Department of Veterans Affairs **VHA HANDBOOK 1160.04**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **March 7, 2012**

VHA PROGRAMS FOR VETERANS WITH SUBSTANCE USE DISORDERS (SUD)

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook defines a continuum of specialized programs for treatment of eligible Veterans with Substance Use Disorders (SUD) within the Department of Veterans Affairs (VA) VHA Office of Mental Health Services.

2. SUMMARY OF MAJOR CHANGES. Revisions reflect conformity with Handbook 1160.01 on Uniform Mental Health Services in VA Medical Centers and Clinics.

3. RELATED ISSUES. VHA Handbooks 1160.01 and 1162.02.

4. RESPONSIBLE OFFICE. The Office of Mental Health Services (10P4M) in the Office of Patient Care Services (10P4) is responsible for the contents of this Handbook. Questions may be referred to (206) 768-5483.

5. RECISSIONS. None.

6. RECERTIFICATION. This VHA Handbook is scheduled to be recertified on or before the last working day of March 2017.

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CONTENTS

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1. PURPOSE

This Handbook defines a continuum of care for all eligible Veterans with substance use disorders for use by planning and program officials, clinicians, researchers, and educators. It is intended to complement Veterans Health Administration (VHA) Handbook 1160.01 Uniform Mental Health Services in VA Medical Centers and Clinics, within Department of Veterans Affairs (VA) medical facilities and clinics.

2. BACKGROUND

a. Since 1973, the treatment of substance use disorders (SUD) through VA Programs has been an integral part of the Office of Mental Health Services (OMHS). SUD Programs are authorized throughout the integrated continuum of outpatient, residential, and inpatient care and must be available to all eligible Veterans with SUD in accordance with existing authority at Title 38 United States Code (U.S.C.) 1720A and Title 38 Code of Federal Regulations (CFR) 17.38 and 17.80 through 17.83.

b. Pursuant to 38 U.S.C. (1720A(d)(1), SUD specialty treatment services are found in every VA medical facility including an increasing number of Community-based Outpatient Clinics (CBOC). Facilities must make services for SUD available to Veterans who need them, and they must be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the Veteran is eligible. VA offers a comprehensive continuum of care for SUD from outpatient services to residential and inpatient care.

c. Of the approximately 462,000 Veterans with diagnosed SUD seen in VHA during Fiscal Year (FY) 2010, over 147,000 of them received specialty care for SUD. Most patients with SUD were provided services in settings other than SUD specialty care, highlighting the need to address SUD across clinical settings, including primary care and mental health clinics. Of all those with a SUD diagnosis, approximately 53 percent had an alcohol use disorder alone, 22 percent had a drug use disorder alone and 25 percent had both drug and alcohol use disorders. Additionally nearly 640,000 Veterans had a diagnosis of nicotine dependence without another co-occurring SUD.

d. In addition to costs of specialty care, there are substantial 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.

e. VA has found that the treatment methods used have yielded positive treatment outcomes for SUD which have been documented for VA's inpatient and outpatient SUD programs, as well as non-VA programs. Improvements are noted in SUD symptoms as

well as in significant quality of life parameters, such as employment, family, and legal status. Evidence-based psychotherapies are effective for SUD and are recommended in the VA/Department of Defense (DOD) Clinical Practice Guidelines for Management of SUD (http://www.healthquality.va.gov). There is also a robust evidence base for pharmacotherapy of SUD including opioid agonists (e.g., methadone), partial agonists (e.g., buprenorphine) and antagonists (e.g., naltrexone) that have demonstrated effectiveness for dependence on opioids; naltrexone, acamprosate, and disulfiram for alcohol dependence and nicotine replacement; and bupropion and varenicline for tobacco use cessation (VA/DOD Guideline for Management of Tobacco Use).

3. DEFINITIONS

a. **Substance Use Disorders (SUD).** SUD encompass the family of alcohol and other drug-use illnesses that meet diagnostic criteria according to the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV). They include patients who meet diagnostic criteria for abuse or dependence on alcohol, tobacco products, illegal substances, and prescribed psychoactive medications. The diagnosis of SUD must be consistent with the criteria of the mental health diagnosis system approved by VA, i.e., the current edition of DSM-IV.

b. **Clinical Complexity (Comorbidities).** Veterans who are treated for SUD in VA often may have significant complicating features, including:

(1) Psychosocial deficits including homelessness, unemployment, and lack of social support for recovery;

(2) Comorbid anxiety disorders, such as Post-Traumatic Stress Disorder (PTSD), panic disorder, and general anxiety disorder;

(3) Depressive disorders, including major depressive disorder and dysthymia;

(4) Psychoses, including schizophrenia and bipolar disorder; and

(5) Other general medical disorders. Because of the aging of the Veteran population and the contribution of SUD to the development or exacerbation of certain internal medical disorders, including alcoholic hepatitis or infectious diseases like viral hepatitis, Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), assessment of patients with SUD must include a focus on the presence of physical disorders with management for these conditions provided directly or arranged as needed.

c. **Specialized Program for SUD.** Specialized programs require availability of assigned interdisciplinary staff with clinical competence to provide evidence-based psychosocial and pharmacological interventions for stabilization and relapse prevention for Veterans with more severe SUD, or with clinical complexity. Specialized SUD programs must have the capacity to identify co-occurring mental and physical conditions and arrange appropriate follow-up either within the program or by referral to the extent that the Veteran is eligible.

4. SCOPE

Consistent with 38 U.S.C. (1720A(d)(1) and VHA Handbook 1160.01, all VA health facilities must provide care for SUD. It is not the purpose of this Handbook to describe all programs for SUD that could be appropriate and effective within all settings. Innovative programs and research to expand these alternatives are encouraged.

5. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

The VISN Director is responsible for:

a. Ensuring that mental health services are accessible to all eligible Veterans with SUD by providing adequate resources.

b. Ensuring that on the basis of 38 U.S.C. 1782, eligible individuals may be provided consultation, professional counseling, marriage and family counseling, training, and mental health services as necessary in connection with the Veteran's treatment. ***NOTE:*** *Eligible individuals are defined as members of the immediate family or the legal guardian of a Veteran, a family caregiver of an eligible Veteran or a caregiver of a covered Veteran, or the individual in whose household such Veteran certifies an intention to live.*

c. Ensuring that programs are operated in compliance with relevant law, regulation, policy, and procedures.

d. Ensuring that a VISN SUD Representative is designated to provide appropriate services (see par. 7).

6. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The Facility Director is responsible for:

a. Providing and maintaining program oversight to ensure quality services and compliance with VHA policy and procedures.

b. Ensuring that facility staff receives training and consultation in evidence-based pharmacotherapy and psychosocial interventions for SUD.

c. Ensuring special attention is given to addressing the unique needs of special population groups, including women Veterans.

d. Providing appropriate support and resources to ensure that facility SUD programs are able to accomplish their stated mission, goals, and objectives.

e. Providing safe, well-maintained and appropriately-furnished facilities that support and enhance the recovery efforts of all Veterans.

f. Ensuring the timely completion of all mandated reporting, monitoring, and accreditation requirements.

g. Ensuring that VA staff abide by all VHA policies on confidentiality and privacy including VHA Handbook 1605.1, Privacy and Release of Information, as well as all relevant statutory and regulatory authority, which includes 38 U.S.C. 7332 and the Health Insurance Portability and Accountability Act (HIPAA).

7. RESPONSIBLITIES OF THE VISN SUD REPRESENTATIVE

The VISN SUD Representative is responsible for:

a. Assessing the needs and resources for SUD care in the VISN;

b. Consulting with managers of SUD programs within the VISN in implementing the requirements of VHA Handbook 1160.01, and this Handbook;

c. Coordinating services for SUD across facilities in the VISN;

d. Articulating the needs of VISN SUD programs and making recommendations to the National Mental Health Program Director for Addictive Disorders in the Office of Mental Health Services (OMHS);

e. Consulting with national leadership for SUD programs about the impact of anticipated changes in policy on field-based SUD programs; and

f. Acting as a liaison between OMHS, the VISN, facility leadership, Mental Health and Behavioral Sciences (MH&BS) departmental leadership, and the Domiciliary Chief or Mental Health Residential Rehabilitation Treatment Program (MH RRTP) Program Manager.

8. PRINCIPLES OF TREATMENT AND REHABILITATION OF VETERANS WITH SUD

a. **Access to Care.** As is the case for other medical illnesses, VA is committed to providing timely and appropriate access to a high-quality, integrated, comprehensive, and cost-effective continuum of care to eligible Veterans with SUD. This care includes monitoring the Veteran's treatment response to enhance the quality and efficacy of care.

b. **Informed Consent.** Patients have the right to accept, refuse, or discontinue treatment for SUD without limiting their access to other treatment interventions. In accordance with VHA Handbook 1004.01, Informed Consent for Clinical Treatment and Procedures, prior to initiating SUD treatment, practitioners must obtain and document the voluntary informed consent of the patient (or the patient's surrogate if the patient lacks decision-making capacity). The practitioner may obtain either oral or signature informed consent from the patient, but both must be documented. Signature consent is required for treatment with methadone or buprenorphine for opioid dependence.

c. **The SUD Continuum of Care.** The SUD continuum of care includes standard outpatient services, intensive outpatient programs, opioid replacement therapies, residential rehabilitation and acute hospital services (see par. 9*).* The availability of a continuum of care makes it possible for the unique needs of the patient to be matched with the intensity and setting of care required initially, as well as for the patient to move to a more or less intense level of care as needed. The entire continuum of residential services may not be provided by every medical center, but must be available by referral to other VA facilities or by sharing agreements, contracts, or non-VA fee basis care to the extent that the Veteran is eligible. Some components of the continuum may be provided in coordination with neighboring VISNs. Services provided must be based on the individual patient's clinical needs within the least restrictive environment necessary to ensure safety and promote recovery. Not all patients require the entire continuum of services. Patients must move among 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. **Collaborative Care.** Within primary care, general mental health, or other clinical settings outside of specialty SUD programs, patients with SUD may benefit from the involvement of specialized program staff in their further assessment or treatment in cooperation with the primary provider. Specific arrangements vary from setting to setting, but may include collaborative care models or co-located staff from the specialty program.

e. **Special Patient Populations or Comorbidities.** All SUD programming must be sensitive to the needs of special populations including, but not limited to:

(1) The homeless;

(2) Ethnic minorities;

(3) Women;

(4) Geriatric patients;

(5) PTSD patients;

(6) Other mental health comorbidities;

(7) Infectious diseases (e.g., HIV, AIDS, and Hepatitis C); and

(8) Traumatic brain injury (TBI) and spinal cord injury (SCI).

f. **Specialized SUD Programs**. All specialized SUD programs must have the capacity to identify co-occurring mental and physical conditions and arrange appropriate follow-up either within the program or by referral to the extent the Veteran is eligible.

g. **Residential Treatment Facility**. Facilities may establish arrangements with community-based residential rehabilitation treatment facilities and transitional housing resources using

agreements, contracts, or non-VA fee basis care to the extent the Veteran is eligible and that arrangements are consistent with 38 CFR §§ 17.80 through 17.83. Sharing agreements, contracts, and non-VA fee basis care must provide access and quality of service that is consistent with VA standards. These residential and housing arrangements may facilitate access to outpatient care for SUD within VA or provide access to non-VA services that complement program elements available within VA programs.

h. **Treatment Guidelines**. Treatment must be provided consistent with evidence-based treatment guidelines as posted at the Web sites titled VA/DOD Clinical Practice Guideline: Management of Substance Use Disorder at http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp, and guidelines for Treating Tobacco Use & Dependence at the Web site Management of Tobacco Use (MTU) at http://www.healthquality.va.gov/Management_of_Tobacco_Use_MTU.asp. Treatment of co-occurring major depressive disorder or PTSD must be consistent with guidelines for those conditions at the VA/DOD Clinical Practice Guidelines Website at http://www.healthquality.va.gov/index.asp. VHA Criteria for Use documents for Acamprosate, Buprenorphine, and Naltrexone Injection are posted on the Pharmacy Benefits Management Internet site at http://www.pbm.va.gov/CriteriaForUse.aspx.

i. **Performance and Outcome Monitoring.** Performance and outcome monitoring of SUD programs are conducted by OMHS (10P4M) in cooperation with the Program Evaluation and Resource Center (PERC) at the Palo Alto, CA VA medical facility, and the Centers of Excellence in Substance Abuse Treatment and Education (CESATE) at the Philadelphia, PA and Seattle, WA VA medical facilities in conjunction with other facilities and VISNs. Outcome monitoring includes both patient population outcome measures and program performance monitoring. Such measures assist in evaluating the quality and effectiveness of treatment.

9. SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES AND PROGRAM ELEMENTS

a. **SUD Specialty Programs.** SUD specialty programs are designated inpatient, residential, and outpatient programs specifically designed to meet the needs of Veterans with SUD, particularly those Veterans with new onset, severe, or complex conditions (e.g., mental health and general medical co-morbidities). These programs provide a continuum of care from intensive inpatient and residential services to outpatient care. To enhance accessibility to specialized services and reduce stigma, efforts are made to provide services within other settings, such as primary care, CBOCs, PTSD clinics and residential settings without designated SUD bedsections. SUD specialty programs must provide comprehensive services; for example, for Veterans with concurrent PTSD and SUD, services must be provided either within the SUD program or in close coordination with PTSD program staff with SUD treatment expertise. ***NOTE:*** *Programs are strongly encouraged to make available gender-specific services when clinically needed for Veterans with SUD including services for those with consequences of Military Sexual Trauma (MST).*

(1) **Patients Served.** In FY 2010, approximately 147,000 unique Veterans of all service eras were treated in specialized SUD programs.

(2) **Requirements for VA Medical facilities and CBOCs.** Every VA Medical facility is required to have specialized outpatient SUD services, and to provide or arrange timely access to inpatient medical withdrawal management or stabilization and intensive early recovery services. All CBOCs are required to have SUD support capability with onsite full or part-time staff or by telemental health with parent VA medical facilities or through referral using sharing agreements, contracts, or non-VA fee basis care to the extent the Veteran is eligible. Full or Part-time staff must be SUD specialists.

(3) **Access Requirements.** In accordance with VHA Handbook 1160.01, all Veterans new to mental health services must have an initial assessment within 24 hours. For mental health conditions determined to be non-urgent, the first appointment for a full evaluation must be within 30 days. Established patients must have follow up appointments within 30 days of their desired appointment time. This requirement applies to Veterans of all service eras and all diagnoses.

b. **SUD Treatment Outpatient Clinics.** SUD Treatment Outpatient Clinics provide settings for initial and continuing outpatient care to patients with SUD other than those engaged in opioid agonist treatment in a regulated opioid treatment program. Treatment is designed to provide the full-range of clinically indicated treatment and rehabilitation services for patients with SUD, including ambulatory withdrawal management; treatment of the psychological and behavioral aspects of addiction with evidence-based addiction-focused pharmacotherapy and psychosocial interventions; and recovery-oriented services, including vocational rehabilitation services and other skills training needed to initiate and sustain SUD recovery.

(1) **Staffing.** Staff for SUD Outpatient Clinical Teams must include, at a minimum, three clinicians with expertise in SUD, as well as appropriate administrative support. At least one of these clinical staff must be a licensed independent provider (e.g., Masters of Social Work social worker, doctoral-level psychologist) with credentialed and privileged or documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. Unless there is OMHS approval for a waiver, at least 0.5 full-time equivalent (FTE) employee prescribing staff must be dedicated within the program staff to provide addiction-focused pharmacotherapy that must be considered for all patients with alcohol or opioid use disorders, as well as general medical evaluation and pharmacotherapy for co-occurring mental health disorders. In facilities without opioid treatment programs, the SUD Outpatient Team must provide access to a medical provider with a waiver to prescribe buprenorphine for opioid dependence. The number of SUD staff must be based on workload and clinical complexity, but interdisciplinary teams are preferable to implement biopsychosocial treatment plans (see subpar. 8h).

(2) **Duration of Care.** Duration of treatment is clinically determined based on patient symptoms and functioning, with frequency of contact generally decreasing with more stable recovery.

(3) **Capacity Requirements.** Community standards typically involve active caseloads of 25-50 Veterans in relatively 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). The distribution of caseloads among “prescribers” and “non-prescribers” may vary by facility, but many patients may require contact with both. There are no

VA data to indicate the appropriate “active panel size" but more than 50 patients per case manager would likely limit effective efforts to retain or reengage patients in early recovery. OMHS continues to evaluate the patient-clinician ratio and will provide updated guidance to the field, as necessary.

(4) **Requirements for VA Medical facilities and CBOCs.** All VA Medical facilities are required to have SUD specialty services, based on locally determined patient population needs. SUD specialists must be located in larger CBOCs (>5000 unique patients annually) based on patient needs, but all CBOCs must have the capability of SUD specialist access even if by tele-mental health.

(5) **Decision Support Systems (DSS) Identifiers.** DSS identifiers include 513 (Substance Use Disorder, individual), 514 (Substance Use Disorder, home visit), 545 (Telephone, Substance Use Disorder) and 560 (Substance Use Disorder, group).

c. **Intensive Outpatient SUD Treatment.** Intensive Outpatient Programs (IOP) for SUD provide a specialized form of care that falls between residential or inpatient care and the more traditional models of ambulatory care. This setting involves treatment of SUD that can provide pharmacotherapy and psychosocial interventions with therapeutic activities 3 or more hours per day, 3 days a week at a minimum. Intensive outpatient treatment is intended to help patients with SUD establish a period of initial abstinence, identify initial recovery goals, initiate care for co-occurring medical and mental health conditions, develop interpersonal support for recovery, and promote engagement in continuing care for relapse prevention. IOP may serve as an initial level of care, or as a step-down program from inpatient or residential care, or as an additional support for patients who are not progressing well in standard ambulatory care.

(1) **Patients Served.** Patients served are Veterans in need of initial intensive treatment for a limited period of time (e.g., 3 to 6 weeks), but who do not need the security or structure of an inpatient or residential program. SUD services can also be provided to Veterans in residential rehabilitation programs operating under a “supportive residential” staffing model.

(2) **Principles of IOP Services.** IOP services require capacity in differential diagnosis, recovery planning, psychosocial rehabilitation, evidence-based practices in SUD treatment, and evidence-based practices in psychosocial rehabilitation, including care for co-occurring disorders. Capacity for both medical evaluation and planning for continuing outpatient care is also required. Continuity of care with other SUD services and other mental health services that the patient has or may receive must be ensured. IOP services are most useful when convenient and readily accessible to patients. VHA Handbook 1160.01 requires that all medical facilities provide access to either an IOP or a Residential Rehabilitation Treatment Program (RRTP) that specializes in SUD services or that has an SUD track. In some individual cases, and to the extent that the Veteran is eligible, it may be preferable to offer the patient the option for IOP-equivalent services through other means, such as contracting with a community program approved by the manager of the relevant local SUD program. If possible, services must be offered in the evenings or on weekends for the convenience of patients who are working, have child care responsibilities, or have travel problems during the work day. Staffing must be adequate to provide safe, effective, and appropriate clinical care.

(3) **Motivational Incentives.** Therapeutic use of motivational incentives (also known as Contingency Management) is identified in VHA Handbook 1160.01 as an evidence-based treatment for SUD. It is most appropriately implemented as an adjunctive treatment for patients receiving care during the early phase of recovery in an intensive outpatient program, although it may be used in other SUD treatment settings. Many patients present to treatment with some period of abstinence and are seeking assistance for relapse prevention. For other patients, a major focus during early recovery is initiating a period of continuous abstinence from substance use; therapeutic use of motivational incentives is an evidence-based procedure consistent with this goal. When clinically indicated, use of motivational incentives must be available to all patients meeting locally established patient inclusion criteria that are consistent with published evidence. The target behavior to be reinforced by the motivational incentives must be clearly defined and objectively measured (typically abstinence from non-prescribed substances with verification using laboratory or point of care testing of specimens). Other behaviors consistent with recovery goals may also be encouraged with motivational incentives, including appointment attendance and medication adherence. Prior to implementing motivational incentives as part of the treatment plan, voluntary informed consent must be obtained verbally from the patient and documentation must reflect a discussion of the target behavior, how it needs to be monitored, and the procedures that determine when incentives are provided. Participation in the motivational intervention is to be voluntary and patients are free to discontinue this adjunctive intervention at any time without limiting their access to other treatment interventions. Procedures must also be established by the program to ensure that the motivational incentives provided by the program are properly secured and explicit accountability procedures are followed.

(4) **IOP Administration and Staffing.** IOPs must be organized under the clinical supervision of the overall manager of the SUD program, if that position is present in the facility, or by the Mental Health Director, or by the Mental Health lead for the facility. The manager of the IOP must come from an appropriate clinical discipline (e.g., Psychiatrist, Psychologist, Social Worker, or Psychiatric Nurse) and have 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 and procedures. 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 .5 FTE employee administrative staff. At least one of these clinical staff must be a licensed independent provider (e.g., licensed Master of Social Work, licensed doctoral-level psychologist) with credentialed and privileged or documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. Unless there is Office of Mental Health approval for a waiver, at least 0.5 FTE prescribing staff must be dedicated within the IOP staff to provide addiction-focused pharmacotherapy that must be considered for all patients with alcohol or opioid use disorders, as well as general medical evaluation and pharmacotherapy for co-occurring mental health disorders. OMHS continues to evaluate the patient-clinician ratio and will provide updated guidance to the field, as necessary.

(5) **Duration of Care.** Duration of care is based on clinical improvement mutually determined by patient and program staff. Typical duration of care is 3-6 weeks, with the goal of

confirming at least 2 consecutive weeks of abstinence and that the patient is sufficiently stable to warrant a less intensive level of standard outpatient care.

(6) **Capacity Requirements.** IOPs must have the capacity to involve patients in the indicated intensity of care within 1 week of assessed need. The minimum patient flow to warrant an IOP is an average of two admissions per week.

(7) **Requirements for VA Medical facilities and CBOCs.** VA Medical facilities are required to provide an intensive level of care to stabilize patients in early recovery. This can be through either an IOP, or a residential level of care, or both.

(8) **Decision Support Systems (DSS) Identifiers.** The DSS identifiers for this program element are 547 (Intensive Substance Use Disorder Treatment - Group), 548 (Intensive Substance Use Disorder Treatment - Individual), 513 (Substance Use Disorder, Individual), 514 (Substance Use Disorder, home visit), 545 (Telephone, Substance Use Disorder), and 560 (Substance Use Disorder, Group).

d. **Opioid Treatment Programs (OTP).** The first line treatment for patients with chronic opioid dependence is OTP with an agonist (e.g., methadone) or partial agonist (e.g., buprenorphine) medication, in combination with psychosocial services. In the future, other pharmacotherapy for opioid dependence may be approved for use in regulated opioid treatment programs. OTPs must meet the requirements outlined in 42 CFR Part 8, Certification of Opioid Treatment Programs.

(1) **Patients Served.** Patients served are Veterans with chronic opioid dependence who have not previously received treatment or who have not sustained recovery without agonist or partial agonist treatment.

(2) **Staffing.** OTP program staffing requires an interdisciplinary staff consistent with federal regulations, including a physician with expertise in pharmacotherapy of opioid dependence and competence to provide general medical evaluation and pharmacotherapy for co-occurring mental health disorders. At least one of the other clinical staff must be a licensed independent provider (e.g., licensed Masters of Social Work, licensed doctoral-level psychologist) with credentialed and privileged or documented competencies in delivery of evidence-based psychosocial interventions for SUD and competence to identify and address co-occurring mental health conditions. Administrative staff support is essential given the importance of tracking program attendance and laboratory monitoring of treatment response.

(3) **Duration of Care.** Opioid agonist treatment is part of a long term approach to chronic disease management for opioid dependence. Extended duration of care (including indefinite duration of outpatient care) is associated with the best clinical outcome.

(4) **Capacity Requirements.** Community standards typically involve active caseloads of 40-50 Veterans in various stages of recovery per case manager FTE employee, depending on clinical complexity and the extent of additional resources for case management services (e.g., housing placement). There are no VA data to indicate the appropriate “active panel size” but

more than fifty to every one FTE employee would likely impair effective efforts to retain or reengage patients in early recovery.

(5) **Requirements for VA Medical Facilities.** VA medical facilities are required to provide treatment for opioid dependence using either an OTP or an outpatient treatment plan that includes the partial agonist buprenorphine. VA medical facilities without OTPs are required to make arrangements for access to methadone treatment for eligible Veterans if buprenorphine treatment is not clinically effective.

(6) **Decision Support Systems (DSS) Identifiers.** DSS identifiers for this program element are 523 (Opioid Substitution), 514 (Substance Use Disorder, home visit) and 545 (Telephone, Substance Use Disorder). Note that encounters for Veterans receiving office-based buprenorphine outside of an approved OTP would use DSS identifiers consistent with SUD Treatment Outpatient Programs rather than 523.

e. **SUD-PTSD Team or Specialist.** Given the high prevalence of co-occurring SUD and PTSD, a SUD specialist serves as a contributing member of each facility's PTSD team or service. Integrated or coordinated concurrent treatment of PTSD and SUD is considered an evidence-based practice that is actively promoted across the system. This can be achieved either by having staff capable of providing PTSD care within the SUD program, having SUD care within a PTSD program, or through coordinating concurrent care between programs. All facilities have been funded to add an SUD specialist as a full team member within the PTSD Clinic. This staff provides SUD services, as needed, within the PTSD clinic and collaborates with the SUD specialty care programs to arrange access to additional SUD services as needed.

(1) **Patients Served.** Patients served are Veterans with co-occurring PTSD and SUD who are being seen in a PTSD specialty care program or an SUD specialty program.

(2) **Staffing.** SUD and PTSD specialists serve as team members within PTSD Clinical Teams (PCT) and as a liaison to SUD specialty care services.

(3) **Duration of Care.** Duration of care is determined by Veteran clinical (symptom or functional) status.

(4) **Requirements for VA Medical Facilities and CBOCs.** Every VA medical facility is required to have an identified SUD-PTSD specialist to provide or facilitate integrated concurrent treatment of co-occurring PTSD and SUD. Similar services need to be available in CBOCs, which can be offered by embedded VA staff, telemental health, referral to community-based providers or, non-VA fee-basis to the extent the Veteran is eligible.

(5) **Decision Support Systems (DSS) Identifier.** The DSS identifier for all services provided by SUD/PTSD Teams or SUD Specialists within PTSD teams is DSS ID 519 (Substance Use Disorder/PTSD teams). DSS ID 519 SUD/PTSD TEAMS records visits to a treatment team designed to treat SUD (drug and alcohol) in conjunction with PTSD, which includes provider and support services. Only five Northeast Program Evaluation Centers (NEPEC) approved SUPT programs may use this code in the primary position. Facilities

without a NEPEC approved SUPT program must use this code in the secondary or credit position when the service is provided by a designated SUD-PTSD specialist.

f. **Domiciliary Substance Abuse Program (Dom SA) or Substance Abuse Residential Rehabilitation Treatment Program (SARRTP).** The Dom SA or SARRTP provide a residential level of care to Veterans with SUD and are a part of the MH RRTP. The MH RRTP mission is to provide state-of-the-art, high-quality residential rehabilitation and treatment services for Veterans with multiple and severe medical conditions, co-occurring mental illnesses, or psychosocial deficits. The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness. The Dom SA and SARRTP programs provide a 24 hour-7 day a week structured and supportive residential environment as a part of SUD rehabilitative treatment before full community re-entry.

(1) **SUD Rehabilitation.** Rehabilitation efforts involve continuing SUD treatment and relapse prevention, treatment for co-occurring mental health conditions where indicated, safe medication management procedures, and efforts directed at securing employment and at establishing housing and support systems in the community.

(2) **Bed Designation.** Beds may be designated as SARRTPs or may be placed within a Domiciliary Residential Rehabilitation Treatment Program (DRRTP). In the latter case, these beds are equivalent to the Domiciliary-SA bed category and must be part of a larger DRRTP. ***NOTE:*** *For more information see VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP).*

(3) **Patients Served.** Patients served are Veterans with SUD, including those with co-occurring PTSD or other mental health conditions, in need of rehabilitation for these disorders and who have better self-care and self-control capabilities than those requiring inpatient care.

(4) **Staffing.** Minimum staffing for SARRTPs is addressed in the MHRRTP Handbook 1162.02.

(5) **Length of Stay or Duration of Care.** Length of stay or duration of care is based on individualized clinical need and other options available in the continuum of care. Facilities with a DOM SA or SARRTP and other MHRRTP bed sections must focus on relatively briefer lengths of stay in the SARRTP (e.g., 30-60 days) focused on stabilizing Veterans in early recovery and preparing them to pursue recovery goals in other RRTP settings or as outpatients. In either case, continuing care for relapse prevention is indicated.

(6) **Capacity Requirements.** Every VISN is required to have at least one facility with specialty SUD care bedsections available in a residential rehabilitation setting. In facilities with MH RRTPs that do not have SUD specialty bedsections, SUD specialists must be part of the RRTP staff to promote integrated care for SUD.

(7) **Program Admission.** Veterans cannot be denied admission to an SARRTP or DOM SA based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last residential

admission, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

(8) **SARRTP and DOM SA Care.** SARRTP and DOM SA are not an appropriate level of care to provide acute medically-managed or medically-monitored detoxification to Veterans at moderate to severe risk of withdrawal. Veterans assessed as meeting the criteria for ambulatory withdrawal management consistent with the VA/DOD Clinical Practice Guidelines may be admitted as part of a plan to provide treatment and rehabilitation for SUD. These Veterans must meet the admission criteria for a SARRTP and DOM SA and be willing to participate in on-going treatment and rehabilitation as part of the residential continuum of care. SARRTP and DOM SA are not used as short-term housing of Veterans needing ambulatory detoxification, unless it is integrated with clinically-indicated on-going residential treatment and rehabilitation.

(9) **Requirements for VA Medical Facilities and CBOCs.** VA medical facilities and CBOCs can refer patients to residential care programs. VA medical facilities provide support for medical needs of residential patients and in case of mental disorder exacerbation can provide inpatient clinical services. Patients in residential care programs must be provided with appropriate access to medical and mental health care regardless of whether the patient's usual care occurs at the facility, a CBOC, or another referring facility. CBOCs and other referring facilities must provide or arrange follow up after discharge of the patient.

(10) **Treating Specialty Code.** Treating Specialty Code for SARRTP services is 1M (Substance Abuse Resid Prog) and treating specialty code for Domiciliary Substance Use Disorder Programs is 86 (Domiciliary Substance Abuse).

(11) **Outpatient Services.** Outpatient services provided by residential staff such as screening, continuing care, telephone contacts, etc., must be captured by including the following as primary or secondary MH RRTP DSS Identifiers:

(DSS) Identification NUMBER	Primary (P) Secondary(S) or Either (E)	DSS ID NAME
588	E	Residential Rehabilitation Treatment Program (RRTP) Aftercare – Individual
593	E	Residential Rehabilitation Treatment Program (RRTP) Outreach Services
595	E	Residential Rehabilitation Treatment Programs (RRTP) Aftercare – Group
596	E	Residential Rehabilitation Treatment Programs (RRTP) Admission Screening Services
597	P	Telephone/Residential Rehabilitation Treatment Programs (RRTP)
598	E	Residential Rehabilitation Treatment Program (RRTP) Pre-Admission - Individual
599	E	Residential Rehabilitation Treatment Program (RRTP) Pre-Admission - Group

NOTE: *Services performed by staff not attached to the SARRTP must be reported using the appropriate outpatient DSS identifiers.*

g. **Inpatient SUD Settings.** Acute hospital-based 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, and effective linkage to continuing care in the residential or outpatient setting for relapse prevention. Stabilization services involve significantly shorter lengths of stay than the inpatient programs of past years and the emphasis is now on promoting continuity to longer term care in RRTPs or in IOPs. Once numerous throughout the system, there are now very few SUD high-intensity inpatient units remaining, with many facilities providing withdrawal management and stabilization service in general inpatient psychiatry, medical and surgical units. Consultation to these medical, surgical and psychiatric units by staff with SUD expertise is an important service to help identify and manage withdrawal risk, assist with assessment and promote consideration of and engagement with appropriate follow-up options including SUD specialty care. Inpatient General Mental Health units frequently serve Veterans with SUD. Although unit staff needs to be able to manage their care, consultation and, in some cases treatment, by the facility's SUD specialists may be required. Assessment for suicidal or violent behavior, required for all patients admitted for inpatient care, must always be performed with Veterans with SUD both upon admission and immediately prior to discharge. ***NOTE:*** *It is important to note that over the years the Vietnam Era Veterans in need of inpatient services have had increasing medical problems and less severe distress, resulting in some shifting of staff numbers and skill sets. The new Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) generation of Veterans is as young as Vietnam Veterans were when SUD inpatient programs were first instituted and their levels of distress can be such that staffing patterns and skill sets may need to be evaluated locally to ensure safe and effective treatment in early recovery.*

(1) **Patients Served.** Patients served are Veterans with SUD clinically determined to require the inpatient level of safety and intensity of services.

(2) **Staffing.** This is dependent on configuration with other inpatient mental health units.

(3) **Length of Stay (LOS) or Duration of Care.** Length of stay (LOS) or duration of care is clinically determined based on patient symptoms and functioning. In FY 2010, average LOS for SUD high-intensity inpatient programs was less than 7 days.

(4) **Treating Specialty Code.** All acute, inpatient SUD settings must use Treating Specialty Code 74 (Substance Abuse – High Intensity).

h. **SUD care in General Mental Health Clinic Settings.** Most care for Veterans with SUD in any given year is provided outside of SUD Specialty Care settings, including General Mental Health Clinics. Most VA clinicians are familiar with, and many can manage, stabilized or low-severity SUD. This is typically true of Mental Health (MH) clinicians in CBOCs, although specialty SUD services are required to be available at least by consultation in person or using tele-mental health as noted. Veterans who have been treated in specialized SUD programs may be stabilized sufficiently to be followed over the long-term in general MH settings.

(1) **Patients Served.** Patients served are Veterans with stabilized, low severity, or uncomplicated SUD.

(2) **Staffing.** Staffing is divided among MH Clinic staff. All VA MH staff must be expected to have the ability to recognize, diagnose and manage this lower acuity level of SUD.

(3) **LOS or Duration of Care.** LOS or duration of care is determined by Veteran clinical (symptom or functional) status. Patients may require further care by specialty SUD if they suffer relapse or are at high-risk of relapse.

(4) **Capacity Requirements.** Capacity requirements are determined according to the MH Clinic standards.

(5) **Requirements for VA Medical Facilities and CBOCs.** All VA medical facilities and CBOCs must be able to provide SUD care.

NOTE: *Services performed by staff not attached to any of the preceding SUD Specialty Treatment Programs must be reported using the appropriate outpatient DSS identifiers for their clinical setting (e.g., Mental Health Clinic).*

i. **Summary of Reporting Codes for Substance Use Disorder Programs**

para	SUD Services, Program Elements or Settings	DSS ID #	Spec Code	MPCR Account
9b-c	Substance Use Disorder, Individual	513		2316
9b-c	Substance Use Disorder, home visit	514		2316
9b-c	Telephone, Substance Use Disorder	545		2780
9b-c	Substance Use Disorder, Group	560		2316
9c	Intensive Substance Use Disorder Treatment - Group	547		2316
9c	Intensive Substance Use Disorder Treatment - Individual	548		2316
9d	Opioid Substitution	523		2316
9e	Substance Use Disorder/PTSD teams/specialists	519		2317
9f	Substance Use Disorder Residential Rehabilitation Treatment Program (SARRTP)		1M	1713
9f	Domiciliary SA		86	1511
9g	Inpatient Ward SA Hi Intensity		74	1313

10. REFERENCES

a. Institute of Medicine (IOM), *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, Washington, DC: National Academies Press; 2006.

b. McKay JR. Is there a case for extended interventions for alcohol and drug disorders? *Addiction.* 2005:100:1594-1610.

c. McLellan AT, Lewis DC, O'Brien CP, et al. Drug dependence: a chronic medical illness. *Journal of the American Medical Association (JAMA).* 2000;284(13):1689-1695.

d. Miller WR, Wilbourne PL. Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders, *Addiction,* 2002;97:265-272.

e. National Institute on Drug Abuse (NIDA), *Principles of Drug Addiction Treatment: A Research-Based Guide;* 1999. National Institutes of Health (NIH) Publication No. 99- 4180. Available at www.nida.nih.gov/PODAT/PODATIndex.html

f. National Quality Forum (NQF), *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices A Consensus Report*, Washington, DC: NQF; 2007.

g. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), *American Psychiatric Association*.

h. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

i. VHA Handbook 1605.01, Privacy and Release of Information.

j. VHA Handbook 1907.01, Health Information Management and Health Records.

k. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

l. VHA Handbook 1160.02, Clozapine Patient Management Protocol (CPMP).

m. VHA Handbook 1160.03, Programs for Veterans with Post-Traumatic Stress Disorder (PTSD).

n. VHA Handbook 1162.02 Mental Health Residential Rehabilitation Treatment Program (MH RRTP).

o. Title 38 U.S.C. Section 1720A, Treatment and Rehabilitative Services for Persons with Drug or Alcohol Dependency.

p. Title 38 U.S.C. Section 7332, Confidentiality of Certain Medical Records.

q. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

r. Title 17 CFR §§17.38, Medical Benefits Package, and 17.80 through 17.83, Use of Services of Other Federal Agencies.

s. Title 42 CFR Part 8, Certification of Opioid Treatment Programs.

GUIDELINES AND USEFUL WEB SITES

1. **Department of Veterans Affairs (VA) and Department of Defense (DOD) Clinical Practice Guidelines.**

a. Current Clinical Practice Guidelines for SUD and commonly co-occurring mental conditions can be found at: *http://www.healthquality.va.gov/index.asp*

b. These include:

(1) Substance Use Disorder (SUD),

(2) Major Depressive Disorder (MDD),

(3) Post-Traumatic Stress Disorder (PTSD), and

(4) Tobacco Use Cessation.

2. **Informational Web sites**. The following Web sites are used for informational needs only:

a. National Institute on Alcohol Abuse and Alcoholism, Helping Patients Who Drink Too Much: A Clinician's Guide ***at:*** ***http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/guide.htm*** .

b. Division of Pharmacologic Therapies (DPT), Center for Substance Abuse Treatment (CSAT***)*** within the Substance Abuse and Mental Health Services Administration. ***http://www.dpt.samhsa.gov/regulations/certification.aspx*** **.**

c. Opioid Treatment Regulation at: ***http://www.dpt.samhsa.gov/regulations/regindex.aspx*** **.**

d. VA Pharmacy Benefits Management Services, Clinical Guidance including Drug Criteria for Use at: ***http://www.pbm.va.gov/*** .