed on the latest developments in SUD prevention and treatment through participation in VA medical facility, CBOC and national teleconferences and continuing education. **NOTE:** *Required and recommended trainings for this directive are included in paragraph 3.*

(10) Ensuring evidence-based harm reduction interventions are available to all Veterans with SUD consistent with current guidance on harm reduction in VHA.

(11) Regularly evaluating VA medical facility performance on SUD metrics compiled by the PERC Director and making program changes as indicated to optimize SUD care as reflected in improved performance on those metrics.

(12) Ensuring operation of specialty SUD programs in accordance with current VHA policies and procedures.

o. **VA Medical Facility Opioid Treatment Program Medical Director.** The VA medical facility OTP Medical Director is responsible for:

(1) Working in collaboration with the OTP sponsor to meet the requirements outlined in Certification of Opioid Treatment Programs (42 C.F.R. § 8.11).

(2) Working in collaboration with the OTP sponsor and VA medical facility pharmacy leadership to ensure availability of pharmacy staffing as needed. **NOTE:** See Appendix E for additional information.

p. VA Medical Facility Substance Use Disorder-Posttraumatic Stress Disorder Specialist. **NOTE:** For additional information about the VA medical facility SUD-PTSD Specialist, see Appendix B, paragraph 2.d. The VA medical facility SUD-PTSD Specialist, through either direct patient care or supporting clinical staff working with Veterans diagnosed with co-occurring PTSD and SUD, is responsible for:

(1) Coordinating treatment planning and delivery of services that best meet the needs of Veterans diagnosed with co-occurring PTSD and SUD regardless of the setting of care where services are being provided.

(2) Consulting on Veterans' care with VA health care providers throughout the VA medical facility who may directly interact with Veterans presenting with co-occurring SUD and PTSD.

(3) Acting as a liaison between all relevant programs to ensure the Veteran has access to additional SUD or PTSD services as needed, and as a consultant to VA medical facility staff on strategies for adapting care secondary to trauma (i.e., trauma-informed treatment approaches). **NOTE:** See VHA Directive 1160.03(1), Programs for Veterans with Post-Traumatic Stress Disorder (PTSD), dated November 16, 2017, for responsibilities associated with PTSD.

q. VA Health Care Provider. VA health care providers are responsible for:

(1) Providing Veteran-centered SUD care that is consistent with the current VA-DoD Clinical Practice Guideline for the Management of SUD (<https://www.healthquality.va.gov>).

(2) Complying with the principles of treatment and rehabilitation for Veterans with SUD, including measurement based SUD care, as stated in Appendix A.

(3) According to privileges or scope of practice, assessing Veterans that present with substance use concerns for the presence of SUD and related medical disorders and clinical complexities to determine management for these conditions and providing comprehensive care directly or arranging coordinating care as needed. This includes assessing for pregnancy, discussing pregnancy intention and coordinating care for pregnant, postpartum and lactating Veterans with maternity care providers when indicated.

(4) Obtaining and documenting in the electronic health record the informed consent of the Veteran (or the Veteran's surrogate if the Veteran lacks decision-making capacity) prior to initiating SUD treatment. **NOTE:** Consent must be documented consistent with national policy defined by VHA Handbook 1004.01(5), Informed Consent for Clinical Treatment and Procedures, dated August 14, 2009.

(5) Offering naloxone to all Veterans with OUD and stimulant use disorder being managed by the VA health care provider.

(6) Completing the Suicide Behavior and Overdose Report if the patient has immediate care needs.

(7) Contacting the patient's primary care, mental health or SUD providers as clinically indicated (see Appendix F).

3. TRAINING

a. The following trainings are **required**:

(1) Clinical and non-clinical SUD staff must complete mandatory suicide risk and intervention training as specified in VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

(2) Clinical and non-clinical SUD staff must complete mandatory Prevention and Management of Disruptive Behavior (PMDB) training as specified in VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

b. The following one-time training is **strongly recommended**:

(1) All SUD staff at VA medical facilities as appropriate to discipline: CLE-118 Withdrawal Assessment CIWA/COWS (Talent Management System #4490709).

(2) VISNs and VA medical facilities also are encouraged to offer additional training specific to management of SUD to all clinically active staff engaged in the treatment or care of Veterans diagnosed with a SUD. **NOTE:** *Information on available SUD-specific trainings can be found at: <https://dvagov.sharepoint.com/sites/VHASUD/>. This is an internal VA website that is not available to the public. It is the responsibility of OMH to own, develop and make available all training products and cannot be delegated to the VISN or VA medical facilities.*

4. RECORDS MANAGEMENT

All records regardless of format (e.g., 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 should be addressed to the appropriate Records Officer.

5. BACKGROUND

a. VA offers a comprehensive continuum of care for SUD, from outpatient services to residential and inpatient care.

b. According to internal VHA data, of the approximately 550,000 Veterans with a diagnosed SUD (other than tobacco use disorder) seen in VHA in recent years, over 170,000 received specialty care for SUD, and over 15,000 received specialty residential and inpatient care. However, most Veterans diagnosed with a SUD were provided services in settings other than specialty SUD care, highlighting the need to address SUD across clinical settings, including in primary care, inpatient mental health and general mental health clinics. **NOTE:** See *VHA Directive 1056, National Smoking and Tobacco Use Cessation Program, dated September 5, 2019, for information about evidence-based smoking and tobacco use cessation treatment.*

c. While the availability of and patterns of use for addictive substances change over time, the need to treat those with SUD persists. The impact of addiction is not limited to those diagnosed with a SUD. For example, there are substantial direct costs for SUD-related health care conditions and indirect costs to the Veteran and to society in terms of family impact, lost wages and incarceration, that are not easily measured.

d. VA employs evidence-based medication and psychosocial interventions for the treatment of SUD as recommended by the VA-DoD Clinical Practice Guideline for the Management of SUD and the U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence. These guidelines can be found at: <http://www.healthquality.va.gov> and <https://www.ahrq.gov/prevention/guidelines/tobacco/index.html>, respectively.

6. DEFINITIONS

a. **Buprenorphine.** Buprenorphine is a partial mu opioid receptor agonist that is prescribed for the treatment of OUD as part of a comprehensive treatment plan. Buprenorphine is primarily prescribed as buprenorphine/naloxone to decrease the likelihood of diversion and misuse of the medication. **NOTE:** *By Federal law, only qualified providers as determined by SAMHSA and DEA may prescribe buprenorphine for the treatment of OUD.*

b. **Chronic Disease Management.** For purposes of this directive, chronic disease management is an integrated approach to managing SUD that includes ongoing monitoring, patient education and coordination of care with the setting of care based on the Veteran's expressed preferences. **NOTE:** *As a function of chronic disease management, care is not time limited and treatment for co-occurring mental health, medical and psychosocial concerns is provided non-contingent on the current status of the Veteran's SUD diagnosis or current substance use.*

c. **Harm Reduction.** For purposes of this directive, harm reduction is a set of practical strategies and ideas aimed at reducing negative health consequences associated with substance use. Harm reduction approaches include Syringe Service Programs and naloxone distribution. Harm reduction approaches take a Veteran-centered approach with the primary goal of minimizing morbidity and mortality regardless of whether the patient successfully achieves stable remission of their disease. **NOTE:** *This definition is adapted from the Center for Disease Control's*

National Harm Reduction Technical Assistance Center. For additional information on harm reduction, see <https://harmreductionhelp.cdc.gov/s/>.

d. **Naloxone**. Naloxone is an opioid antagonist that can displace opioids from receptors in the brain and, if given in a timely manner at an appropriate dose during an opioid overdose, can reverse the opioid-related respiratory depression that is the proximal cause of opioid overdose mortality.

e. **Opioid Treatment Program**. An OTP is a program that provides medication-assisted treatment (MAT) for people diagnosed with an OUD and is governed by the Certification of Opioid Treatment Programs, 42 C.F.R. § 8.11. **NOTE:** *In lieu of the historical term MAT, VHA uses M-OUD.*

f. **Qualified Provider**. A qualified provider is a VA health care provider with a DEA-X license who can prescribe buprenorphine for the treatment of OUD (i.e., medical doctor, doctor of osteopathy, nurse practitioner or physician assistant) as determined by SAMHSA and DEA. A DEA x-waiver is issued to qualified providers authorizing them to conduct maintenance and withdrawal treatment using buprenorphine. **NOTE:** *In some instances, these qualified providers may be referred to as Drug Addiction Treatment Act 2000 (DATA) waived providers. Dependent on authorization from the Center for Substance Abuse Treatment, the waiver specifies the number of patients a qualified provider may treat at any one time.*

g. **Recovery**. Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. **NOTE:** *For further information, see the SAMHSA Working Definition of Recovery, located at <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>.*

h. **Shared Decision-Making**. For purposes of this directive, SDM is a formal communication process for consensus building between a VA health care provider and patient when multiple evidence-based treatment alternatives exist to treat the patient's condition or problem. The provider and patient jointly participate in the process to arrive at a clinical decision or treatment plan. SDM requires three components: 1) clear, accurate and unbiased medical evidence about reasonable alternatives, including no intervention and the risk and benefits of each; 2) clinician expertise in communicating and tailoring the evidence for individual patients; and 3) patient values, goals, informed preferences and concerns, which may include treatment burden.

i. **Substance-Related Disorders**. Substance-related disorders encompass ten separate categories of substances (alcohol, caffeine, cannabis, hallucinogens, phencyclidine and related compounds, inhalants, opioids, sedatives-hypnotics-anxiolytics, stimulants, tobacco and other (or unknown) substances) according to the Diagnostic and Statistical Manual (DSM) of Mental Disorders. They are divided into two groups:

(1) Substance-induced disorders (e.g., intoxication, withdrawal and substance-induced psychiatric disorders).

(2) Substance Use Disorders (SUDs) (as defined below).

j. **Substance Use Disorder.** SUD is a problematic pattern of substance use leading to clinically significant impairment or distress that meets diagnostic criteria according to the current DSM of Mental Disorders. **NOTE:** *The diagnosis of SUD must be consistent with the criteria of the most current mental health diagnosis system approved by VA, i.e., the current edition of DSM.*

7. REFERENCES

- a. 38 U.S.C. §§ 1720A, 7332.
- b. 38 C.F.R. §§ 17.38, 17.80-17.83.
- c. 42 C.F.R. § 8.11-8.12.
- d. VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.
- e. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- f. VHA Directive 1056, National Smoking and Tobacco Use Cessation Program, dated September 5, 2019.
- g. VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.
- h. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.
- i. VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.
- j. VHA Directive 1100.20, Credentialing of Health Care Providers, September 15, 2021.
- k. VHA Directive 1106, Pathology and Laboratory Medicine Service, dated July 27, 2018.
- l. VHA Directive 1108.01(1), Controlled Substances Management, dated May 1, 2019.
- m. VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023.
- n. VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), dated November 16, 2017.
- o. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

p. VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019.

q. VHA Directive 1215, Standards for Veterans Health Administration Centers of Excellence, dated February 14, 2017.

r. VHA Directive 1605, VHA Privacy Program, dated September 1, 2017.

s. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatment and Procedures, dated August 14, 2009.

t. VHA Handbook 1106.01, Pathology and Laboratory Medicine Service (PALMS) Procedures, dated January 29, 2016.

u. Agency for Healthcare Research and Quality, Treating Tobacco Use and Dependence: 2008 Update, <https://www.ahrq.gov/prevention/guidelines/tobacco/index.html>.

v. American Psychiatric Association Diagnostic and Statistical Manual (DSM) of Mental Disorders: <https://www.psychiatry.org/psychiatrists/practice/dsm>.

w. Center for Disease Control, National Harm Reduction Technical Assistance Center. <https://harmreductionhelp.cdc.gov/s/>.

x. Landrum B, Knight DK, Flynn PM. The impact of organizational stress and burnout on client engagement. J Subst Abuse Treat. 2012 March;42(2):222-30.

y. Managerial Cost Accounting Office SharePoint: <http://vaww.mcao.va.gov/index.asp>. **NOTE:** *This is an internal VA website that is not available to the public.*

z. National Center for PTSD. PTSD Treatment Decision Aid: The Choice is Yours: <https://www.ptsd.va.gov/apps/decisionaid/>.

aa. National Quality Forum, March 2018, NQF: NQP Shared Decision Making Action Brief: https://www.qualityforum.org/Publications/2017/10/NQP_Shared_Decision_Making_Action_Brief.aspx.

bb. SAMHSA. Shared Decision-Making Tools: <https://brss-tacs-decision-tool.samhsa.gov>.

cc. SAMHSA Working Definition of Recovery: <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>.

dd. Stratification Tool for Opioid Risk Mitigation (STORM) Implementation: <https://dvagov.sharepoint.com/sites/VHAPER/STORM/SitePages/Start.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

ee. Suicide Risk Identification and Management SharePoint:

<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>.

NOTE: *This is an internal VA website that is not available to the public.*

ff. Treatment Improvement Protocol (TIP) 26: Treating Substance Use Disorder in Older Adults | SAMHSA Publications and Digital Products:

<https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011>.

gg. U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: <https://www.healthquality.va.gov/>.

hh. VA Office of Mental Health and Suicide Prevention, Substance Use Disorder Policy Resource Page:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

ii. VA Substance Use Disorder SharePoint Site:

<https://dvagov.sharepoint.com/sites/VHASUD/>. **NOTE:** *This is an internal VA website that is not available to the public.*

jj. VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders: <https://www.healthquality.va.gov>.

PRINCIPLES OF TREATMENT AND RECOVERY FOR VETERANS WITH SUBSTANCE USE DISORDERS

1. ACCESS TO CARE AND RETENTION IN TREATMENT

a. The Department of Veterans Affairs (VA) is committed to providing timely and appropriate access to a high-quality, integrated, comprehensive, cost-effective and patient-centered continuum of care to eligible Veterans with substance use disorders (SUD) and substance-related disorders.

b. Same-day services in outpatient specialty SUD programs must be available to any Veteran that is in crisis or has another need for immediate care for the management of SUD. The Veteran must receive immediate attention from a VA health care provider at the VA medical facility.

c. All new Veterans requesting or referred for SUD care who present in person must receive an initial screening evaluation the same day. For any Veteran contacting VA by telephone, text or app, the evaluation must occur no later than the next calendar day and may occur by a face-to-face visit or via telehealth (video or audio).

d. The full spectrum of SUD-related care is critical for rapidly engaging Veterans into care and in providing the critical care necessary to treat SUDs. VA medical facilities are encouraged to evaluate current resources, barriers to care and opportunities for expansion across the SUD treatment spectrum and respond as appropriate.

e. One of the primary goals of SUD care is retaining Veterans with SUD in treatment as retention in treatment is one of the best proxies for improved outcome. Veterans will not have treatment discontinued because of continued substance use or relapse. Harm reduction strategies will be employed to improve patient outcomes. Harm reduction provides interventions that reduce the negative health consequences associated with substance use. Harm reduction approaches take a Veteran-centered approach with the goal of minimizing morbidity and mortality and preventing negative health consequences of substance use.

f. Peer Support can assist Veterans with accessing and remaining engaged in treatment. VA medical facilities are required to ensure that Peer Support services are available to all Veterans receiving SUD care.

g. Data shows that SUD treatments are successful among patients with dual diagnoses. Services must be designed and available to provide care for Veterans with SUD and mental health conditions, alone or together, regardless of acuity or chronicity.

h. Data shows that women's specific SUD programs, if available, increase engagement of women Veterans in treatment. Resources for care of women Veterans with SUD can be found at

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance->

<U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** This is an internal VA website that is not available to the public.

i. VA medical facilities must not deny care to any enrolled Veterans because they are under the influence of substances, are actively using substances, are experiencing withdrawal symptoms, are diagnosed with a SUD or are physically dependent on substances. Services and treatments must be provided both to address the Veteran's immediate needs and to promote their engagement in ongoing SUD care.

j. VA medical facilities must not deny or delay appropriate care for SUD to any enrolled Veteran on the basis of the length of the Veteran's current abstinence from alcohol or other substances, the number of previous treatment episodes the Veteran has had, the Veteran's use of substances, the Veteran's legal history or any other mental health disorders the Veteran may have.

k. Every VA medical facility must have services available to meet the care needs of enrolled Veterans with both SUD and Posttraumatic Stress Disorder (PTSD) or other mental health conditions. When active treatment is required for both conditions, it can be provided in specially designed dual diagnoses programs or with treatment planning, care coordination and collaboration between providers, through services provided by both SUD and mental health programs.

l. VA recognizes that access to care can be adversely impacted by the stigma associated with SUD. To help mitigate stigma, VA strongly encourages all staff who serve Veterans with SUD to use Veteran-centric, science-based language that destigmatizes SUD and encourages Veterans' engagement and collaboration in their treatment.

2. INFORMED CONSENT

Treatment decisions must reflect a discussion that allows Veterans to choose treatment goals and select from clinically indicated treatment options. Veterans have the right to accept, decline or discontinue treatment for SUD without limiting their access to other indicated treatment. In accordance with Veterans Health Administration (VHA) Handbook 1004.01(5), Informed Consent for Clinical Treatment and Procedures, dated August 14, 2009, prior to initiating SUD treatment, VA health care providers must obtain and document the voluntary informed consent of the Veteran (or the Veteran's surrogate if the patient lacks decision-making capacity). VA health care providers must document that consent was obtained from the Veteran.

3. SUBSTANCE USE DISORDER CONTINUUM OF CARE

a. Stepped care is a defining principle for the provision of SUD treatment where less complex and more stable Veterans diagnosed with SUD can be effectively treated by primary care, mental health and other non-SUD specialists. VHA has embraced this model for meeting the substance use treatment needs of Veterans. Veterans with more complex and less stable SUD require more comprehensive and intensive treatment

provided in specialty SUD care settings. In a stepped care model, Veterans move seamlessly between less intensive general care settings to more intensive specialty SUD care as clinically indicated and consistent with data-informed, shared decision-making that considers the Veteran's needs and preferences (i.e., measurement-based care (MBC)).

b. The continuum of care for provision of SUD services using a stepped care model includes:

(1) **Level 0.** Foundational services including self-care.

(2) **Level 1.** Interventions in primary care, non-specialty SUD care and general mental health clinics.

(3) **Level 2.** Specialty SUD outpatient services, intensive outpatient SUD programs, Opioid Treatment Programs, residential rehabilitation and acute inpatient services.

c. The continuum of care allows the intensity and setting of care to continuously adjust to meet the unique needs of the Veteran. VA medical facilities that do not directly provide the entire continuum of services must make these services available through referrals to other VA medical facilities or by sharing agreements, contracts or community care to the extent that the Veteran is eligible. Some components of the continuum may be provided in coordination with other Veterans Integrated Services Networks (VISNs). Services provided must be based on the Veteran's clinical needs and preferences within the least restrictive environment necessary to ensure safety and promote recovery. Not all Veterans require the entire continuum of services. Veterans move across the components of the continuum as is clinically appropriate, with an emphasis on continuity of care to minimize disruptions in treatment and facilitate recovery in the Veteran's community of choice.

d. Because SUD is a chronic relapsing condition, harm reduction interventions are recognized as a requisite element of the SUD continuum of care. These interventions include, but are not limited to, syringe services programs, opioid overdose education and naloxone distribution and low-threshold access to and initiation on medications for SUD.

4. COLLABORATIVE CARE

a. Within the primary care, general mental health, inpatient mental health, medical specialty programs, geriatrics and extended care programs (e.g., community living centers and home-based primary care) or other clinical settings outside of specialty SUD programs, Veterans with SUD may benefit from the involvement of specialized program staff in their further assessment or treatment in cooperation with the primary provider. Consistent with provision of stepped care for SUD, VA health care providers in primary care, general mental health and other clinical settings must directly treat the SUD with consultation available from specialty SUD program staff.

b. Veterans treated within specialty SUD programs may also require collaborative care for significant complicating features, including but not limited to:

(1) Psychosocial needs, including homelessness, unemployment and lack of social support for recovery.

(2) Trauma and stressor-related disorders, such as PTSD.

(3) Anxiety disorders, such as panic disorder and generalized anxiety disorder.

(4) Depressive disorders, including major depressive disorder and persistent depressive disorder (dysthymia).

(5) Schizophrenia spectrum and other psychotic disorders, and bipolar and related disorders.

(6) Neurocognitive disorders or other conditions that impair cognitive functioning.

(7) Other general medical conditions, including pain, pregnancy, alcohol-related hepatitis or infectious diseases such as viral hepatitis and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. **NOTE:** *Assessment of Veterans with SUD must include a focus on the presence of medical disorders with management for these conditions provided directly or arranged as needed.*

c. Treatment providers are encouraged to consider and discuss with Veterans the option of including the Veteran's family or other caregivers as care partners in SUD treatment, especially for those Veterans with cognitive impairment who need some external supports.

5. MEASUREMENT-BASED CARE

a. MBC is the use of Veteran self-reported measures, collected repeatedly over the course of treatment, to individualize and improve mental health care. MBC consists of three steps: collect, share and act. All specialty SUD programs must provide measurement-based care that includes:

(1) **Collect.** Veterans-reported outcome measures administered repeatedly throughout the Veteran's course of care.

(2) **Share.** Timely feedback of the assessment data to the Veteran.

(3) **Act.** Use of the assessment data to inform shared decision-making and treatment planning between the Veteran and SUD treatment professionals.

b. At a minimum, VA health care providers must measure response to treatment using the Brief Addiction Monitor (e.g., BAM-Revised (BAM-R) or BAM-Intensive Outpatient Program (BAM-IOP)) to support the delivery of measurement-based SUD care.

c. Measurement must occur at the initiation of treatment, at termination of treatment, at transition between levels of care and at regular intervals during phases of treatment that last more than 30 calendar days at the same level of care.

d. Frequency of measurement must take into consideration the intensity of treatment and anticipated duration of care in addition to the Veteran's presenting treatment needs. At a minimum, monthly measurement is required during first 90 days of the Veteran's outpatient treatment episode and the BAM must be administered within 7 days prior to or following admission to SUD specialty care and within 7 calendar days prior to or following transition to a lower or higher level of care.

e. With re-assessment intervals of 30 days or longer, VA health care providers and non-Licensed Independent Practitioners are encouraged to share data (BAM-R or BAM-IOP) with Veterans as soon as possible but no later than 7 calendar days from the time of data collection. With re-assessment intervals of less than 30 days, VA health care providers are encouraged to share data (BAM-R or BAM-IOP) with Veterans as soon as possible but no later than 3 calendar days from the time of data collection.

6. RESIDENTIAL TREATMENT

a. Each VISN must make available residential treatment for SUD through Domicillary (DOM) SUD programs or designated tracks within other Mental Health Residential Rehabilitation Treatment (MH RRTP) Programs. **NOTE:** *VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019, provides detailed requirements for residential treatment. See Appendix B for additional information about SUD treatment services and programs.*

b. VA medical facilities may establish residential treatment arrangements with community-based residential rehabilitation treatment facilities and transitional housing resources using agreements, contracts or community care to the extent the Veteran is eligible and that arrangements are consistent with 38 C.F.R. §§ 17.80-17.83. Sharing agreements, contracts and community care must provide access and quality of service that is consistent with VA health care standards. These residential and housing arrangements may facilitate access to outpatient care for SUD within VA or provide access to community care services that complement program elements available within VA programs. **NOTE:** *Transitional housing in combination with intensive outpatient SUD treatment is not equivalent to residential treatment for SUD. Rather, such arrangements allow for treatment of Veterans who do not require a residential level of care, but who are unable to participate in intensive outpatient treatment without housing support.*

SUBSTANCE USE DISORDER TREATMENT SERVICES AND PROGRAMS**1. SUBSTANCE USE DISORDER SERVICES**

a. Specialty substance use disorder (SUD) programs and services include SUD outpatient clinics, Intensive Outpatient Programs (IOP), Opioid Treatment Programs (OTP), SUD/Posttraumatic Stress Disorder (PTSD) teams or specialists, Domiciliary (DOM) SUD programs and acute inpatient SUD services. All specialty SUD programs and services are designed to meet the needs of Veterans with a SUD diagnosis, particularly those Veterans with new onset, unstable, severe or complex SUD conditions (e.g., co-occurring mental health and medical conditions). These programs provide a continuum of care from outpatient care to intensive inpatient and residential treatment. Specialized SUD programs require availability of assigned interdisciplinary staff with clinical competence to provide evidence-based psychosocial and pharmacological interventions for treatment of SUD. Specialized SUD programs must have the capacity to offer harm reduction services, identify co-occurring conditions, provide concurrent treatment and arrange appropriate follow-up care when indicated.

b. Resources and guidance on the provision of evidence-based treatments for SUD including, but not limited to, Contingency Management (CM), are available at the Office of Mental Health and Suicide Prevention (OMH) SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal Department of Veterans Affairs (VA) website that is not available to the public.*

c. SUD programs must complete the Directive Implementation Support Tool (DIST) that assesses the program's compliance with the SUD directive and identifies areas where a policy waiver and/or action plan is needed. **NOTE:** *The criteria for this assessment are established by OMH. The DISTs are sent through the VISN to the Office of Mental Health SUD section for review and discovery of trending national results. The local facility is responsible for addressing gaps identified in the checklist.*

d. SUD programs must provide updates to the SUD Treatment Locator: <https://www.va.gov/directory/guide/SUD.asp> when there are changes in contact information or available services for the program.

e. Specialized programs are necessary for treatment of individuals with SUDs whose treatment needs cannot be met in other levels of care, such as primary care, pain clinics, general mental health or other specialty mental health programs. However, when Veterans are assessed as stable with low severity or uncomplicated SUD, SUD care may be provided in non-SUD specialty settings. Many VA health care providers are familiar with and can manage stabilized or low-severity SUD. Such services may include brief interventions, (e.g., brief cognitive behavioral therapies, motivational interviewing/enhancement and care management) as well as provision of pharmacotherapy for opioid, tobacco and alcohol use disorders.

f. Every VA medical facility is required to have specialized outpatient SUD services, and to provide or arrange timely access to inpatient or outpatient medical withdrawal management or stabilization and intensive early recovery services, including residential and intensive outpatient services. Health care providers determine the most appropriate care modality or combination of modalities (e.g., video telehealth, phone or in-person care) based on the needs and preferences of the Veteran and the state of technology and evidence-based practice to facilitate convenient, effective and safe access to care in accordance with Veterans Health Administration (VHA) policy on use of telehealth technologies. All Community Based Outpatient Clinics (CBOCs) are required to provide access to specialty SUD services with onsite staff, by telehealth with VA medical facilities or through referral using community care to the extent the Veteran is eligible. Specific requirements are delineated below.

g. SUD programs must utilize the “Abstinence Contingency Management Note” template when documenting the provision of CM rewarding abstinence. Resources for Contingency Management rewarding abstinence and the note template are available on the SUD SharePoint:

<https://dvagov.sharepoint.com/sites/VHASUD/SitePages/CM.aspx>. **NOTE:** *This is a VA website that is not available to the public.*

h. To enhance accessibility to SUD services and reduce stigma, VA medical facilities must also make SUD services available within other settings as delineated by requirements for each level of care defined by this directive. This may include provision of specialty SUD services within patient aligned care teams (which includes Primary Care Mental Health Integration), general mental health, CBOCs, PTSD clinics, inpatient mental health units and residential settings without designated SUD bed sections. VA health care providers providing SUD services outside of specialty SUD care are expected to have access to a SUD specialist for consultation purposes. **NOTE:** *Programs are strongly encouraged to make available sex-specific services when clinically needed for Veterans with SUD.*

i. IOPs must have the capacity to accept Veterans in the indicated intensity of care within 7 calendar days of referral. The minimum patient flow to warrant an IOP is an average of two admissions per week. VA medical facilities that do not have at least 1,250 Veterans diagnosed with SUD may not have sufficient demand to warrant a stand-alone IOP program. In this case, VA medical facilities may choose to provide Veterans an intensive level of SUD care (at least 9 hours per week of services), including evidence-based psychosocial and pharmacotherapy options, within their overall SUD or mental health treatment programs, or via sharing agreements, telehealth or community care options. The table below shows the requirements for types of treatment programs within different facilities:

Type of Treatment Program	VA Medical Facility	Large CBOC (>10,000 unique Veterans annually)	CBOC
SUD Outpatient Clinics	Required	Required	Available via telehealth
IOP	Required	Access to VA IOP, residential treatment or through community care	Access to VA IOP, residential treatment or through community care
Opioid Treatment Program	Accessible at VA medical facility or through community care	Accessible at VA medical facility or through community care	Accessible at VA medical facility or through community care
DOM SUD Program	Available within the VISN	Available within the VISN	Available within the VISN
Inpatient SUD Treatment	Available at VA medical facility or through community care	Available at VA parent facility or through community care	Available at VA parent facility or through community care
SUD-PTSD Specialist or Team	Required	Accessible via telehealth or use of community care	Accessible via telehealth or use of community care

2. SPECIALTY SUBSTANCE USE DISORDER PROGRAMS

a. **Substance Use Disorder Outpatient Clinic.** SUD Outpatient Clinics provide settings for initial and continuing outpatient care to Veterans whose care needs cannot be met in less intensive settings. Programming is designed to provide the full range of clinically indicated treatment and rehabilitation services for Veterans with SUD, including ambulatory withdrawal management; treatment of the psychological and behavioral aspects of addiction with evidence-based addiction-focused pharmacotherapy and psychosocial interventions; group mutual help; and recovery-oriented services, including vocational rehabilitation services and other skills training needed to initiate and sustain SUD recovery. SUD Outpatient Clinics must provide a minimum of two evidence-based psychosocial interventions for SUD, one of which must be individual or group cognitive behavioral interventions for SUD. Further, SUD Outpatient Clinics must provide access to all medications recommended by guidelines for the treatment of SUD, with the exception of methadone, which can only be provided for the treatment of opioid use disorder in an accredited OTP.

b. **Intensive Outpatient Program.** All VA medical facilities must provide access to IOP SUD services. IOP for SUD provides an intensity of care that falls between residential or inpatient care and general outpatient care. Intensive outpatient treatment

for SUD is intended to help Veterans establish clinical stability, identify initial recovery goals, provide evidence-based treatments for SUD, initiate care for co-occurring medical and mental health conditions, develop interpersonal support for recovery and promote engagement in continuing care. IOP services may also serve as a step-down program from inpatient or residential care or step-up care for Veterans needing additional support.

(1) IOP services provide integrated, evidence-based psychosocial and pharmacotherapy interventions for SUD at a minimum of 9 hours per week, with the daily schedule individualized to meet the unique needs of each Veteran. SUD IOPs must provide a minimum of two evidence-based psychosocial interventions for SUD and must offer both cognitive behavioral interventions for SUD (individual or group) and CM. Additional evidence-based psychosocial treatments may include 12-step facilitation and motivational enhancement therapy. Further, SUD IOPs must provide access to all guideline recommended medications, with the exception of methadone which can only be provided for the treatment of opioid use disorder (OUD) in an accredited OTP.

(2) All IOPs must provide motivational incentives (also known as CM) to reinforce SUD recovery behaviors. CM may be offered in other treatment settings and for other indications; for example, to promote abstinence in cannabis use disorder or to improve adherence to injectable naltrexone for treatment of opioid or alcohol use disorder. Access to CM is not limited to Veterans participating in IOPs; CM can be beneficial to Veterans in all levels of care. A standard course of CM is 12 weeks in duration, so CM would typically bridge from IOP to standard outpatient SUD care. VA medical facilities must adhere to the current standards of care for the provision of CM as defined by the CM guidance available on the OMH SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

(3) IOP services must include medical evaluation and planning for continuing outpatient care. Other services provided by the IOP include differential diagnosis, recovery planning, psychosocial rehabilitation and care for co-occurring disorders.

(4) Continuity of care with other SUD services and other mental health services that the Veteran has or may receive must be coordinated by all VA health care providers working with the Veteran.

(5) In some cases, and to the extent that the Veteran is eligible, it may be preferable to offer the Veteran the option for IOP-equivalent services through other means, such as community care or through telehealth. If possible, services should be offered in the evenings or on weekends for the convenience of Veterans who are working, have childcare responsibilities or have travel conflicts during the workday. When services are offered in the evenings or on weekends, staffing must be adequate to provide safe, effective and appropriate clinical care.

c. **Opioid Treatment Program.** The Substance Abuse and Mental Health Services Administration (SAMHSA)-certified OTPs treat Veterans with OUD using first-line evidence-based medications, including methadone or buprenorphine, in combination with psychosocial services. OTPs must meet the requirements outlined in Certification of Opioid Treatment Programs (42 C.F.R. § 8.12). See Appendix E for additional details.

d. **Substance Use Disorder-Posttraumatic Stress Disorder Team or Specialist.** Given the high prevalence of co-occurring SUD and PTSD, a SUD-PTSD specialist or team at each VA medical facility serves to coordinate treatment planning and delivery of services that best meet the needs of Veterans diagnosed with co-occurring PTSD and SUD.

(1) Integrated or coordinated concurrent treatment of PTSD and SUD is considered an evidence-based practice that is actively promoted across the system. This practice includes having PTSD treatments recommended by the VA-Department of Defense (DoD) Clinical Practice Guidelines for PTSD available to Veterans with SUD and PTSD.

(2) SUD-PTSD specialists provide and coordinate SUD services for Veterans receiving PTSD treatment, facilitate PTSD treatment for those receiving SUD specialty care and act as a liaison to help all relevant programs collaborate to ensure the Veteran has access to additional SUD services as needed.

(3) SUD-PTSD specialists serve as team members within PTSD Clinical Teams (PCT) or other mental health teams that treat PTSD and as a liaison to specialty SUD care services. It is expected that the SUD-PTSD specialist spends a minimum of 50% time in direct clinical service providing care for Veterans with PTSD and SUD that is consistent with VA-DoD Clinical Practice Guidelines. This includes PTSD or SUD treatment for Veterans concurrently receiving the other or integrated care for Veterans who need both. In addition, SUD-PTSD specialists must spend a minimum of 20% time in liaison activities such as attending team and staff meetings on PTSD and SUD clinical teams and educating colleagues about evidence-based treatments and resources for concurrent treatments. **NOTE:** *VHA Directive 1160.03(1), Programs for Veterans with Posttraumatic Stress Disorder (PTSD), dated November 16, 2017, provides national policy for PCT programs and other PTSD services.*

e. **Domiciliary Substance Use Disorder Programs.** The DOM SUD programs are a bed section within the MH RRTP continuum of residential care and provide a residential level of care to Veterans with a SUD. Veterans served by the DOM SUD programs require more intensive treatment than can be provided by an IOP, but do not require acute inpatient mental health or medical care. Veterans may be referred for DOM SUD services in lieu of IOP services if barriers exist to accessing an IOP (e.g., transportation).

(1) DOM SUD programs are required to follow VA-DoD Guideline for the Management of SUD (<http://www.healthquality.va.gov>). DOM SUD programs must provide a minimum of 4 hours per day of diagnosis specific treatment and rehabilitation including integrated, concurrent treatment for co-occurring conditions, including serious

mental illness and PTSD. DOM SUD programs must provide a minimum of two evidence-based psychosocial interventions for SUD one of which must be individual or group cognitive behavioral interventions for SUD. Addiction-focused pharmacotherapy for alcohol, opioid and tobacco use disorders must be available within all DOM SUD programs.

(2) DOM SUD programs must provide access to a variety of mutual support services either onsite or in the community (e.g., Alcoholics Anonymous, Self-Management and Recovery Training, Peer Support, other groups as appropriate).

(3) The DOM SUD programs provide 24 hours a day, 7 days a week structured and supportive residential treatment as a part of a broader SUD rehabilitative continuum, with a requirement that Veterans continue to receive outpatient SUD treatment as part of a comprehensive continuing care plan following discharge.

(4) Veterans assessed as meeting the criteria for withdrawal management consistent with the VA-DoD Clinical Practice Guideline (www.healthquality.va.gov) may be admitted to a DOM SUD program as part of a plan to provide treatment and rehabilitation for SUD. These Veterans must meet the admission criteria for the program and be willing to participate in ongoing treatment and rehabilitation. Veterans at low risk for complications, with mild to moderate withdrawal, or who would otherwise be managed as outpatients, can be managed in residential treatment programs providing clinically managed or medically monitored withdrawal management. Medical monitoring includes nursing and medical support. Veterans that require medically managed withdrawal must be referred for acute inpatient care.

(5) Every VISN is required to have at least one VA medical facility with a DOM SUD bed section available. In VA medical facilities with MH RRTPs that do not have SUD specialty bed sections, SUD specialists must be part of the MH RRTP staff to promote integrated care for SUD.

(6) VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019, provides detailed national policy for clinical and administrative operations of the DOM SUD programs, including admission criteria.

f. **Acute Inpatient Substance Use Disorder Services.** Acute inpatient SUD care is focused on assessing withdrawal risk, evidence-based withdrawal management, comprehensive biopsychosocial assessment, medical and mental health stabilization, identifying initial recovery goals, initiating or arranging for care of co-occurring medical and mental health conditions, starting medication for alcohol, opioid and tobacco use disorders and effective linkage to continuing care in the residential or outpatient settings for Veteran-centric recovery goals. Stabilization services, such as management of alcohol withdrawal or other psychiatric emergencies, involve significantly shorter lengths of stay, and the emphasis is on promoting transition to longer term care in DOM SUD or in outpatient SUD specialty care (e.g., IOPs). When inpatient withdrawal management is indicated based on an assessment by a VA health care provider, this may be

accomplished on medicine, surgery or mental health units facilitated by consultation and collaboration from specialty SUD care, as clinically indicated.

(1) Assessment for suicidal or violent behavior is required for all Veterans at both admission and discharge from inpatient mental health care including, but not limited to, the treatment of SUD. Assessment of suicide risk must align with the VHA unified strategy for suicide risk screening and evaluation (VA Suicide Risk Identification Strategy: Risk ID). Staff-specific requirements, as well as education and training materials are also available on the Suicide Risk Identification and Management SharePoint: <https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>. **NOTE:** *This is an internal VA website and is not available to the public.*

(2) Current medication for alcohol and opioid use disorders must be continued during inpatient hospitalization unless contraindicated. If not currently prescribed, medications for the treatment of alcohol use and opioid use disorders must be offered to Veterans prior to discharge to promote continued recovery after stabilization.

(3) VA medical facilities must adhere to the current standards of care for alcohol withdrawal management. Guidance is available on the OMH SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

(4) Opioid detoxification alone (i.e., without transition to medication treatment for OUD before hospital discharge) is not recommended for Veterans with OUD.

(5) Patients who are hospitalized specifically for management of withdrawal must have their follow up appointment scheduled with an outpatient SUD specialty provider within 7 calendar days of discharge. Patients with an unplanned discharge (e.g., against medical advice) from inpatient mental health treatment including, but not limited to treatment for SUD, must be offered an appointment within 24 hours of discharge with a second appointment within 7 calendar days of discharge to facilitate continuing care for mental health and SUD care.

3. DURATION OF CARE

a. Duration of treatment must be clinically determined using measurement-based care focused on symptoms and functioning, with frequency of contact generally decreasing with more stable recovery.

b. Typical durations of care or lengths of stay exist for certain settings, e.g., IOP, DOM SUD and acute inpatient SUD programs. However, every patient's duration of care will be determined collaboratively with the patient, informed by data on the patient's clinical status and consistent with clinical need.

(1) **Intensive Outpatient Program.** Duration of IOP treatment based on clinical improvement is mutually determined by Veteran and program staff. Typical duration of care is 3 to 6 weeks, with the goal of confirming at least 2 consecutive weeks of clinical stability and that the Veteran is sufficiently stable to warrant a less intensive level of standard outpatient care.

(2) **Domiciliary SUD Programs.** Length of stay in a DOM SUD program is based on the individualized clinical need of the Veteran and discharge options available in the continuum of care. Compared to other MH RRTPs, DOM SUD bed sections provide relatively briefer lengths of stay (e.g., 30 to 60 days) focused on stabilizing Veterans in early recovery and preparing them to pursue recovery goals in other MH RRTP settings or as outpatients. Veterans discharging from DOM SUD programs are expected to engage in outpatient SUD care for a period of time following discharge to sustain treatment gains.

(3) **Acute Inpatient Substance Use Disorder Treatment.** Length of stay for acute inpatient SUD treatment is clinically determined based on symptoms and functioning. In some instances, Veterans may be stabilized in the emergency department without requiring inpatient admission before engaging in outpatient or residential treatment.

c. The VA health care outpatient provider must make every effort to facilitate Veteran retention in SUD care for at least 90 calendar days. Given the chronic nature of SUD with periods of remission followed by return to use, some Veterans may require longer periods of continuing care consistent with chronic disease management. Further, medication for SUD in most instances must be maintained for an extended period that will exceed 90 days.

(1) Outpatient continuing care for the treatment of SUD must be offered to Veterans discharged from acute inpatient or residential treatment, regardless of length of stay.

(2) Veterans whose condition is stable may receive ongoing care (i.e., chronic disease management) within non-SUD specialty settings, such as general mental health or primary care clinics for periods exceeding 90 days.

4. SUBSTANCE USE DISORDER SPECIALTY STAFFING

a. General SUD staffing guidelines are noted in the sections below.

(1) **Substance Use Disorder Outpatient Clinical Teams.** SUD Outpatient Clinical Teams must include, at a minimum, three VA health care providers with expertise in SUD, as well as appropriate administrative support. At a minimum 1.0 full-time equivalent (FTE) clinical staff must be a licensed independent mental health provider who is credentialed and privileged or with documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. A minimum 0.5 FTE qualified provider must be dedicated within the program to provide medication for Veterans with alcohol, tobacco or opioid use disorders, as well as general medical evaluation and

pharmacotherapy for co-occurring mental disorders. SUD outpatient clinical teams may include providers from a variety of disciplines including, but not limited to, addiction therapists, registered nurses, clinical pharmacist practitioners, physician assistants, peer specialists and chaplains. **NOTE:** *For a definition of Licensed Independent Practitioners, see VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.*

(2) **Intensive Outpatient Program.** IOPs must be organized under the clinical supervision of the VA medical facility Program Director, SUD. The manager of the IOP must be a clinician with training and expertise in SUD service delivery. The IOP manager has primary responsibility for concurring in all IOP admissions and is responsible for program policy, procedures and operations. The IOP must be able to plan for continuing outpatient care. The IOP must be staffed by an interdisciplinary clinical team. Appropriate supporting administrative and clerical staff must be provided to allow for efficient operation. In addition to staffing for standard SUD outpatient services, IOP program staffing requires a minimum of at least 2.5 FTE employee clinical staff and 0.5 FTE employee administrative staff. At least one of these clinical staff must be a licensed mental health provider (e.g., licensed social worker, licensed doctoral-level psychologist, psychiatrist, physician assistant, clinical pharmacist practitioner) credentialed and privileged by VA or with documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. At least 0.5 FTE provider must be dedicated within the IOP to provide medication which must be considered for all Veterans with alcohol, tobacco and opioid use disorders, as well as general medical evaluation and pharmacotherapy for co-occurring mental disorders.

(3) **Domiciliary SUD Programs.** Core minimum staffing requirements based on the number of DOM SUD operational beds are delineated in VHA Directive 1162.02.

b. VA medical facilities must consider minimum requirements in the context of demand for inpatient SUD services, outpatient specialty SUD treatment, wait times and recommended caseloads. **NOTE:** *The number of SUD staff must be based on workload and clinical complexity, but interdisciplinary teams are preferable to implement biopsychosocial treatment plans.*

(1) Community standards typically involve active caseloads of 25 Veterans in early recovery (first 90 days) per clinician FTE employee, depending on clinical complexity and the extent of additional resources for case management services (e.g., housing placement). **NOTE:** *See Landrum B., Knight, D.K., and Flynn P.M., The Impact of Organization Stress and Burnout on Client Engagement (2012).*

(2) The distribution of caseloads among “prescribers” and “non-prescribers” may vary by VA medical facility, but most Veterans require contact with both.

(3) There are no VA data to indicate the appropriate “active caseload size” but more than 50 Veterans per case manager would likely limit effective efforts to retain or reengage Veterans in early recovery.

(4) Reasonable caseload size may depend on the organization of care within the VA medical facility; for example, SUD programs that provide comprehensive services for co-occurring SUD and mental health conditions may require lower caseloads than SUD programs that provide SUD focused services in collaboration with general mental health teams providing care for mental health conditions.

c. VA medical facilities and all SUD specialty programs must provide access to qualified providers to prescribe medications for SUD, such as buprenorphine for opioid use disorder.

5. WORKLOAD CAPTURE FOR SUBSTANCE USE DISORDER PROGRAMS AND SERVICES

a. VA medical facilities utilize a variety of software packages to capture outpatient and inpatient delivery of care, including outpatient encounters, inpatient appointments in outpatient clinics, all inpatient professional encounters not captured elsewhere and all inpatient mental health professional services. **NOTE:** See *VHA Directive 1082, Patient Care Data Capture*, dated March 24, 2015.

b. All clinical services provided by staff working in specialty SUD programs must be captured by using procedures that allow for designation as a specialty SUD service (e.g., appropriate stop codes or charge orders consistent with the software package used at the VA medical facility) that is associated with individual and group clinics. The Managerial Cost Accounting Office SharePoint provides the most recent guidance for appropriate capture of workload at <http://vaww.mcao.va.gov/index.asp>. **NOTE:** This is an internal VA website not available to the public.

c. Services performed by staff not attached to any of the preceding outpatient specialty SUD treatment programs must be captured using clinics or procedures consistent with their clinical setting (e.g., Mental Health Clinic, primary care).

MONITORING AND RESPONDING TO SUBSTANCE USE

1. MONITORING FOR SUBSTANCE USE

a. Monitoring for substance use can occur through the testing of urine, blood, oral fluid or breath samples. Monitoring for substance use within mental health inpatient, residential and outpatient programs is a core aspect of clinical care and treatment planning. As such, a test result that indicates substance use has occurred is used to inform treatment decisions and must not be used to deny or delay access to care. Monitoring for substance use is a critical element for ensuring Veteran safety by assisting in the identification of the potential for overdose or serious drug interaction. In administration of certain services or interventions such as urine screens, care should be taken to be sensitive to the needs of the Veteran (e.g., history of trauma).

b. Urine drug screens are the primary means used during inpatient, residential and outpatient mental health treatment to monitor for drug use, while breath samples are used routinely to monitor for recent alcohol use. Oral fluid testing, in some instances, may provide a viable alternative to the use of both urine and breath samples.

2. PROCEDURES

Inpatient mental health units, Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) and outpatient SUD treatment programs must develop local procedures specific to monitoring for substance use. Procedures must be consistent with Veterans Health Administration (VHA) Laboratory and Pathology policy (VHA Directive 1106 Pathology and Laboratory Medicine Service, dated July 27, 2018, and VHA Directive 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008). MH RRTP procedures must be consistent with VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 16, 2019.

3. URINE DRUG SCREENING

a. The use of urine drug screens and confirmatory testing to monitor for drug use is the current standard of care.

b. All Department of Veterans Affairs (VA) medical facilities and community-based outpatient clinics (CBOCs) must make available routine urine drug screening and confirmatory testing that allows screening for the following substances. **NOTE:** *Decisions about substances included in routine urine drug screen panels must consider local variation in substances of misuse and may require inclusion of substances beyond those listed.*

(1) Amphetamines.

(2) Methamphetamine.

- (3) Benzodiazepines.
- (4) Cocaine.
- (5) Methadone.
- (6) Marijuana (cannabinoids, THC).
- (7) Oxycodone.
- (8) Morphine and analogs.
- (9) Fentanyl and analogs.
- (10) Buprenorphine.

c. Confirmatory testing must also be available in those cases where additional information is needed (e.g., to determine specific concentration levels of a substance, to identify metabolites, or to identify the specific substance used) or when Veteran self-report is not consistent with laboratory results of the initial urine drug screen.

d. Inpatient mental health units, MH RRTPs and specialty substance use disorder (SUD) treatment programs must have capacity for second-tier selective screening either within VA or using existing contracts available through Pathology and Laboratory Medicine Services. Capacity for second tier testing must include: testing for recent alcohol use using ethyl glucuronide, testing for synthetic cannabinoids or testing for other drugs of misuse not included in the basic panel including testing for the use of fentanyl.

e. Point-of-care screening using test strips or urine cups should be used as a supplementary test to instrument-based laboratory analysis to improve timeliness when clinically warranted. When point-of-care screening is used, the activity must be regulated by Pathology and Laboratory Medicine. Any point of care testing must be approved and overseen by the CLIA Director of the local VA laboratory and procedures within VHA Handbook 1106.01, Pathology and Laboratory Medicine Service (PALMS), dated January 29, 2016, must be followed. Access to basic urine drug screening and confirmatory testing is needed for monitoring substance use. Managers must ensure that staff, as appropriate based on assigned responsibilities, have sufficient training and competencies for urine drug specimen collection, as well as an understanding of how to interpret and respond to positive test results.

4. GENERAL CONSIDERATIONS FOR SUBSTANCE USE MONITORING

a. At the time of program entry (when substance use monitoring is considered a standard component of care) or when substance use monitoring occurs, Veterans must be provided with information about the program procedures related to substance use

monitoring. This must include information about when urine specimens will be requested, the requirements for compliance, the methods used to monitor for substances, whether specimens may be observed and how test results will be used to inform treating planning. Procedures may vary depending on the setting and program in which the substance use monitoring is completed. Signature informed consent is not required for substance use monitoring. Consent must be documented consistent with policy specified in VHA Handbook 1004.01(5), Informed Consent for Clinical Treatment and Procedures, dated August 14, 2009. **NOTE:** *Information provided to the Veteran varies depending on availability of local VA medical facility services.*

b. In both the inpatient mental health units and MH RRTPs, an initial screen must be completed as a routine part of the admission process to detect recent alcohol or drug use (e.g., urine, blood, oral fluid or breath sample). In the MH RRTPs, random monitoring for substance use must be done at least weekly early in treatment for all Veterans, regardless of substance use history or diagnosis. Routine screening by program staff must occur randomly upon return from all authorized absences from the residential unit.

(1) On inpatient mental health units, monitoring for substance use must occur when staff observes behavioral indicators of possible substance use that may or may not coincide with periods where the Veteran may have had access to an addictive substance (e.g., recent visitation).

(2) In outpatient SUD treatment programs, procedures must be in place to allow for twice weekly routine or less frequent random monitoring of substance use whenever possible to inform adjustments to the Veteran's treatment plan. The frequency of substance use monitoring is based on the Veteran's treatment plan. It is strongly encouraged that monitoring for substance use in outpatient programs occurs at least monthly, particularly during the first 6 months of recovery.

(3) Monitoring procedures in all settings must include the use of methods that ensure that samples are not adulterated (e.g., observation of sample collection, temperature strips, additional laboratory tests) and allow for screening for both alcohol and drug use. Routine observation of sample collection for all urine drug screens must not be required; rather, decisions about the need to observe the collection of a sample must be based on clinical considerations with additional means used to detect adulteration in lieu of observation in place.

(4) Results of substance use monitoring and treatment planning decisions must be documented by program staff in the Veteran's medical record.

(5) For urine drug screens, it is strongly encouraged screening be available ensuring rapid preliminary feedback with laboratory confirmation available to obtain quantitative urine toxicology, when appropriate.

c. VA medical facilities must adhere to the current standards of care for addressing possible adulteration of urine samples. Guidance is available on the Office of Mental Health (OMH) SUD Policy Resource Page:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

d. VA medical facilities must adhere to the current standards of care for point of care urine drug testing. Guidance available on the OMH SUD Policy Resource Page:

<https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

5. RESPONDING TO SUBSTANCE USE

a. In responding to substance use, program procedures for managing intoxication must address the immediate safety needs of the Veteran and those around them in a manner consistent with local resources.

b. MH RRTPs and outpatient SUD and mental health treatment programs must not implement procedures that result in Veterans who use a substance during treatment being automatically discharged from treatment. Rather, programs must evaluate each Veteran's substance use individually to determine the contributing risk factors to develop an appropriate treatment plan. This includes having the Veteran remain in the treatment program to address identified treatment needs such as medication and cognitive strategies to reduce and manage cravings. Whenever the treatment team determines to discharge a Veteran from a residential or outpatient program, the treatment team must, together with the Veteran, develop a clear discharge plan that encourages and facilitates continuing care.

c. It is recommended that each VA medical facility take the following steps:

(1) In emergency departments, urgent care clinics, outpatient clinics and inpatient or residential settings, local procedures must be developed for the evaluation of a patient for intoxication when impairment from alcohol is suspected.

(a) Both blood alcohol testing and breathalyzer testing are acceptable methods for screening in this setting.

(b) Local procedures need to require obtaining informed consent except in the case of a medical emergency.

(2) When an intoxicated patient (breath alcohol or blood alcohol greater than the local legal limit (typically 0.08) or showing clinically significant behavioral signs of intoxication) verbally or nonverbally demonstrates intent to operate a motor vehicle, attempts need to be made to persuade (or assist) the patient to arrange other

transportation or remain for extended observation until additional testing shows the level has dropped below the local legal limit and the patient is not showing signs of impairment.

(3) If the patient refuses the breathalyzer or blood test or is unwilling to remain for extended observation, the patient may not be held against their will by clinical staff. It needs to be documented in the medical record, with a witness if possible, that the patient was informed of any safety concerns and advised not to operate a motor vehicle. If the patient refuses to make other arrangements or to remain for observation until no longer intoxicated, the patient must be informed that police will be contacted due to concerns related to public safety.

(4) With Offices of Chief Counsel in the Districts review, procedures and plans must be established to contact VA police or local law enforcement officials in the event that patients who are considered a danger to themselves or others leave against medical advice. These plans must take into account relevant State laws related to intoxicated patients. These plans also must take into consideration the laws governing the release of information about the patient's medical condition. For example, when calling police, the patient must not be described as intoxicated. Instead, the patient could be described as impaired or incapable of driving. No information that is protected by 38 U.S.C. § 7332 (i.e., condition of sickle cell anemia or Human Immunodeficiency Virus, or the condition and treatment of drug or alcohol abuse) may be disclosed.

(a) Disclosure of Patient Information. Disclosure of patient information to police must adhere to VA policy found in VHA Directive 1605, VHA Privacy Program, dated September 1, 2017.

(b) References, including government resources, journal articles, sample competencies and procedures for monitoring and responding to substance use are available on the OMH SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

BUPRENORPHINE PRESCRIBING FOR OPIOID USE DISORDER

1. ACTIONS REQUIRED BY VA MEDICAL FACILITY DIRECTORS AND PROVIDERS

Department of Veterans Affairs (VA) medical facilities must ensure the following:

a. Opioid use disorder (OUD) treatment outside of substance use disorder (SUD) specialty care settings is not prohibited by VA medical facility policies or procedures. Prescribing of buprenorphine products by X-waivered prescribers in their clinical settings must be allowed, including but not limited to primary care, Mental Health, Community-Based Outpatient Clinics and Specialty Care environments (e.g., pain clinics and emergency departments).

b. The prescribing of buprenorphine is not designated as a delineated privilege on privilege forms, as applicable. A delineated privilege for prescribing buprenorphine is not required.

c. VA health care providers prescribing buprenorphine for OUD have the appropriate Drug Enforcement Administration (DEA) X-waiver license which is current, unrestricted and has been primary source-verified in the electronic credentialing record (i.e., VetPro). In accordance with Veterans Health Administration (VHA) policy and medical staff bylaws, if a provider is notified of any pending, proposed or actual change in their DEA licensure status, they must notify their supervisor as specified in VHA Directive 1100.20, Credentialing of Health Care Providers, September 15, 2021. Additionally, it is the VA health care provider's responsibility to prescribe only as legally permitted by their DEA license; any practice beyond what is permitted also will result in an adverse action.

NOTE: *If a VA medical facility provider currently has a delineated privilege for buprenorphine prescribing, a modification of privileges is not required at this time. The VA medical facility provider would only be asked to complete the updated privilege form at the time of re-privileging which would no longer list prescribing of this medication as a delineated privilege.*

d. Local operating procedures do not include any modifiable barriers for Veterans to access SUD treatment programs as OUD treatment may require access to a broader continuum of SUD services. Presence of medical illness must not be a barrier to medications for OUD treatment if the medical illness is not identified as a contraindication for treatment. Further, the presence of SUD must not be a barrier to other medical care when clinically indicated. If a provider does not possess the necessary skills to manage all of a patient's clinical needs, the expectation is for timely, collaborative co-management with providers who have the required expertise.

e. Local operating procedures ensure that every Veteran who would benefit from medication for OUD treatment is evaluated by a prescriber and offered medication as part of their treatment.

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2. For further guidance on strategies for treatment see the Office of Mental Health and Suicide Prevention SUD Policy Resource Page at <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

OPIOID TREATMENT PROGRAMS

1. SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION-CERTIFIED OPIOID TREATMENT PROGRAMS

a. Substance Abuse and Mental Health Administration (SAMHSA)-certified Opioid Treatment Programs (OTPs) treat Veterans with opioid use disorder (OUD) using first-line evidence-based medications, including methadone or buprenorphine, in combination with psychosocial services. OTPs must meet the requirements outlined in Certification of Opioid Treatment Programs (42 C.F.R. § 8.12). **NOTE:** *Federal regulations specify that methadone for the treatment of OUD may only be provided within a SAMHSA-certified OTP. Regulations specify those instances where methadone may be initiated or continued outside of an OTP. Detailed information regarding OTP regulations can be found at <https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf>.*

b. Opioid agonist treatment is part of a long-term approach to chronic disease management for OUD. Extended duration of care (including indefinite duration of outpatient care) is associated with the best clinical outcome. As such, Department of Veterans Affairs (VA) medical facilities must avoid setting defined timeframes for discontinuing medication for OUD. Veteran retention in opioid agonist treatment is considered a primary measure of success, and decisions about discontinuation of medications must be made in collaboration with the Veteran. **NOTE:** *Although participation in other areas of care (e.g., medical, psychiatric, non-opioid SUD) is encouraged, requiring that Veterans participate may create barriers to retention. Therapy such as Motivational Enhancement strategies and Contingency Management may enhance patient participation in other areas of recovery while maintaining engagement in opioid agonist treatment.*

c. VA medical facilities must provide evidence-based pharmacotherapy for opioid use disorder using OTP and office-based buprenorphine treatment. VA medical facilities without OTPs are required to arrange accessible methadone treatment for eligible Veterans through community care if buprenorphine treatment is not clinically effective. For Veterans who reside in areas where OTPs are not available through community care, VA medical facilities must provide other options (e.g., increasing psychosocial rehabilitation through residential treatment while maintaining medications for OUD).

2. OPIOID TREATMENT PROGRAM STAFFING

OTPs must be staffed appropriately to meet the clinical needs of Veterans as well as additional accreditation and regulatory requirements. In accordance with 42 C.F.R. § 8.12, OTPs require a sponsor who is responsible for the operation of the program and ensuring the program is in continuous compliance with applicable laws and regulations. The OTP sponsor must have authority over all aspects of the operation (e.g., human resources, VA medical facility management, security) and is typically the VA medical

facility Director. OTPs have an interdisciplinary staff, including an OTP Medical Director who is a physician with expertise in substance use and mental health disorder treatment and who is responsible for the clinical care of enrolled Veterans. At least one other clinical staff must be a licensed independent mental health provider (e.g., licensed social worker, licensed doctoral-level psychologist, psychiatrist) credentialed and privileged by VA or with documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. OTP staff must have expertise or receive training specific to medication-assisted treatment. As OTPs dispense methadone, the OTP Medical Director is expected to work in collaboration with the OTP sponsor and leadership from the pharmacy to ensure availability of pharmacy staffing as needed. Adequate administrative support is essential given the regulatory and accreditation requirements for SAMHSA-certification and diversion control. **NOTE:** See *Veterans Health Administration (VHA) Directive 1108.01(1), Controlled Substances Management, dated May 1, 2019, for additional information.*

OVERDOSE REPORTING AND RESPONSE

1. The Veterans Health Administration (VHA) is committed to enhancing the safe and efficacious care of Veterans who experience an overdose regardless of substance. Deploying risk mitigation strategies or modifying treatment plans for Veterans who have already experienced an overdose may reduce the likelihood of future overdose events and improve patient outcomes. Providers must conduct regular review of overdose risk in Veterans who experience an overdose. Department of Veterans Affairs (VA) medical facility staff must adhere to current standards for overdose reporting and prevention, as well as data-based risk reviews found on the substance use disorder (SUD) SharePoint site: <https://dvagov.sharepoint.com/sites/VHASUD>. **NOTE:** *This is an internal VA website that is not available to the public.*

2. Reporting through national standardized documentation is required for any overdose that occurred within the past 12 months from the date of notification, regardless of the intent of the overdose (e.g., Suicide Behavior and Overdose Report (SBOR) or Comprehensive Suicide Risk Evaluation). Additional requirements are as follows:

a. Accidental and undetermined overdoses must be reported in an SBOR. For SBOR-reported overdoses of any intention, the patient's primary care and mental health providers, as applicable, must be included as additional signers. When the person filling out the SBOR is not the patient's treatment provider and the patient has immediate care needs, the person filling out the SBOR should contact the patient's primary care and mental health or SUD providers (e.g., phone call, instant message, email). Documentation of SBOR reported overdoses must adhere to current national standards outlined on the SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*

b. A data-based risk review by an interdisciplinary team must be completed consistent with national standards outlined on the SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.* The interdisciplinary team is a VA medical facility-based team that reviews and makes care recommendations for Veterans who have experienced a recent non-fatal overdose. At a minimum the team must include representation from the VA medical facility's SUD program or a mental health provider who can facilitate rapid engagement in specialty SUD care or mental health services when appropriate.

c. For Veterans hospitalized for an overdose, there must be at least four mental health or SUD outreach efforts/clinical contacts within 30 days of discharge.

d. For Veterans with Emergency Department or Urgent Care Center discharges for an overdose, there must be at least four mental health or SUD outreach efforts/clinical contacts within 30 days of discharge.

e. VA health care providers must adhere to the current standards for follow-up after an overdose. Guidance is available on the SUD Policy Resource Page: <https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Substance-U.aspx?OR=Teams-HL&CT=1642727370088>. **NOTE:** *This is an internal VA website that is not available to the public.*