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No Wrong Door: Providing Quality, Collaborative and Timely SUD Care in the VA

February 27, 2025

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No Wrong Door: Providing Quality, Collaborative and Timely SUD Care in the VA

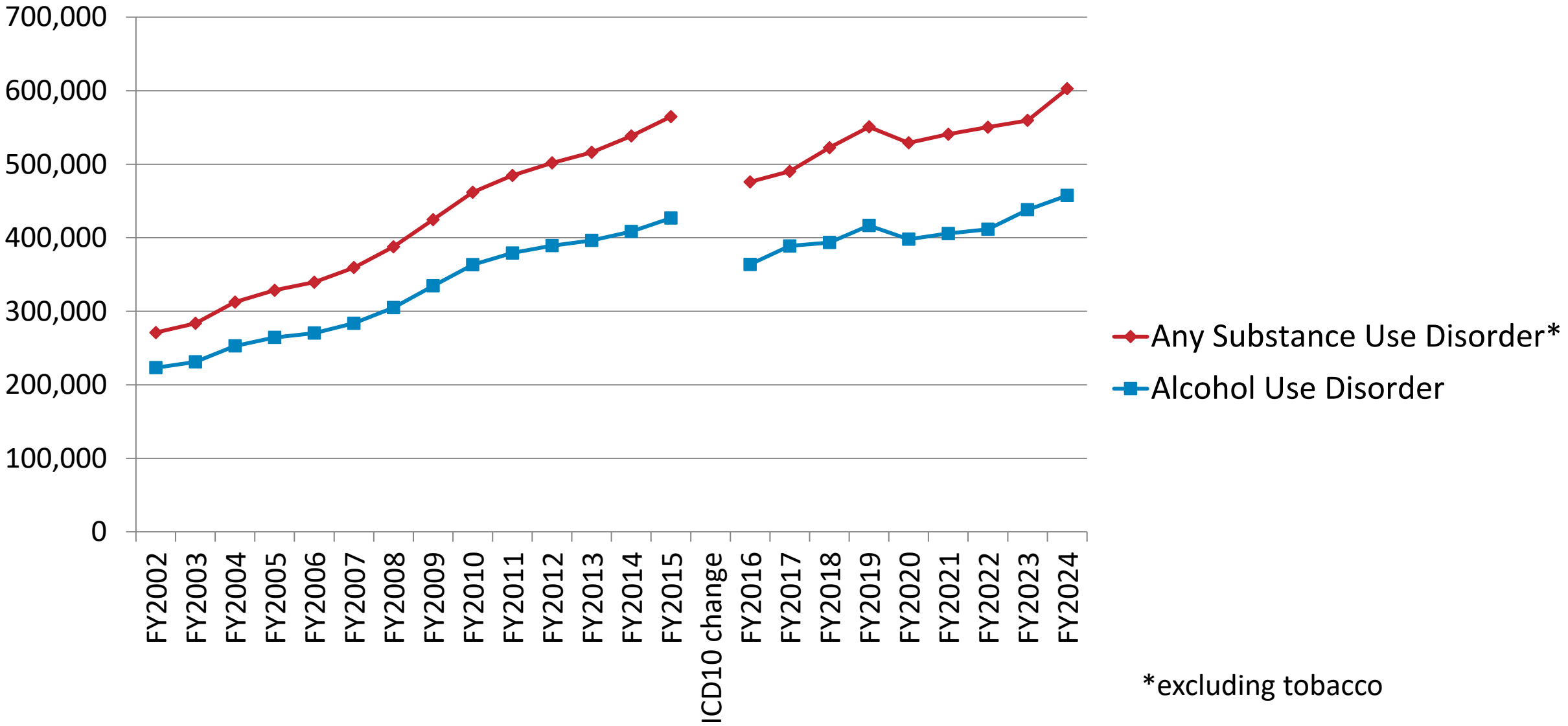
Joseph Liberto, MD

National Mental Health Director, SUD

VA Office of Mental Health

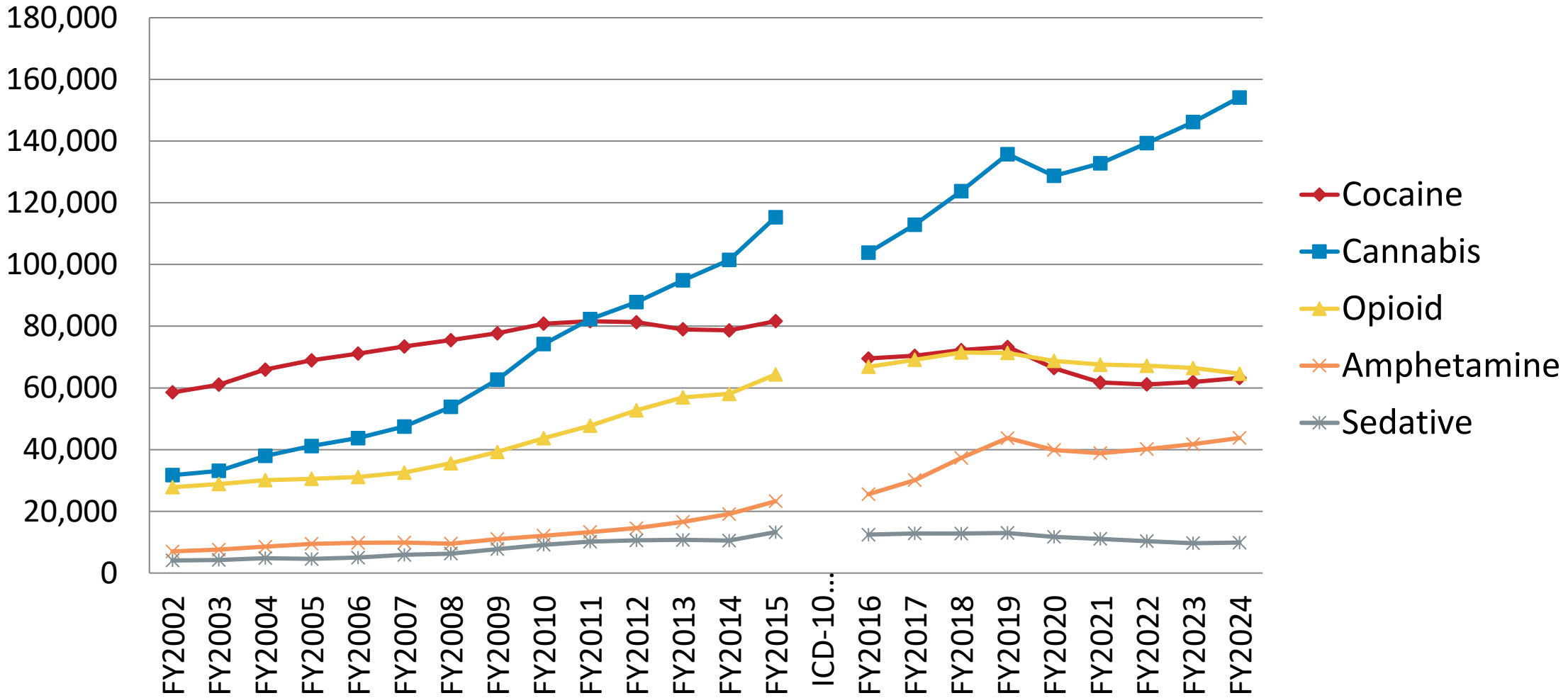
VA Diagnostic and Specialty Care Treatment Trends

VHA Direct Care Trends in Alcohol & Substance Use Disorders

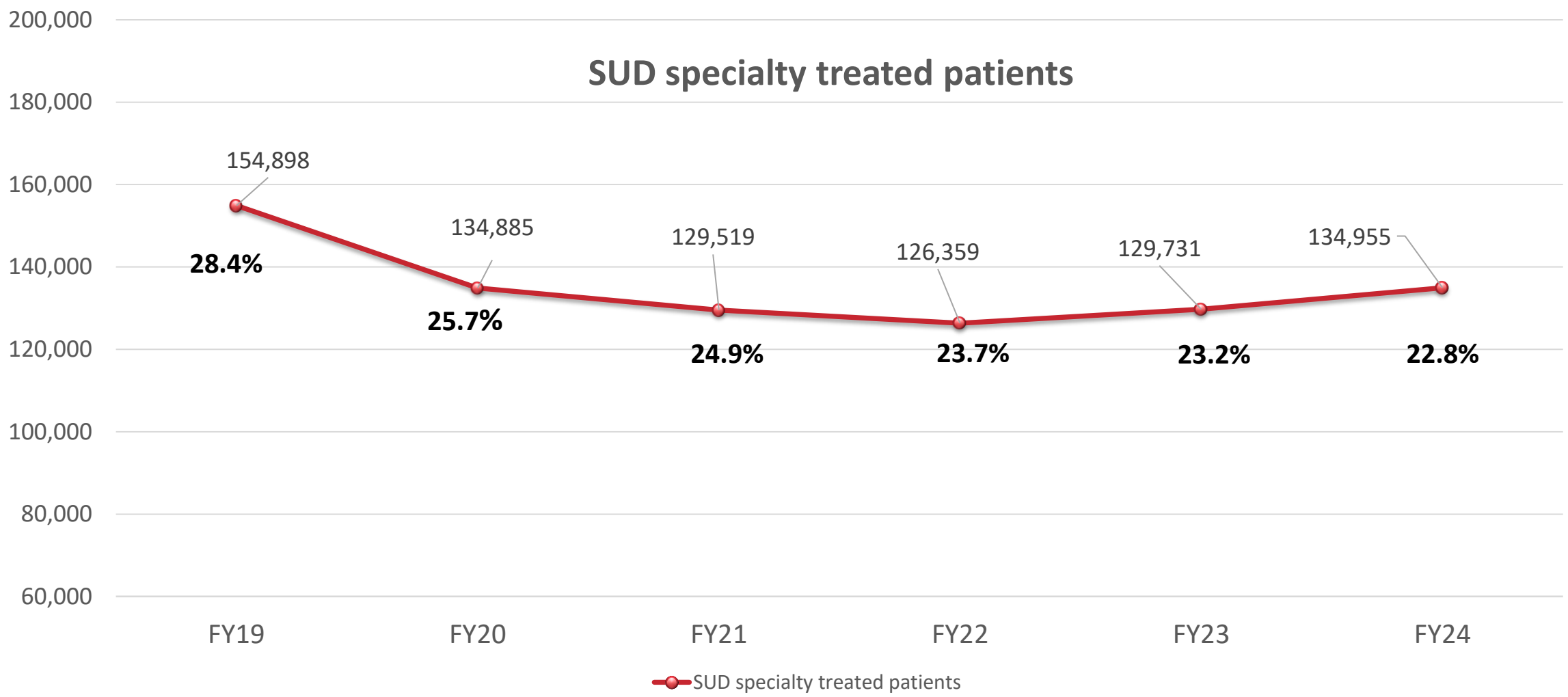


*excluding tobacco

VHA Direct Care Trends in Drug Use Disorders



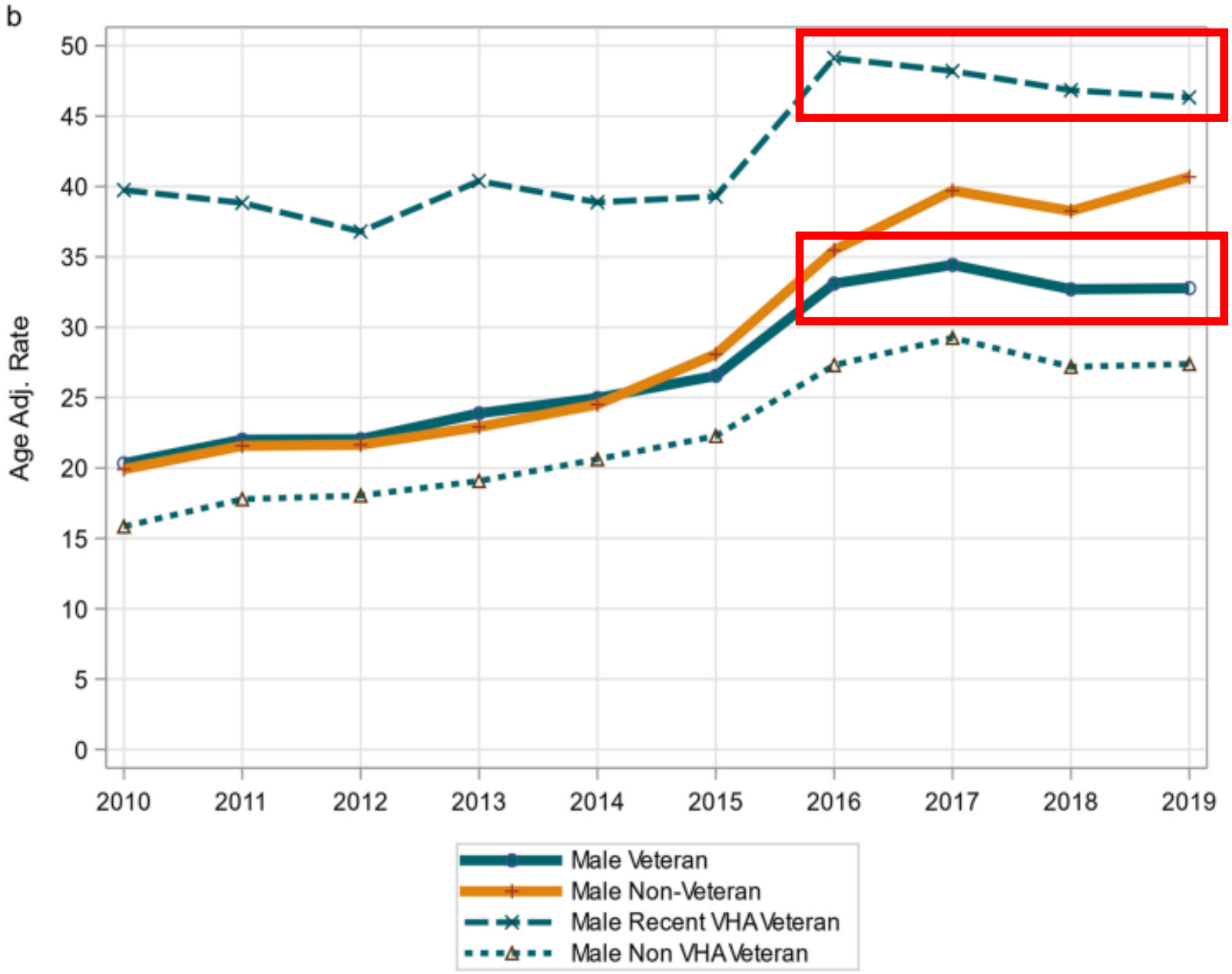
Patients treated in SUD specialty clinics per year



Overdose Epidemic

Veteran drug overdose mortality, 2010–2019 (Begley et al., 2022)

- Veteran men experienced lower age-adjusted overdose rates than non-Veteran men
- While there was an overall increase in age-adjusted overdose mortality among both male Veterans and male non-Veterans, overdose rates among male Veterans decreased relative to male non-Veterans after 2014
  - Average annual percent change (AAPC) was significantly lower for male Veterans (AAPC=6.4) than male non-Veterans (AAPC=9.6)
- While overdose rates across all years were higher among male Veterans with recent VHA use than those without recent use, the rate of increase did not significantly differ according to recent VHA use



Patient characteristics and treatment utilization in fatal stimulant-involved overdoses in the United States Veterans Health Administration (Coughlin et al., 2021)

- **48% of stimulant-related overdose deaths involved opioids**
- **1 out of every 2 cocaine-related deaths involved opioids***
- **1 out of every 3 methamphetamine-related deaths involved opioids***
  - **46% involved synthetic opioids (e.g., fentanyl); 45% involved heroin; 26% involved prescription opioids**
  - **31% of stimulant+opioid overdose deaths involved ANOTHER substance**
    - **18% of all stimulant+opioid overdose deaths involved alcohol**

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*11.10.21 personal communication with Dr. Lin; 90 deaths involved cocaine+methamphetamine+opioids→55% of cocaine-related deaths involved opioids (n=1325) and 37% of methamphetamine-related deaths involved opioids (n=508)

Suicide and Substance Use Disorder

Percentage of All Veteran Overdose Deaths by Intent

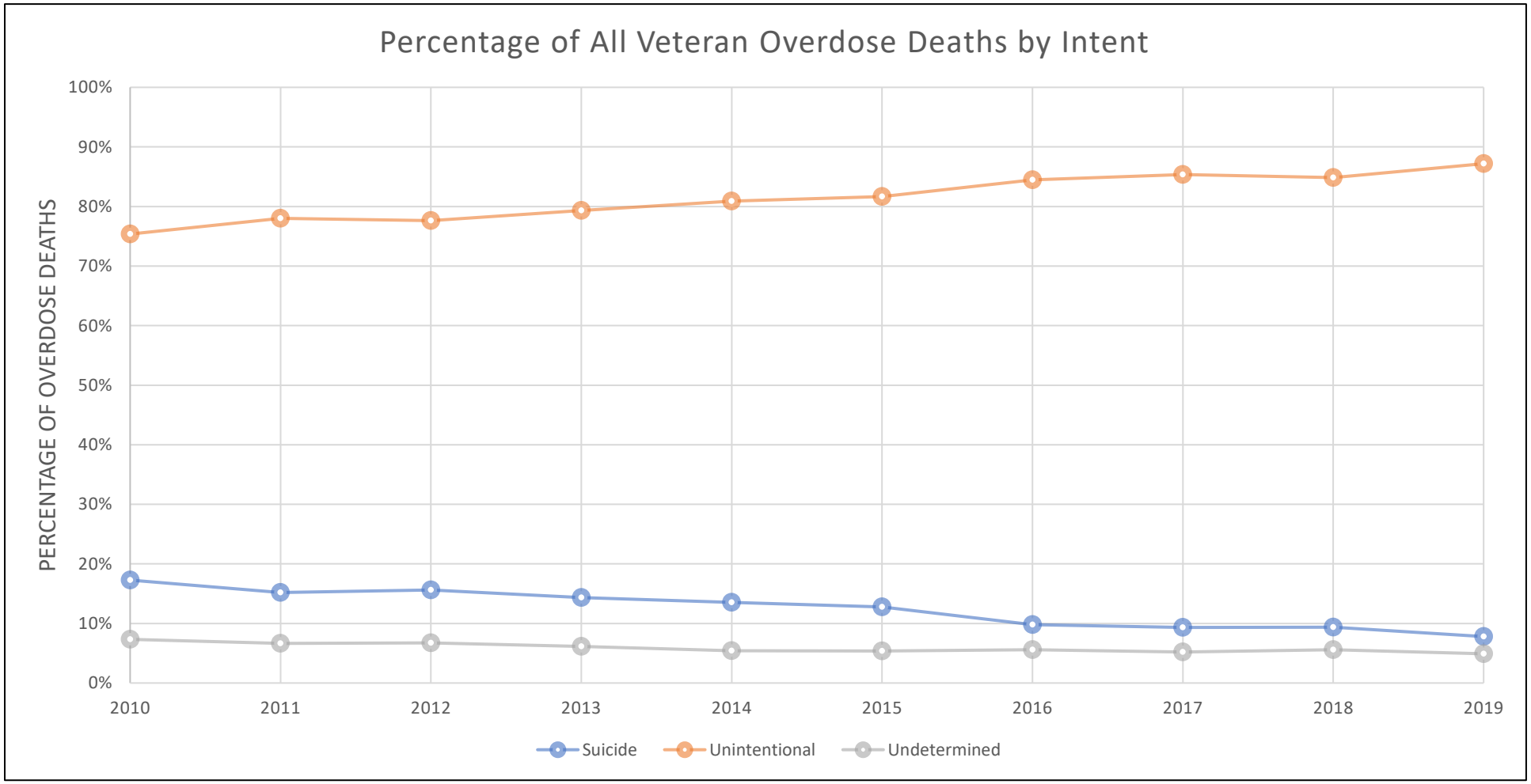


Table 6: Suicide Deaths and Unadjusted Suicide Rates, Recent Veteran VHA Users, by Mental Health (MH) and Substance Use Disorder (SUD) Diagnoses,[76] 2021 and 2022

Diagnoses	Suicide Deaths		Suicide Rates per 100,000 Person-Years		
	2021	2022	2021	2022	Rate Change[77]
Without MH/SUD Condition	952	1,024	27.2	29.6	+2.4
With Any MH/SUD Condition	1,495	1,548	56.9	56.4	-0.5
Anxiety	679	671	66.2	60.3	-5.8
Attention-Deficit Hyperactivity Disorder	85	83	76.4	64.4	-12.0
Bipolar Disorder	213	209	129.1	125.4	-3.6
Depression	943	992	65.2	65.1	-0.1
Other Psychoses	86	98	181.4	207.1	+25.7
Personality Disorder	102	112	139.5	153.3	+13.8
Post-Traumatic Stress Disorder	623	640	52.9	51.3	-1.6
Schizophrenia	84	77	98.7	92.6	-6.1
Substance Use Disorder	621	646	88.7	89.3	+0.6
Alcohol use disorder	482	503	90.9	92.1	+1.2
Cannabis use disorder	204	227	109.2	114.8	+5.6
Cocaine use disorder	70	62	84.5	76.2	-8.4
Opioid use disorder	104	99	119.4	114.3	-5.1
Sedative use disorder	30	37	183.1	236.7	+53.6
Stimulant use disorder	96	87	174.8	153.6	-21.2

Higher rates, even when compared with depression

1.8 to 3.6x rate of depression for:

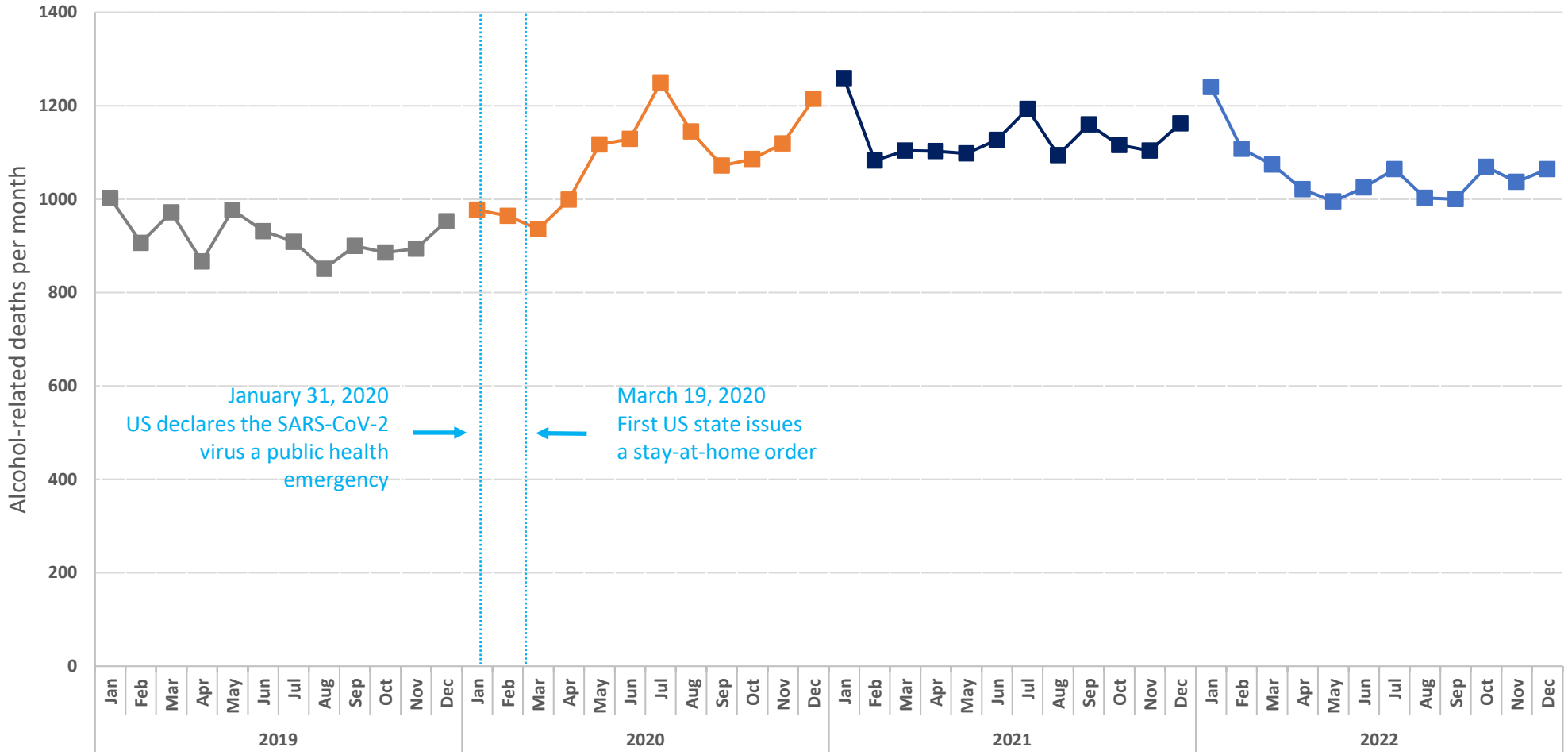
- **opioid use disorder**
- **sedative use disorder**
- **stimulant use disorder**

Nearly 1 in 3 suicide decedents had a SUD diagnosis

https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

Alcohol-Related Deaths During the Pandemic

Alcohol-Related Deaths, Veterans, 2019-2022, by Year and Month



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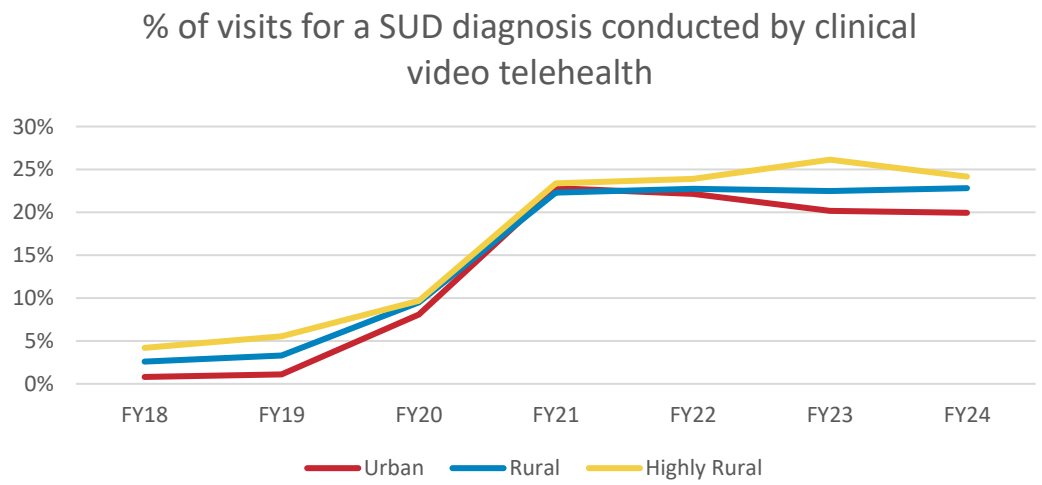
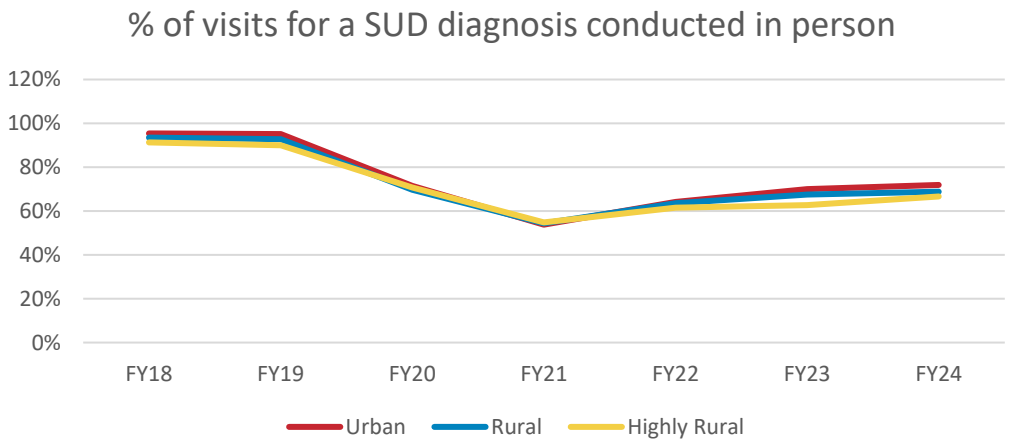
SUD Care in the VA

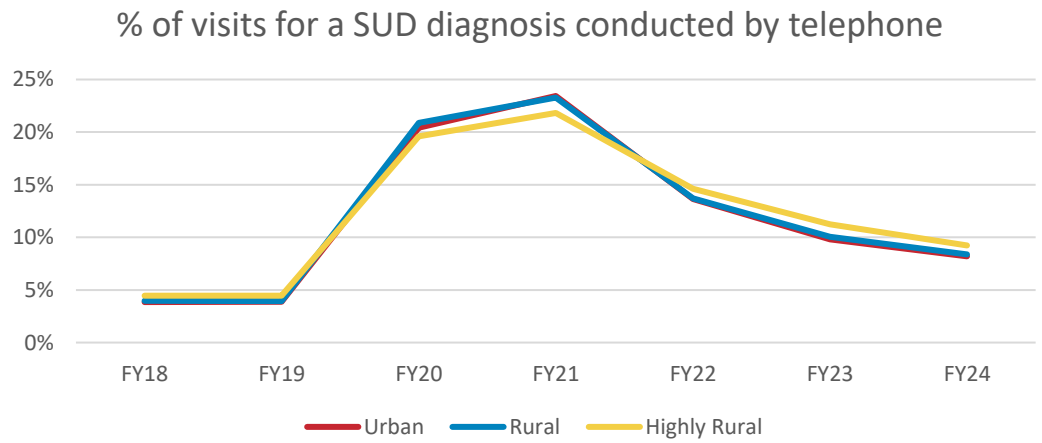
Clinical Video Telehealth and Telephone Care improves access to SUD treatment

- Historically, most SUD care was provided in person. Highly rural and rural patients adopted clinical video health for SUD treatment at higher rates pre-pandemic. The COVID pandemic led to rapid and sustained increase in use of clinical video telehealth for SUD care in urban, rural and highly rural settings.

- Provision of video-enabled tablets to patients with SUD with access barriers was associated with improved SUD treatment engagement (Gurjal et al., 2023). Video-enabled tablet provision to rural patients with mental health disorders was associated with a 20% reduction in emergency department visits and a 22% reduction in suicide behavior (Gurjal et al., 2022).



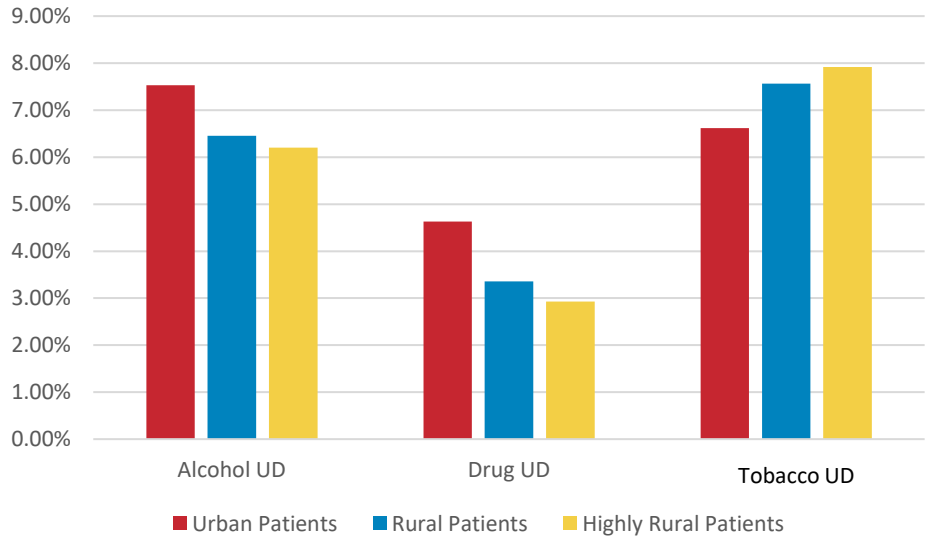


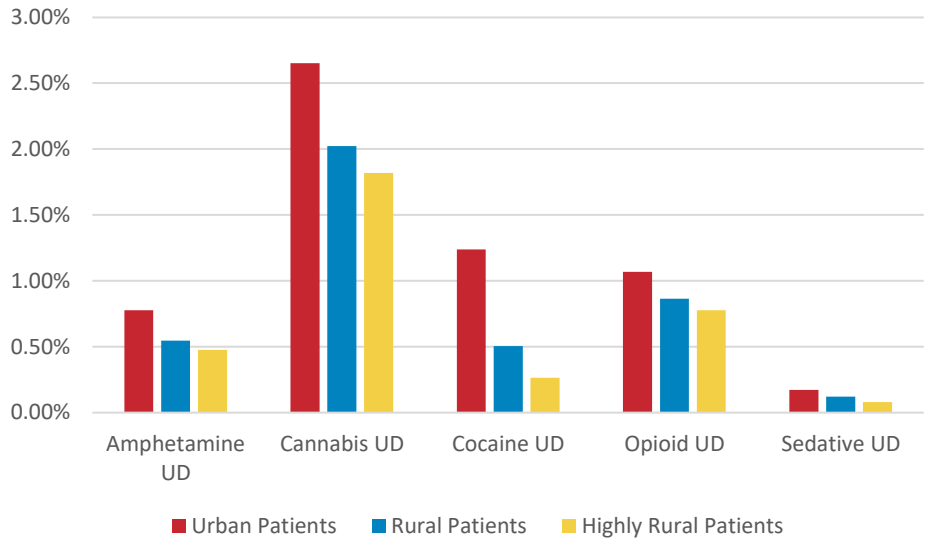


Treated Substance Use Disorder (SUD) Rates in FY24Q4 by Rurality

VA treated 4,208,820 urban, 2,117,586 rural, and 73,785 highly rural patients in the year ending FY24Q4.

Patterns of substance use and treatment seeking for SUD vary geographically. For example, nicotine use disorder was treated at higher rates in rural and highly rural areas, where as cannabis and cocaine use disorders were treated at higher rates in urban areas.





Inpatient Stabilization and Withdrawal Management

Domiciliary SUD

Opioid Treatment Programs & Specialty SUD Treatment

Behavioral Health Interdisciplinary Program (BHIP)

Primary Care Mental Health Integration (PCMHI)

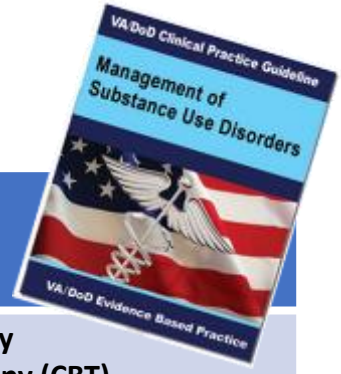
Screening, Brief /Early Intervention

Mutual Support / Peer Support

SUD treatment is provided across settings of care and outside of SUD specialty care.

Medications are provided in general mental health, primary care, pain management, and ED settings

- Screening and Brief Alcohol Intervention
- Treatment (Pharmacotherapy and Psychosocial Interventions) for all SUDs with a focus on:
  - Alcohol use disorder
  - Opioid use disorder
  - Cannabis use disorder
  - Stimulant use disorder
- Promoting Group Mutual Help Involvement (e.g. AA, NA, Smart Recovery)
- Address Co-occurring Mental Health Conditions and Psychosocial Problems
- Continuing Care Guided by Ongoing Assessment
- Stabilization and Withdrawal
- Principles of care: Shared Decision Making and Motivational Principles



SUD	Medications	Psychosocial Interventions
Alcohol	**"Strong for"** **Naltrexone** **Topiramate** **"Weak for" Acamprosate** **Disulfiram** **"Weak for" (2nd Line)** **Gabapentin**	**Behavioral Couples Therapy** **Cognitive Behavioral Therapy (CBT)** **Community Reinforcement Approach (CRA)** **Motivation Enhancement Therapy (MET)** **Twelve-Step Facilitation (TSF)**
Opioid	**"Strong for"** **Buprenorphine/naloxone** **Methadone** **"Weak for"** **ER-Injectable Naltrexone**	
Cannabis		**CBT/MET/Combined CBT/MET**
Stimulants		**Cocaine - CBT/Recovery Focused Behavioral therapy +/- Contingency Management (CM)** **Amphetamine/Methamphetamine – Contingency Management + treatment**

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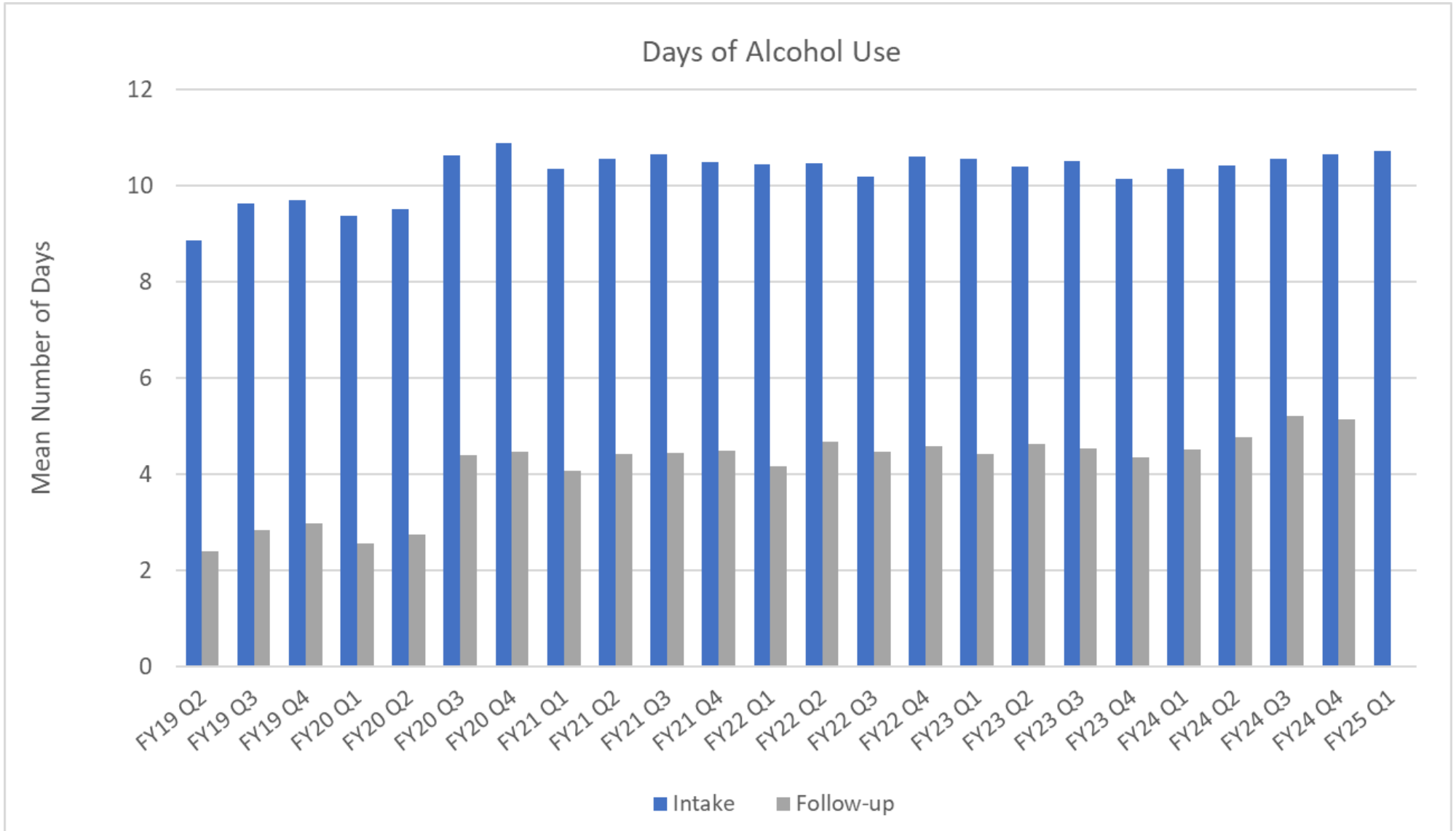
http://www.healthquality.va.gov/guidelines/MH/sud/

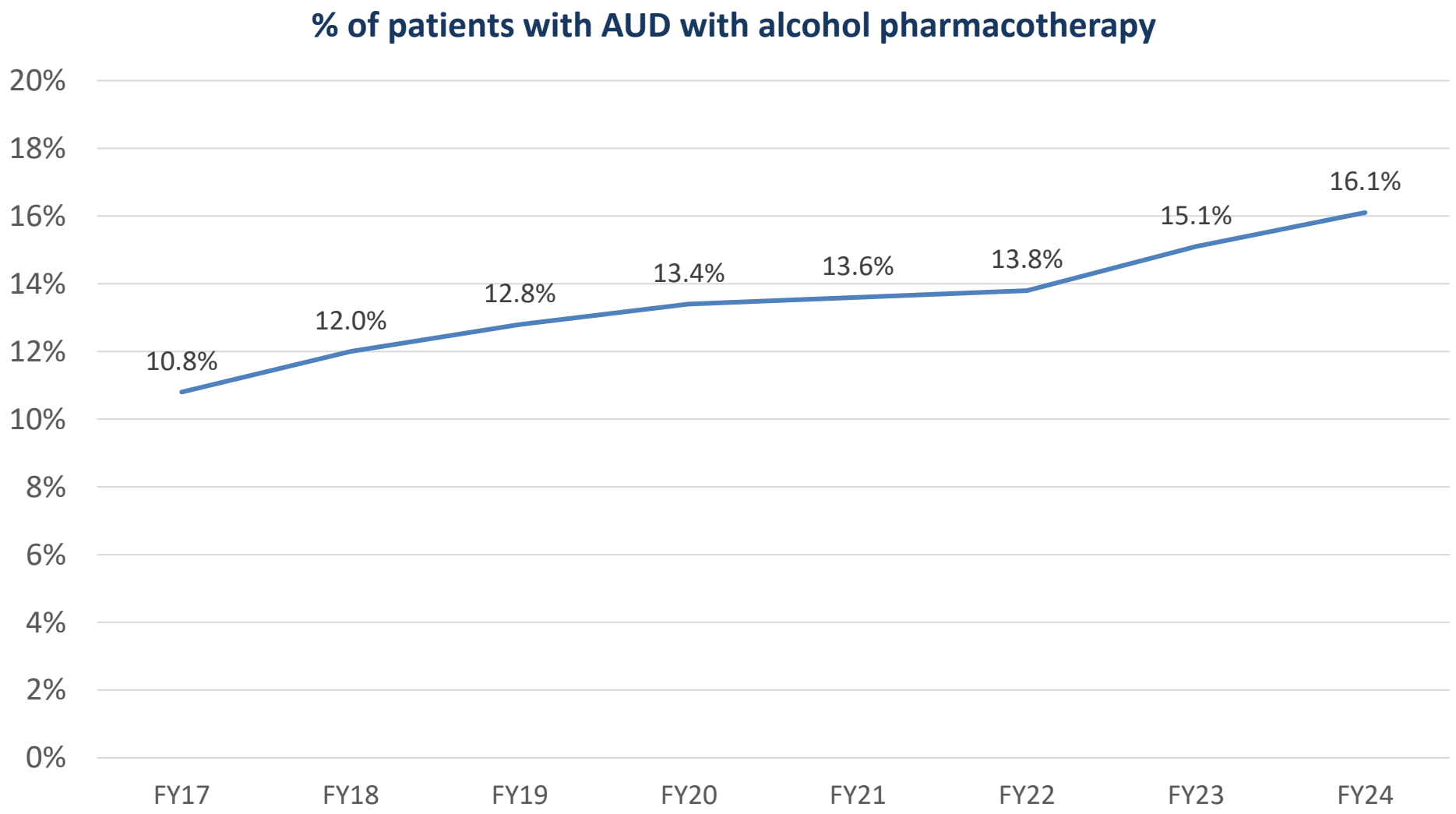
Core Characteristics of Substance Use Disorder (SUD) Services

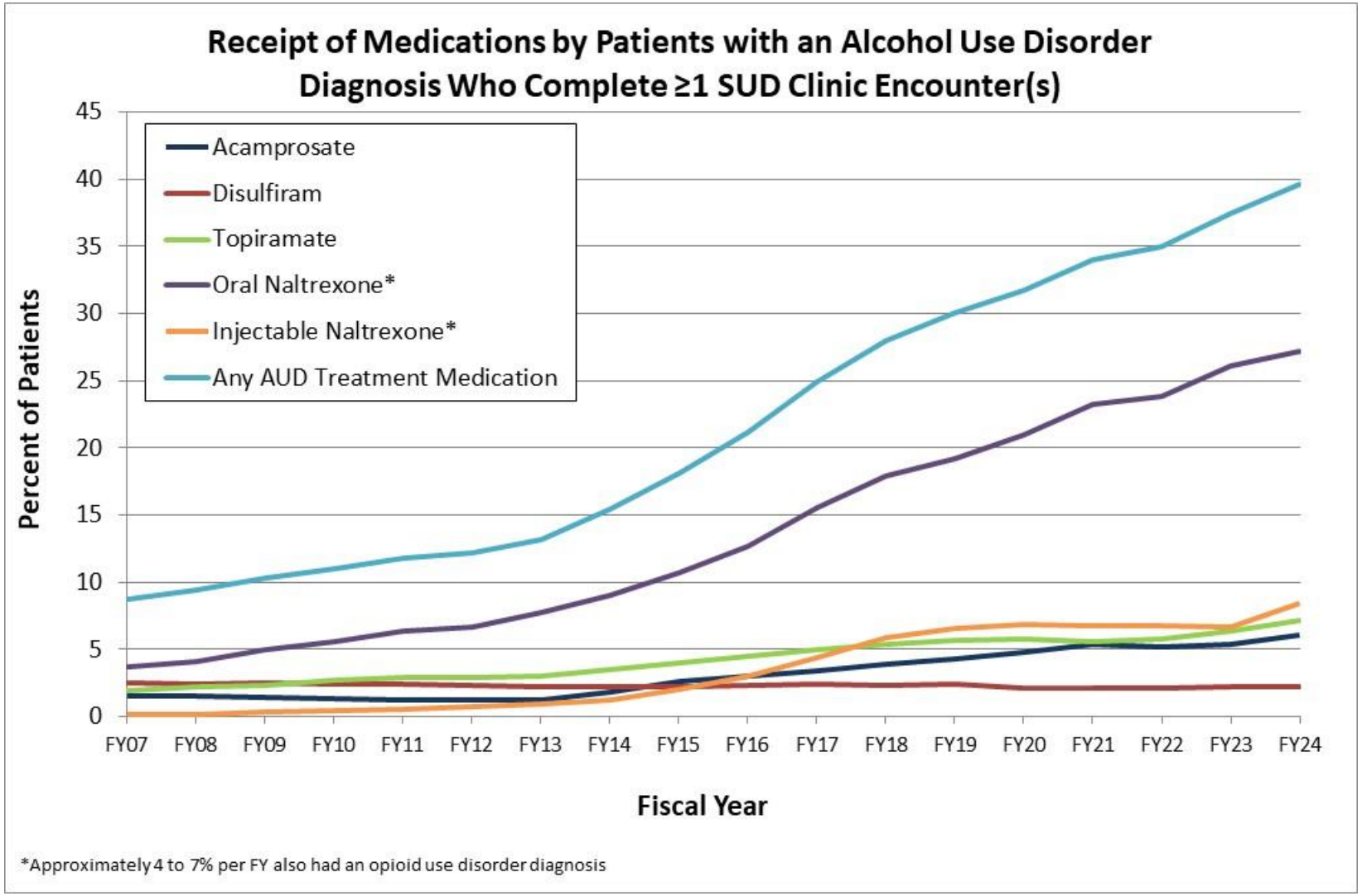
- **Timely** – Same day triage with engagement within 48 hours
- **No Wrong Door**
  - ✓ Provision of SUD treatment in general mental health, primary care, and pain management settings
  - ✓ Initiation of treatment in emergency department and inpatient settings particularly medications
- **Concurrent treatment for co-occurring needs**
- **Veteran-centered and individualized based on needs and preferences of the Veteran** (Whole Health Concepts)
  - ✓ Consideration for prior treatment experience
  - ✓ Patient centric vs. Program centric
  - ✓ Variable Length of Stay (LOS)
- **Use of non-stigmatizing language**
- **Emphasis on engagement with barriers minimized**
- **Responsive to local trends**
- **SUD treatment is not automatically discontinued or limited based on use of a substance**
- **Treatment for SUD is normalized - Focus on retention in treatment**
- **Treatment is informed by use of standardized patient reported outcomes**

Alcohol Use Disorder


Days of Alcohol Use
Mean Number of Days
12
10
8
6
4
2
0
FY19 Q2
FY19 Q3
FY19 Q4
FY20 Q1
FY20 Q2
FY20 Q3
FY20 Q4
FY21 Q1
FY21 Q2
FY21 Q3
FY21 Q4
FY22 Q1
FY22 Q2
FY22 Q3
FY22 Q4
FY23 Q1
FY23 Q2
FY23 Q3
FY23 Q4
FY24 Q1
FY24 Q2
FY24 Q3
FY24 Q4
FY25 Q1
Intake
Follow-up

Patients With AUD With Any Alcohol Pharmacotherapy




Receipt of Medications by Patients with an Alcohol Use Disorder Diagnosis Who Complete ≥1 SUD Clinic Encounter(s)
Percent of Patients
45
40
35
30
25
20
15
10
5
0
Acamprosate
Disulfiram
Topiramate
Oral Naltrexone*
Injectable Naltrexone*
Any AUD Treatment Medication
FY07
FY08
FY09
FY10
FY11
FY12
FY13
FY14
FY15
FY16
FY17
FY18
FY19
FY20
FY21
FY22
FY23
FY24
Fiscal Year
*Approximately 4 to 7% per FY also had an opioid use disorder diagnosis

Opioid Use Disorder (OUD)

Goals and Outcomes

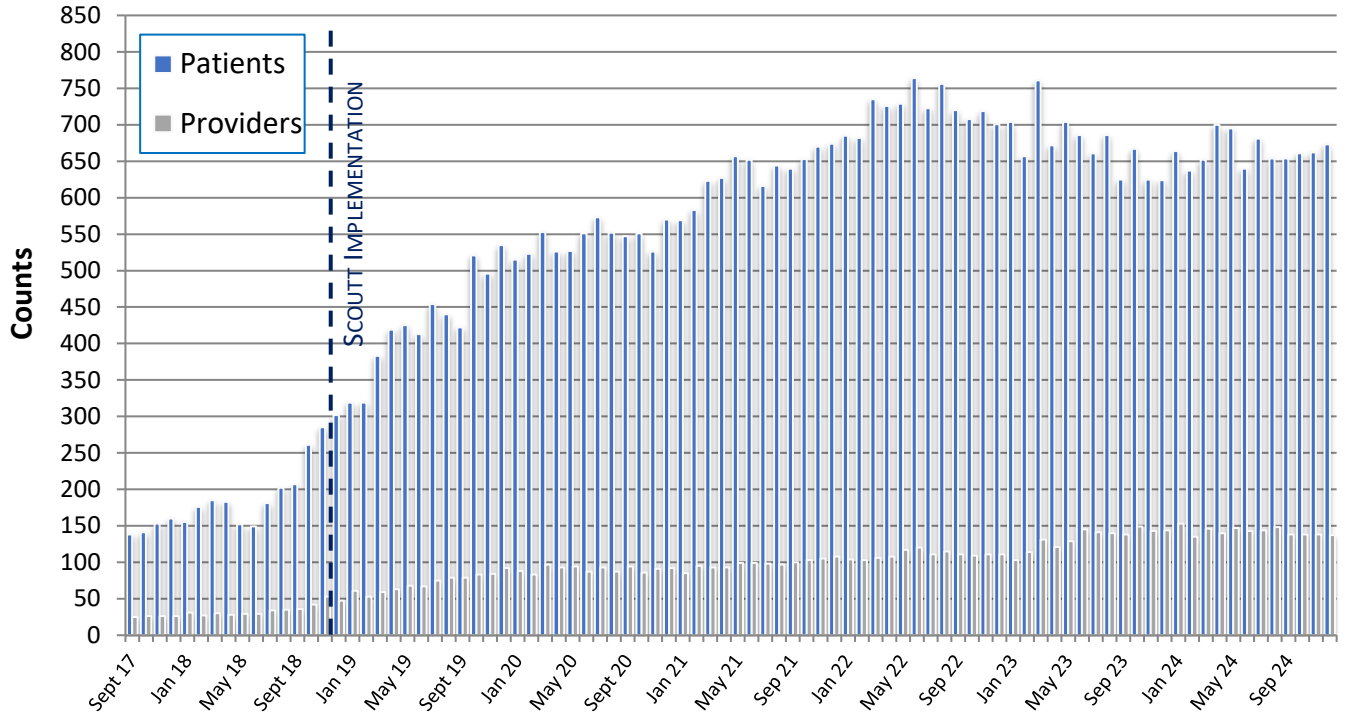
- **Improve** patient survival.
- **Increase** retention in treatment.
- **Increase** patients' ability to gain and maintain employment.
- **Improve** birth outcomes among women who have substance use disorders and are pregnant.
- **Decrease** illicit opiate use and other criminal activity among people with substance use disorders.
- **Contribute to lowering** a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse.

SAMHSA 2020, https://www.samhsa.gov/medication-assisted-treatment

Stepped Care for OUD Train the Trainer (SCOUTT)

- Provision of treatment in locations where Veterans most likely to present
- **Initiative launched in May 2018**
  - VA ILEAD calls: 8,358 attendees
  - Pilot facilitation calls/SCOUTT Action Hour: 5,388 attendees
  - X waiver trainings: 948
  - 2018 Conference: 246 attendees
  - 2020 Conference: 257 attendees
  - 2021 Conference: 786 attendees
  - MAT-VA Journal Club: 9,526 attendees
- **From August 2018 – December 2024:**
  - 233% increase in patients receiving buprenorphine in the Phase 1 Level One Clinics
  - 291% increase in buprenorphine prescribers in Phase 1 Level One Clinics
  - Over 4100 patients have initiated buprenorphine in Phase 1 Level One Clinics

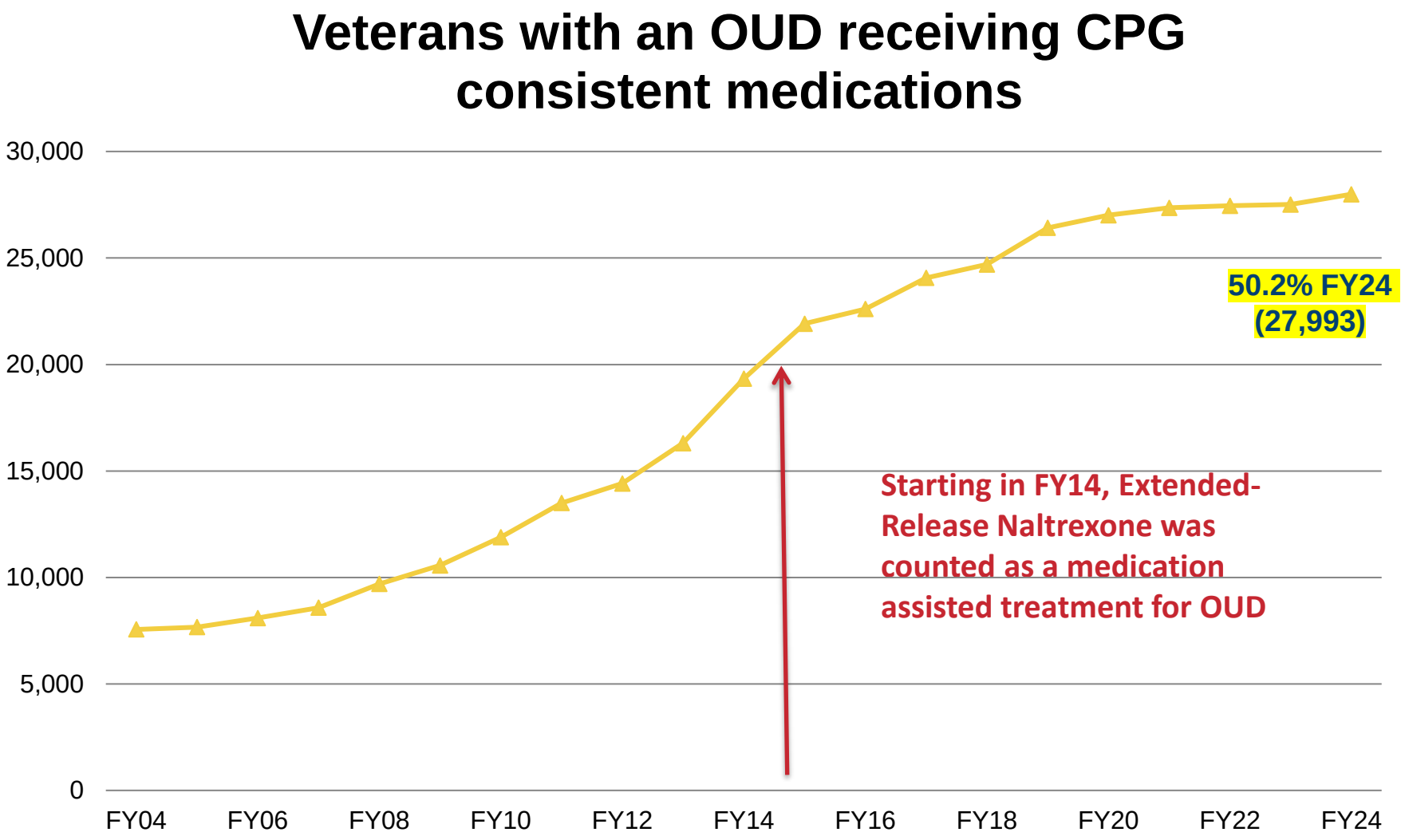
Buprenorphine for Opioid Use Disorder*



**Includes patients with a diagnosis of OUD seen in the implemenation clinic.*

Medication Treatment For Veterans Treated in VHA with an OUD

- **SUD16**: Percentage of VHA-treated Veterans with clinically diagnosed OUD who received indicated medications (i.e., OTP-administered methadone, buprenorphine, or injectable naltrexone)
- Most of this medication provided in SUD specialty care settings.



Stimulant Use Disorder

Metrics: STEP 1, Objective 1

Choose 1 !

CM_Program: Facilities meeting VA requirements to engage in Contingency Management (Displayed as + or -)

1. Provider Trained in Contingency Management
2. Ability to return a urine toxicology sample in 30 min or less
3. VA funds for patient rewards distributed to the facility

CBT-SUD_Provider: Proportion of all Mental health providers at the facility, who have completed training requirements to competently deliver CBT-SUD

- Numerator derived from databases maintained by the OMHSP Psychotherapy Program Office

Contact **Gabi Khazanov**
Gabriela.Khazanov@va.gov

Contact **Maryann Gnys**
Maryann.Gnys@va.gov

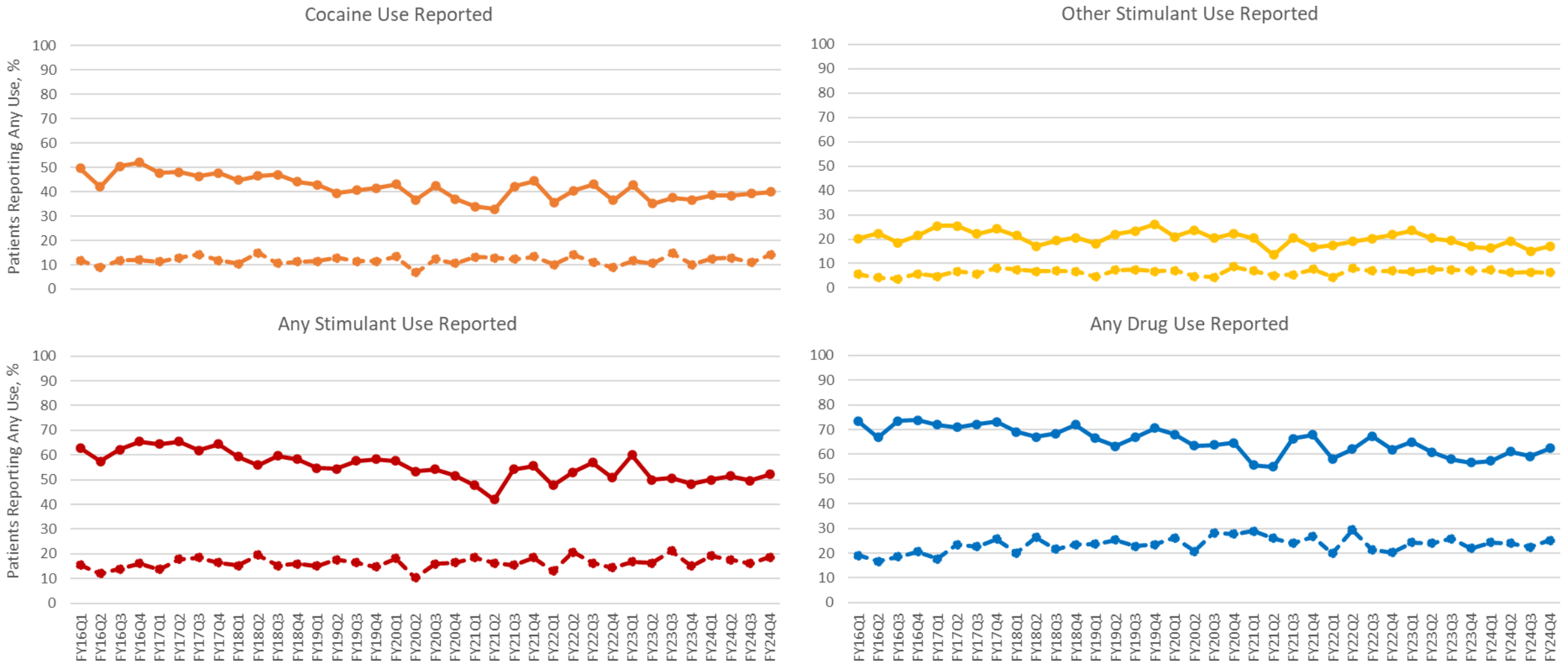
Funding Opportunity to Support Purchase of Patient Self-Testing Products in Support of the Provision of Contingency Management

- Funding is available in fiscal year (FY) 25 for the purchase of patient self-testing products to support the provision of contingency management (CM).
- Funding requests per health care system must not exceed $3,000 for FY 2025 and must be submitted no later than May 31, 2025
- See attached memorandum and contact OMH SUD at VHACOSUDProgram@va.gov with any questions.

Funding.Patient.Self.Testing.FY25

BAM Reported Drug Use at Intake and Follow-up among Patients with A Stimulant Use Disorder in the Prior Year

Solid line: Intake; Dashed line: Follow-up



Key Programs Supporting Evidence-Based Clinical Care Delivery

Enduring Rural Care

- CPPs **increase patient access, improve quality of care, and decrease provider burden** through the delivery and optimization of CMM services for rural Veterans
- The CRVA MH-REACHES project will extend on past efforts and integrate CPPs into Primary Care Mental Health Integration (PCMHI) and Behavioral Health Interdisciplinary Program (BHIP) areas

Focus:

- Dedicated to expanding care to rural Veterans
- Component of SUD care as part of practice
- Support MH specific performance metrics
- Psychotropic Drug Safety Initiative
- Improved safety targets (suicide risk, risk mitigation, etc.)
- Differences in Utilization of SUD Care

CRVA – MH REACHES

(**R**ural **E**xpansion **A**ccess and **C**oordinated **H**ealth **E**fforts in **S**UD)

Sustainment of CRVA SUD FY20

FY24-FY26

28 CPPs at 22 Facilities

19 BHIP & 9 PCMHI

Focus: Increased access to MH care including provision of SUD, including but not limited to OUD, AUD, and StimUD

Increased access to CMM services to rural Veterans with a focus on achieving the quintuple aim (access, quality, patient satisfaction, provider experience, personalized care)

CONSULTATION FOR SUBSTANCE-RELATED CONCERNS AND ADDICTIVE DISORDERS

National Expert Consultation & Specialized Services - Mental Health (NEXCSS-MH)

WE CAN HELP!

ARE YOU:

- Treating Veterans with substance use? Need second opinion? We can help!
- Managing Veterans with chronic pain on opioids? We can help!
- Questions about: medications, psychosocial treatments, or co-occurring psychiatric disorders? We can help!
- Looking to learn more about substance use treatment? We can help!

MORE INFORMATION:

NEXCSS-MH Website
Substance-Related and Addictive Disorders Program Fact Sheet

CONTACT US:

Email: AskTheExpert-SubstanceUseDisorder@va.gov
NEXCSS Office: 203.479.8181

VA Emergency Medicine Addiction Hotline

- Virtual real-time clinician support tool for acute care providers
- Think Poison Control Line but for addiction medicine
- Staffed daily 365 days/yr (including weekends/holidays) from 1 pm to 9 pm PST

Supported by: Office of Mental Health, Pain Management, Opioid Safety, and PDMP (PMOP), National Emergency Medicine Office, VISN 22 Tele-Emergency Care

Addiction Hotline Services

- **Provide low-barrier real-time case discussions from 1pm-9pm PST**
  - Review/responds off-tour messages asynchronously

- Support the assessment and treatment of SUDs (emphasis on opioid and alcohol use)
  - SUD intoxication and withdrawal syndromes

- Discuss treatment of acute pain and adjustments to opioid-based chronic pain regimens to reduce risk of misuse and harm
  - 9% of total VEMAH calls are pain-related

- Discuss Harm reduction and overdose prevention strategies

- On-demand ED provider education
  - Daily addiction pearls
  - CME – Addiction Scholars Program (3-day session every August)
  - Addiction and pain case-based learning sessions (throughout the year)

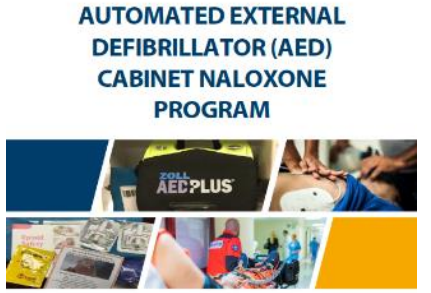
Harm Reduction

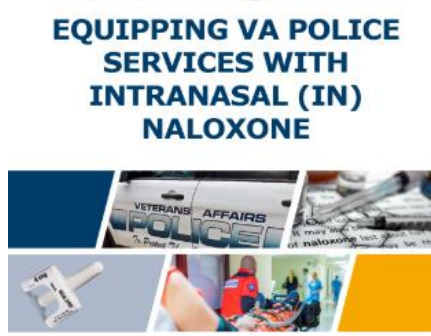
VA Opioid Overdose Education and Naloxone Distribution (OEND)

- National program launched in 2014
- Opioid Overdose Education (OE)—Provide patient education on how to ***prevent, recognize, and respond*** to an opioid overdose
- Naloxone Distribution (ND)—Provide patient with ***naloxone.***
- OEND provides opportunity to discuss risk of opioids
  - **A few minutes of training could save a life!**
- **No cost to patients at-risk** (eliminated copays for naloxone and training)
  - **Please help facilitate getting OEND to Veterans!!!**
- VHA Rapid Naloxone Initiative (3 elements)
  1. **OEND to VHA patients at-risk for opioid overdose (Feb 2025)**
     - ~1.6 million naloxone Rxs dispensed to ~650,000 Veterans by ~73,000 prescribers with ~6,000 opioid overdose reversals
  2. **VA Police Naloxone (Sep 2024)**
     - 4,378 VA police officers carry naloxone with 309 reported opioid overdose reversals
  3. **Select Automated External Defibrillator (AED) Cabinet Naloxone (Sep 2024)**
     - 1,274 AED Cabinets with naloxone with 75 reported opioid overdose reversals

2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award

https://www.youtube.com/watch?v=0w-us7fQE3s





VA

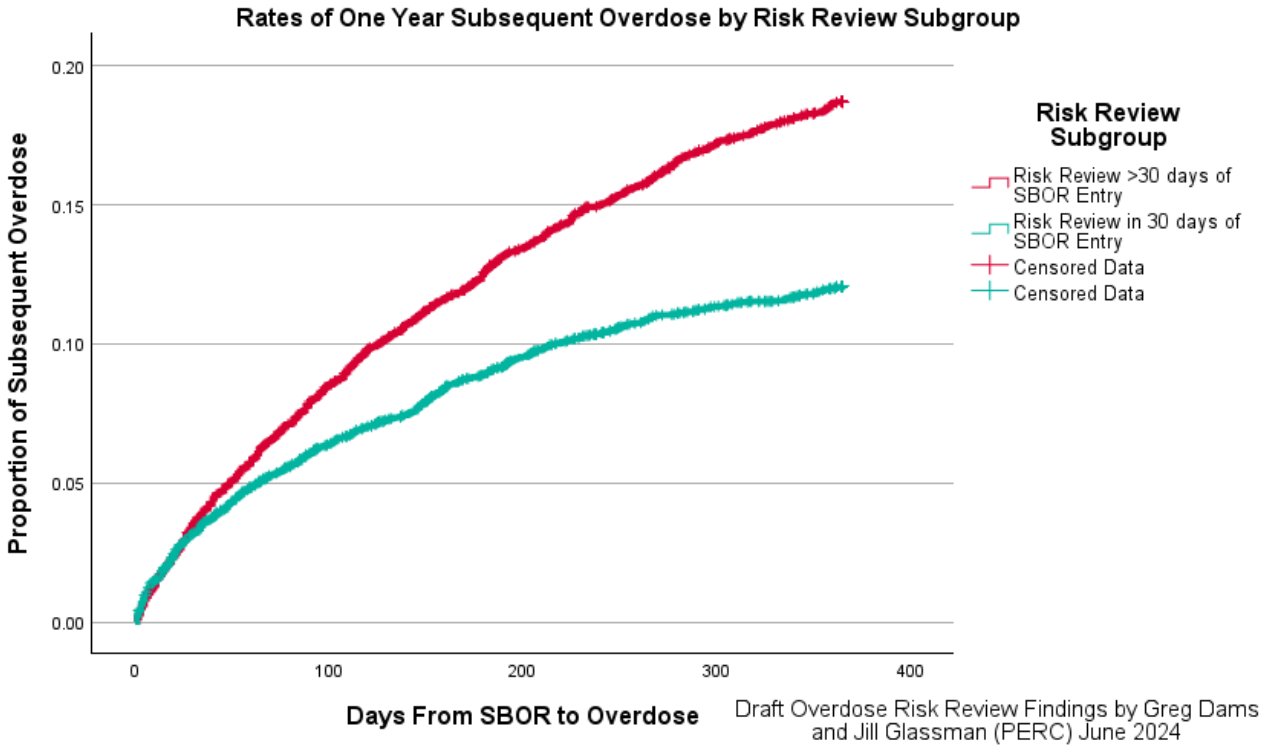
VA OEND SharePoint (implementation models); VA Academic Detailing Service OEND SharePoint (patient, provider, and data resources); Oliva et al. (2017; 2021); Bounthavong et al. (2017, 2020); QUERI Roadmap; NPR feature; Eisenberg—The Joint Commission (TJC) Journal on Quality and Patient Safety Paper, Podcast, Blog; VA Press Release

Diffusion of EXCELLENCE

Veterans Health Administration

Potential Impacts of SBOR Completion and Risk Reviews

- Preliminary evaluation of the effects of this program found that receipt of a case review within 30 days of an SBOR-reported overdose is associated with a significant 38% reduction in risk of subsequent overdose in the next year compared to receiving a more delayed case review (i.e., >30 days)



Draft Overdose Risk Review Findings by Greg Dams and Jill Glassman (PERC) June 2024

"Most of the time we don't know what's out there for us, we don't know what we qualify for. The only way we hear about it is through other Veterans."
– Veteran participant in the SUPERNOVA study

SUPERNOVA=Strategies to improve Utilization of Post-overdose Evidence-based Risk mitigation among Non-fatal Overdoses in VA (SUPERNOVA). VA Health Services Research and Development (HSR&D) Service Directed Research (SDR) Project 21-089, PI: Elizabeth Oliva.
PERC=Program Evaluation Research Center (PERC)

Improving Access to Syringe Service Programs (SSPs) for People Who Inject Drugs (PWID)

- Distribution of syringes/disposal/exchange
- Provision of preventive/risk mitigation strategies (e.g. drug test strips)
- Linkage to SUD care including buprenorphine induction
- Reduction in infectious disease transmission

Program Office Priorities

SELECTED SUBSTANCE USE DISORDER PROGRAM OFFICE PRIORITIES

- **Expanding access to evidence-based treatment**
  - Increasing lifesaving FDA-approved medications for the treatment of opioid use disorder (MOUD) among patients with OUD (including patients in Pain clinics, General Mental Health, Primary Care, Inpatient/Emergency Department and Rural settings)
  - Increasing evidence-based treatment of stimulant use disorder with contingency management and cognitive behavioral therapy for SUD
  - Increasing Pharmacotherapy and Psychotherapy for Alcohol Use Disorder
  - Improving Alcohol Withdrawal Management
  - Increasing access to residential SUD treatment
  - Increasing access to SUD treatment for women Veterans

- **Enhancing evidence-based harm reduction efforts**
  - Increasing Overdose Education and Naloxone Distribution (OEND) to Veterans with OUD or Stimulant Use Disorder*****
  - Promoting Post Overdose Assessment / Care
  - Improving Access to Syringe Service Programs (SSPs) for People Who Inject Drugs (PWID)
    - Provision of preventive/risk mitigation strategies, Linkage to SUD care, Reduction in infectious disease transmission
  - Increasing Utilization of the Stratification Tool for Opioid Risk Mitigation (STORM) database and other Risk Mitigation Strategies

SELECTED SUBSTANCE USE DISORDER PROGRAM OFFICE PRIORITIES

- **Reducing Differences in Utilization of Evidence-Based SUD Care**
  - Addressing SUD healthcare differences in access to SUD evidence-based services
  - Mitigating the risk of stigma on the utilization of evidence-based SUD care

- **Advancing the addiction workforce / Expanding access to recovery support services**
  - Enhancing coordination of care for homeless Veterans
  - Enhancing employment opportunities for Veterans in recovery
  - Increasing Peer Support Services in the SUD Lane

- **Ensure that Spirituality is a Focus of SUD Care**
  - Greater collaboration between OMH-SUD and Chaplaincy Service

FY 2025 SUD Funding

- Sites were allowed to make additional requests to augment and address SUD care gaps in meeting requirements of Directive 1160.04.
- 89 position requests were approved for funding, which included positions such as Psychologists, Social Workers, Nurses, MD/DO, Clinical Pharmacy Specialists, Peer Specialists
- The Directive Implementation Support Tool was released to the field in FY25Q1 and is a platform used to assess compliance with the SUD Directive and identify areas for improvement

Key Metrics

Measures of Performance	FY 2024 Target	FY 2024 Q4 Actual	FY 2025 Target	FY 2025 Q1 Actual
The percentage of patients with OUD receiving FDA-approved pharmacotherapy for OUD	49%	50.2%	51%	50.2%
The percentage of patients with OUD who have had a prescription filled for naloxone in the last 12 months	75%	69.4%	75%	69.9%
The percentage of patients with Stimulant Use Disorder who have had a prescription filled for naloxone in the last 12 months	55%	49.6%	55%	50.6%
The percentage of patients with a non-fatal overdose in the past quarter who receive a case review by an interdisciplinary team with expertise in pain, SUD, suicide risk, mental health conditions and pharmacy	80%	86.8%	90%	87.1%
Number of SUD specific purpose-funded positions (aligned with the President's budget) on board this year divided by the number of approved specific purpose-funded positions in FY 2022 through FY 2024	70%	65.1%	70%	65.1%

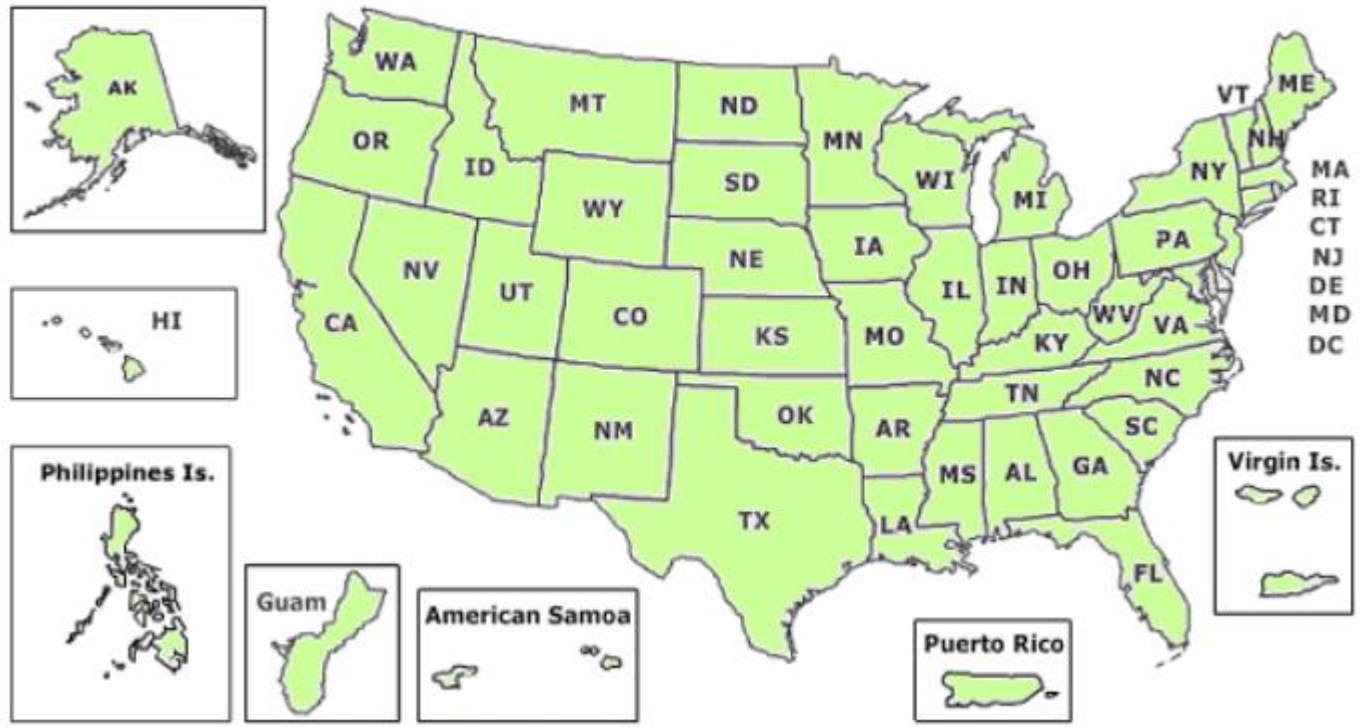
Measures of Performance	FY 2024 Target	FY 2024 Q4 Actual	FY 2025 Target	FY 2025 Q1 Actual
The percentage of patients on long-term opioid therapy with a urine drug screen	89%	89.2%	90%	89.4%
The number of patients receiving CM	1,200	1,461	1,700	1,581
The number of programs by the end of the fiscal year that have an SSP	50	38	50	38
Percentage of Veterans identified as very high-risk for overdose or suicide and have a SUD diagnosis who are currently receiving SUD treatment	55%	51.9%	55%	*51.9%

*Data for this measure represents FY24Q4 point in time total

Title	Day and time (Eastern time)	Meeting Details	POC
VHA National SUD Community of Practice Call	4th Tuesday every other month @ 2:00 PM Feb., Apr., Jun., Aug., Oct., Dec.	Join Microsoft Teams Meeting By phone: +1 872-701-0185,,122916721# United States, Chicago Phone Conference ID: 122 916 721#	Joseph.Liberto@va.gov
Best SUD Care Anywhere **(EES-sponsored webinar)**	4th Tuesday every other month @ 2:00 PM Jan., Mar., May, Jul., Sep., Nov.	Adobe, register in TMS for CEUs	Ryan.Trim@va.gov
National OTP Leaders Call	1st Monday @ 1:00 PM	Join Microsoft Teams Meeting By phone: +1 872-701-0185,,444446540# United States, Chicago Phone Conference ID: 444 446 540#	Joseph.Liberto@va.gov
SUD-PTSD Specialist Call	1st Tuesday every other month @ 1:00 PM Feb., Apr., Jun., Aug., Oct., Dec.	Join Microsoft Teams Meeting By Phone: +1 872-701-0185,,872103856# Phone Conference ID: 872 103 856#	Joseph.Liberto@va.gov
Tobacco Cessation Community of Practice Call	4th Thursday @ 12:00 PM	Join Microsoft Teams	Dana.Christofferson@va.gov
Tobacco Use Treatment **(EES-sponsored webinar)**	4th Monday every other month @ 3:00 PM Feb., Apr., Jun., Aug., Oct., Dec.	Adobe, register in TMS for CEUs	Dana.Christofferson@va.gov
Stepped Care for OUD **(EES-sponsored webinar)**	2nd Wednesday @ 1:00 PM	Adobe, register in TMS for CEUs	Spencer.Calder@va.gov
VHA Opioid Safety and Risk Mitigation Call	2nd Wednesday @ 3:00 PM	Adobe, register in TMS for CEUs	Elizabeth.Oliva@va.gov
SUD-MBC National Community of Practice Call	1st Friday @ 2:00 PM	Join Microsoft Teams Meeting By phone: +1 872-701-0185,,444551480# United States, Chicago Phone Conference ID: 444 551 480#	Eric.Hawkins@va.gov
Adv. MI/MET Consultation	2nd Tuesday @ 3:00 PM and 3rd Friday @ 2:00 PM		
SCOUTT Facilitation Call	1st Wednesday @ 12:00 PM	Join Microsoft Teams Meeting	Spencer.Calder@va.gov
MAT – VA/SUD Journal Club Webinar	3rd and 4th Wednesdays @ 12:00 PM	https://veteransaffairs.webex.com/veteransaffairs/j.php?MTID=m19c6fa3d6b5dc83a81afae3d77d4c2c8	Spencer.Calder@va.gov
SSVF-SUD Provider Meeting	4th Thursday @ 1:00 PM	**Join the Microsoft Teams Meeting**	Alan.Haras@va.gov Leah.Ingraham@va.gov

Update SUD Treatment Locator

- Encourage program managers within your VISN to review the program information currently listed in the [Substance Use Disorder (SUD) Program - Locations (va.gov)]
- Please provide updates on type of treatments offered, POCs, and contact information to VHASUDProgramLocator@va.gov. Congress is checking the locator for accuracy-likely on behalf of Veterans and family members in their districts/states who may need this information for resource purposes



Resources

- VA Substance Use Disorder (SUD) Resources
  - VA-DoD Clinical Practice Guidelines for the Management of SUD: www.healthquality.va.gov/guidelines/MH/sud/
  - SUD SharePoint: dvagov.sharepoint.com/sites/VHASUD/
  - SUD Internet site: www.mentalhealth.va.gov/substance-abuse/index.asp
  - SUD Program Locator: https://www.va.gov/directory/guide/SUD.asp
  - SCOUTT SharePoint: dvagov.sharepoint.com/sites/VHASUD/SCOUTT
  - VA Academic Detailing Resources: dvagov.sharepoint.com/sites/vhaacademicdetailing/
    - Alcohol Use Disorder (AUD): dvagov.sharepoint.com/sites/vhaacademicdetailing/SitePages/AUD.aspx
    - Opioid Use Disorder (OUD): dvagov.sharepoint.com/sites/vhaacademicdetailing/SitePages/OUD.aspx
    - Opioid Overdose Education and Naloxone Distribution (OEND): dvagov.sharepoint.com/sites/vhaacademicdetailing/SitePages/OEND.aspx

  Evidence-Based Psychotherapy:
  - Behavioral Couples Therapy for SUD: dvagov.sharepoint.com/sites/VACOMentalHealth/bct-sud/SitePages/Home.aspx
    - Motivational Interviewing and Motivational Enhancement Therapy: dvagov.sharepoint.com/sites/VACOMentalHealth/MI/SitePages/Home.aspx
    - Cognitive Behavioral Therapy for SUD: dvagov.sharepoint.com/sites/VACOMentalHealth/cbt-sud/SitePages/Home.aspx
  - Tobacco & Health SharePoint: https://dvagov.sharepoint.com/sites/VHAtobacco/SitePages/Home.aspx
  - Measurement-Based Care (MBC) SharePoint: Measurement Based Care in Mental Health - Home (sharepoint.com)

  External SUD resources
  - SAMHSA TAP 32 Clinical Drug Testing in Primary Care: TAP 32: Clinical Drug Testing in Primary Care | SAMHSA
  - Information on Drug Classes: www.nida.nih.gov; https://www.dea.gov/factsheets

  VA Dashboards
  - Stratification Tool for Opioid Risk Mitigation (STORM): https://dvagov.sharepoint.com/sites/VHAPERC/Reports/SitePages/STORM_home.aspx
  - Suicide Prevention Population Risk Identification and Tracking for Exigencies (SPPRITE): https://dvagov.sharepoint.com/sites/VHAPERC/Reports/SitePages/SPPRITE_home.aspx

OMH SUD Virtual Conference Series for FY2025

Anticipated Date	Topic
April 21st	Women Veterans and SUD
June 4th	Measurement-Based Care
August 27th	Overdose Awareness, Education, Prevention, and Response
September 25th	SUD and Suicide Prevention

- Half-day virtual trainings scheduled over the course of the year
- Attendees need to register for each webinar separately
- Also planning an MI Education Course
- Questions? Contact VHACOSUDProgram@va.gov

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Mental Health

SUD and BHIP: Providing Collaborative and Continuous Care

Andrea Rehmert, PhD
Special Assignment, National BHIP Program
Office of Mental Health

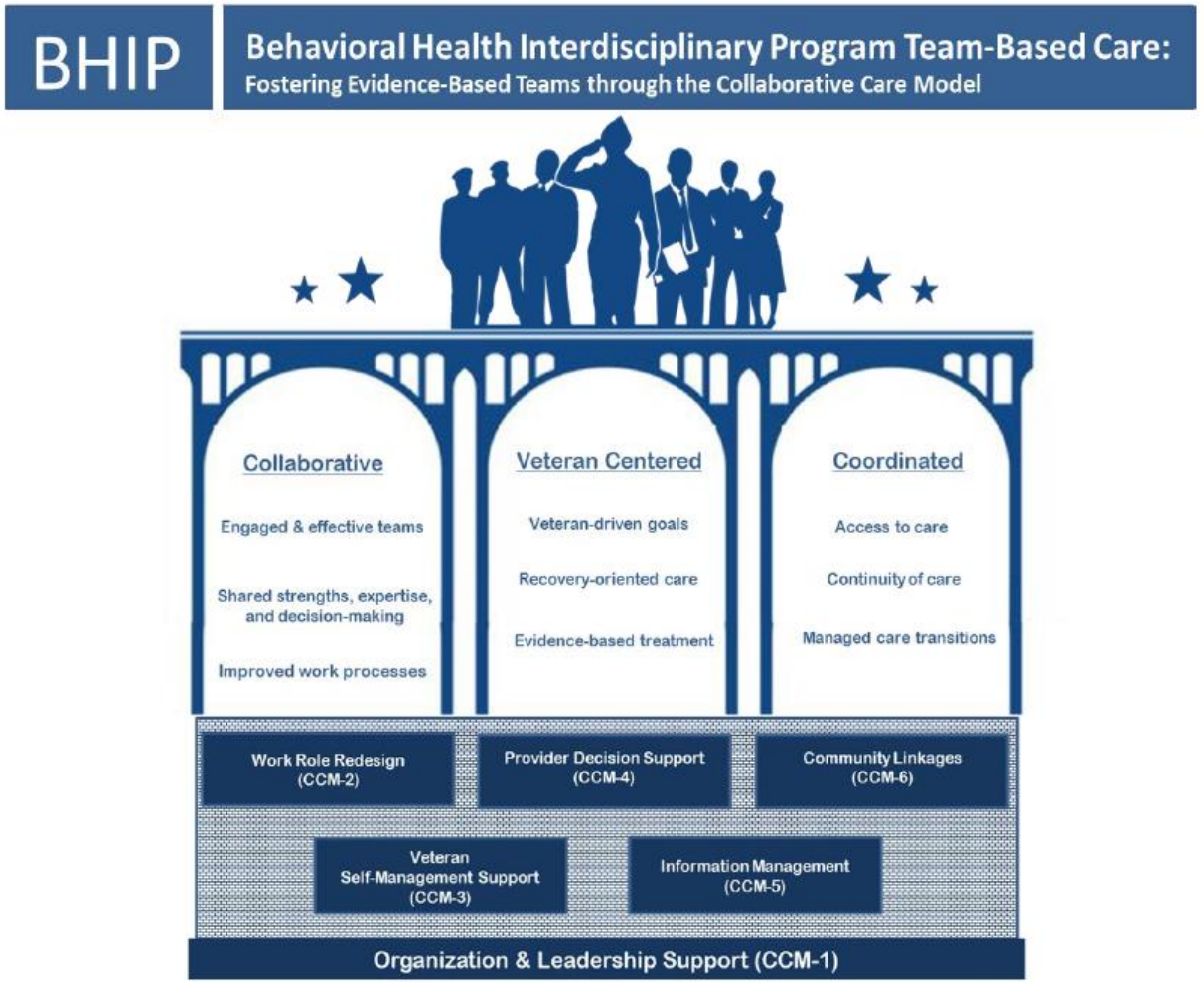
Ari –Lev Lowell, PhD
BHIP Program Manager
West Texas VA Healthcare System

February 27, 2025

What is BHIP?

Behavioral Health Interdisciplinary Program

- Interdisciplinary team of outpatient mental health (MH) providers and administrative support staff
  - Focus on team-based care
  - Practice closer to top of license/scope
  - Dedicate time for indirect patient care activities
- Providing care for a specific group of Veterans
  - Providing timely access to proactive, comprehensive, Veteran-centered, evidence-based care
  - Measuring progress & outcomes (Measurement-Based Care/MBC) and focusing on continuous improvement (Veteran and team)
  - Coordinating care within and across BHIP teams, MH service, & beyond



What is Collaborative Chronic Care Model (CCM)?

- CCMs provide an evidence-based model of organizing mental health care
- BHIP teams have been restructured according to the CCM elements
- CCM principles have been shown to:
  - Reduce rate of mental health hospitalizations
  - Improve mental health status for Veterans with multiple mental health conditions
  - Improve clinician team function in terms of clarity of team member roles and prioritization of team over individual goals

CCM Goal: Anticipatory, Continuous, Evidence-Based, Collaborative Care via…				
CCM-2: Work Role Redesign	**CCM-3: Veteran Self-Management Support**	**CCM-4: Provider Decision Support**	**CCM-5: Information Management**	**CCM-6: Community Linkages**
• Care management • Need-driven access • Activated follow-up	• Focus on the individual's values and skills • Shared decision-making • Self-mgt skills • Recovery-orientation	• Provider education • Practice guidelines • Specialty consultation	*Population*: • Registry *Provider:* • Feedback *Patient:* • Outcome tracking • Measurement-based care	• Additional resources • Peer-based support
CCM-1: Organizational Leadership and Support				

BHIP Staffing Ratios

Employee Category	Recommended Minimum FTEE for Mental Health Team Panel Size of 1,000
Total MH Clinician: Licensed Independent Providers (LIPs) and Advanced Practice Providers	6.0 (e.g., pharmacotherapy & psychotherapy providers for the full range of disorders, with specialty/expertise in mood disorders, PTSD and other anxiety disorders, SUD, SMI, pain management, medical issues, etc.)
Administrative Support	1 (e.g., medical support assistant, program support assistant)
Non-LIPs	1 (e.g., nurse, peer support specialist, addiction therapist)
Care Coordination/MHTC 2.0	1 (e.g., RN/SW/LPMHC care coordinator)
Total FTEE (minimum)	**9.0 (8.0 clinical)**

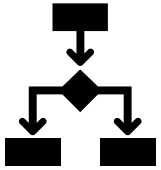
- Consistent with overall recommended minimum staffing of 7.72/1000
- Recommended BHIP have a total panel size of 1,000 Veterans, and the ratio of medical providers to therapists is 1:2, so 2 medical providers and 4 therapists per team

Expected Outcomes Based on the Literature

- Higher levels of MH staffing have been associated with **decreased suicidal behavior** among patients within a health care system.[1-3]
- In VHA specifically, a 1% increase in mental health staffing led to a **1.6% reduction in suicide-related events** overall, with the greatest effects (a 2.6% reduction in suicide-related events) seen in VHA facilities in the bottom third of staffing level.[3]

***Structure*: Staffing**

- Increase in VA mental health capacity
- Decreased staff turnover in foundational services, like BHIP



***Process:* CCM**

- Increase in standardized processes that promote maximal efficiencies within the team

Outcomes

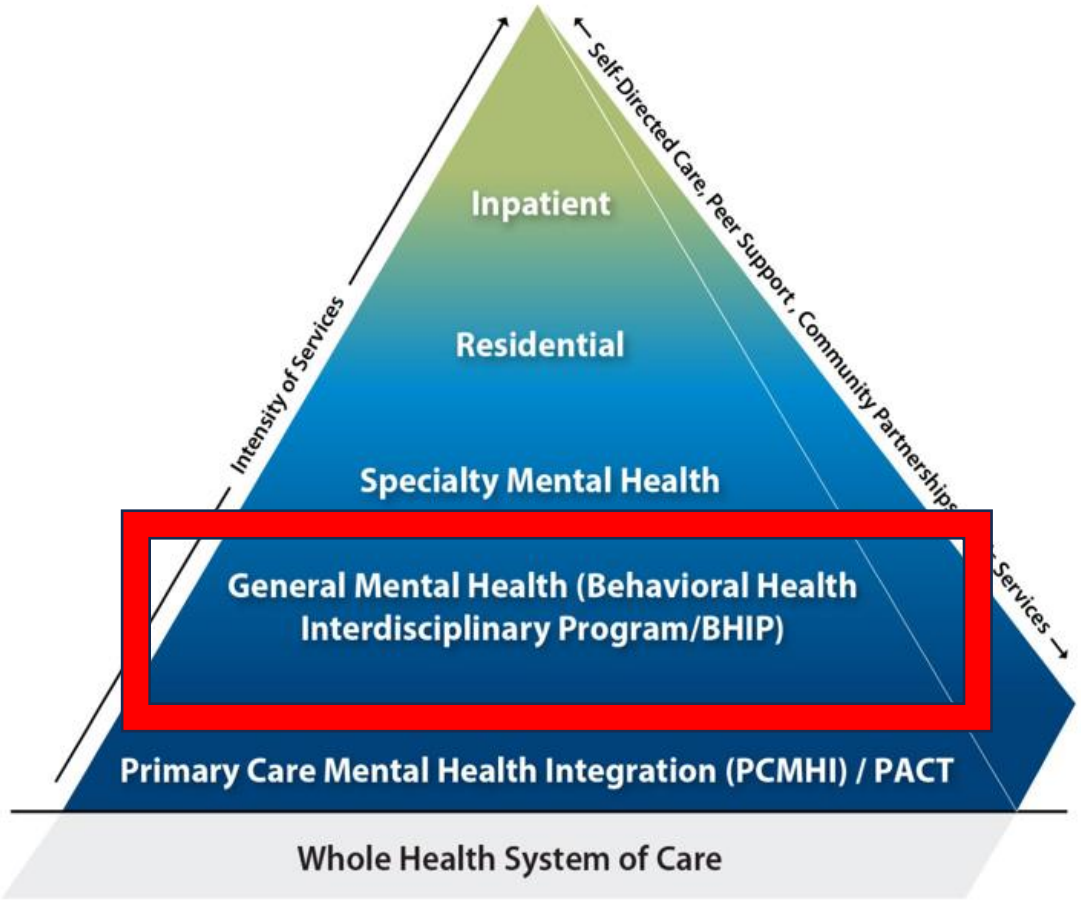
- Increased access and quality
- Decreased suicide rates

PEC Portal - Staff and Productivity (sharepoint.com)

Slide credit: Dr. Kendra Weaver and Dr. Lauren Sippel

BHIP on the Continuum of Care

- Per VHA Directive 1160.01 – "**Every VA medical facility is required to implement BHIP care.** Full implementation means each BHIP team must incorporate the evidence based Collaborative Chronic Care Model (CCM) as the practice model and be staffed to serve approximately 1,000 GMH unique Veterans."
- BHIP teams are the 'home' for all mental health patients whose mental health care needs cannot be managed in PACT or an integrated care setting.
- BHIP is crucial to the VA's stepped mental health continuum of care model



BHIP Care Coordinator/MHTC 2.0 Overview

Mental Health Treatment Coordinator (MHTC) – The MHTC is a Social Worker, Registered Nurse, or Licensed Professional Mental Health Counselor embedded within a Behavioral health Interdisciplinary Program (BHIP) team specifically tasked to provide care coordination for the Veterans assigned to that BHIP team. The primary role of the MHTC is care coordination and proactive population management, not direct care provision (e.g., ongoing psychotherapy). The MHTC serves as a point of contact (POC) for Veterans receiving mental health care and provides needed care coordination (and access to care management and case management when necessary), as needed, to promote care continuity across all MH services. All Veterans receiving outpatient mental health treatment services, other than brief consultation or care through providers in Patient-Aligned Care Teams (PACT), Primary Care-Mental Health Integration (PCMHI), or other integrated care settings should be assigned to a BHIP team home with an MHTC (with rare exceptions).

MHTC 2.0 Overview – Key Takeaways

- Care Coordination
- Transitions and Graduations
- Proactive Population Management
- Anticipating Needs
- Point of Contact
- Member of BHIP Team
- Care Continuity

Snapshot of BHIP Implementation Requirements: BHIP-CCM Enhancement

4b: Process Summary: Establish Times for Discussing Clinical Cases

Date:

Describe our process:

- Process for clinical meetings:
- Process for huddles:

Next review date:

4e: Process Summary: Establish Procedures for Anticipating Veterans' Clinical Needs

Date:

Describe our process:

Next review date:

4f: Process Summary: Establish Treatment Planning Procedures that Incorporate Veteran Goals

Date:

Describe our process:

Next review date:

5a: Process Summary: Establish Outpatient Liaison Procedures to Ensure Veteran Access to Needed Specialty Care

Date:

Describe our process:

Next review date:

5b: Process Summary: Establish Procedures for Liaison and Follow-up for Patients During Inpatient and MH Residential Admissions

Date:

Describe our process:

Next review date:

5c: Process Summary: Establish Procedures for Linking Veterans to Community Resources

Date:

Describe our process:

Next review date:

Current State of BHIP

- FY22 Memo – BHIP Expansion [2022 BHIP Memo Package Instructions (sharepoint.com)]
- 39.5% of sites have completed their BHIP-CCM 27 Processes and Implementation Checklist (55 out 139 sites).
- 43.91% of BHIP teams have an identified MHTC 2.0, which is equal to 472 BHIP Teams nationwide (increase of 12 teams from last month).

VISN -> Facility	# of Teams (in PCMM)	Recommended # of Teams (Attachment D)*	Difference
VISN 1	42	36.51	5.5
VISN 2	36	39.66	-3.7
VISN 4	52	42.17	9.8
VISN 5	33	30.03	3.0
VISN 6	87	61.48	25.5
VISN 7	88	70.44	17.6
VISN 8	83	90.57	-7.6
VISN 9	49	41.89	7.1
VISN 10	75	73.08	1.9
VISN 12	60	39.45	20.5
VISN 15	44	36.34	7.7
VISN 16	71	64.30	6.7
VISN 17	71	65.80	5.2
VISN 19	62	47.59	14.4
VISN 20	41	40.26	0.7
VISN 21	75	48.10	26.9
VISN 22	71	73.96	-3.0
VISN 23	40	48.33	-8.3
Total	**1080**	**949.96**	**130.0**

BHIP and SUD – Collaboration

- All Veterans receiving SUD level of care must have an MHTC 2.0 assignment on the BHIP Team.
- Level of care coordination is determined by treatment team and needs of the Veteran.
- SUD and BHIP must work together to provide highest quality care.
- Veterans can step down to BHIP or PACT once episode of care in SUD is complete.

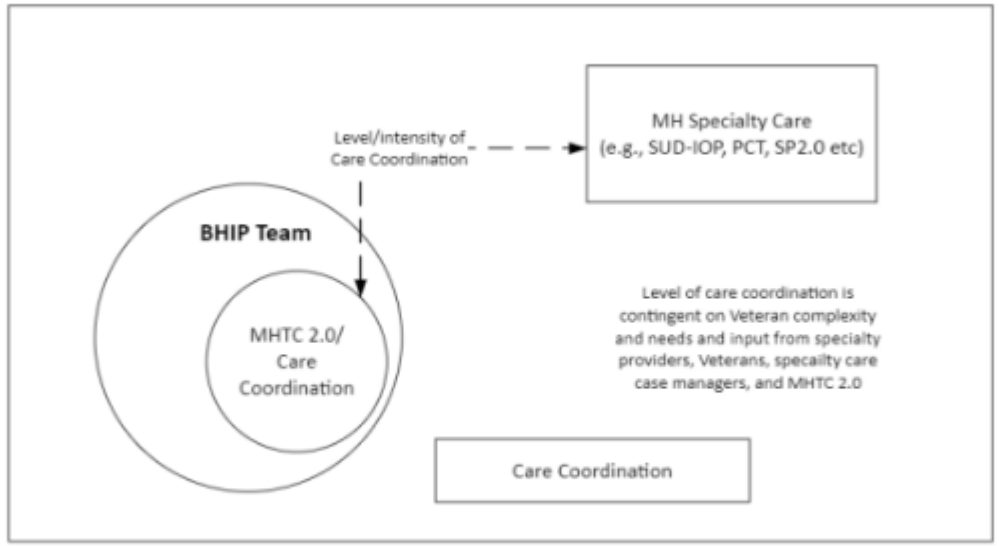
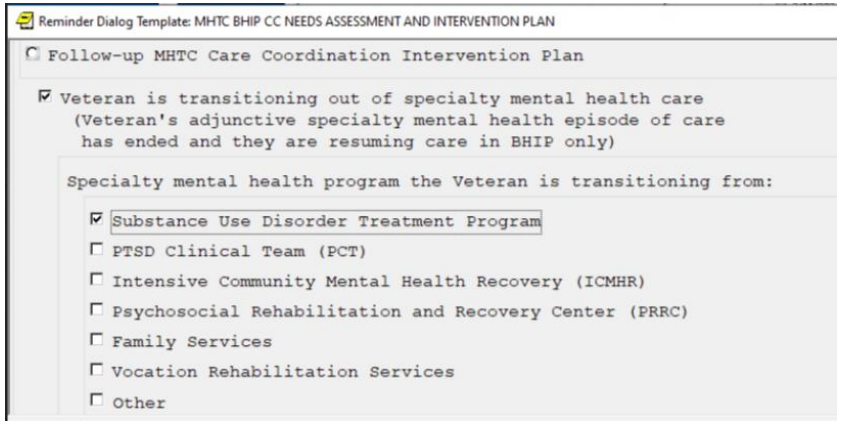
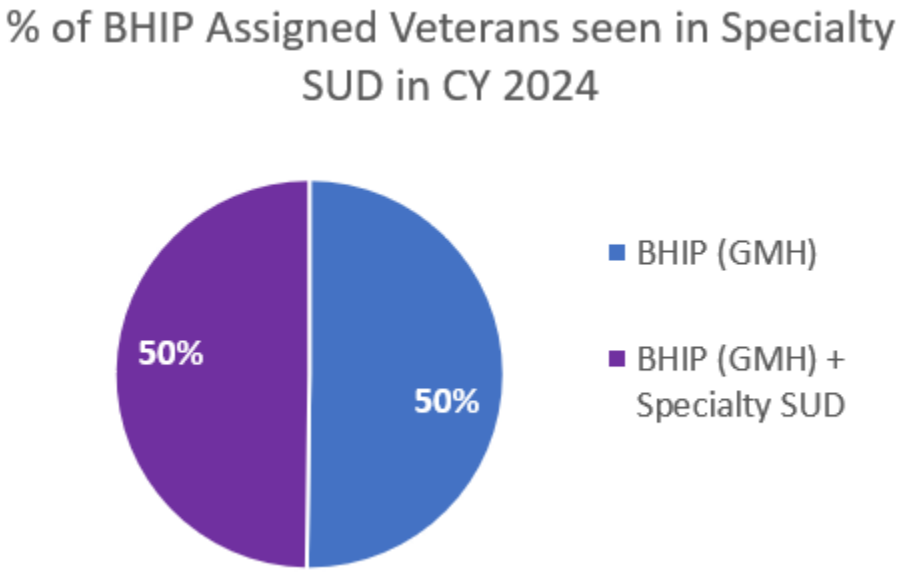


Figure 2. Graphic depiction of the relationship between the BHIP Team, MHTC, and specialty care program in terms of level and intensity of mental health care coordination that may occur when a Veteran is receiving an episode of care from a specialty care program.

BHIP and SUD – Data

- So far, since 4/12/2024, 61 Veterans have been transitioned back to BHIP from SUD specialty care.
- In calendar year 2024 (1/1/24 – 12/31/24):
  - 123,070 unique Veterans were seen last year in BHIP (GMH)
  - 61,800 Veterans had both a BHIP team assignment, at least one visit in BHIP (GMH), and at least one visit is SUD Specialty.



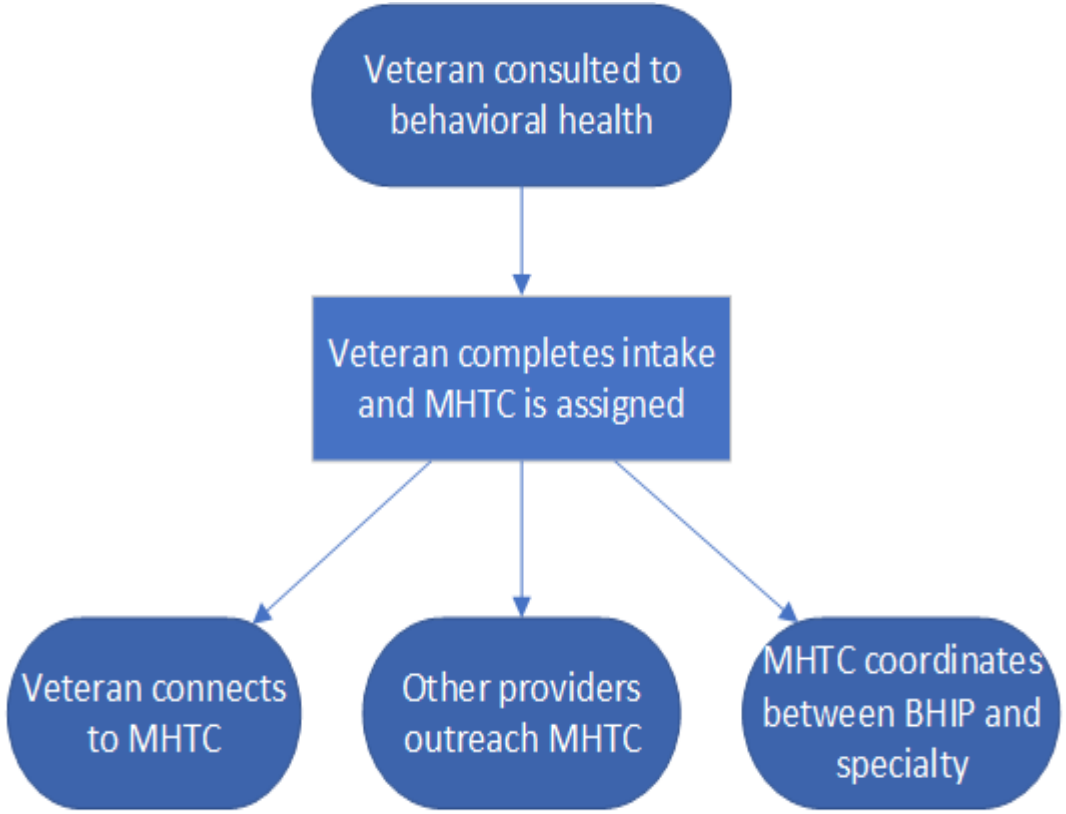


Data pulled by PERC Team on 2/10/25 from CDW

West Texas VA: MHTC role in care coordination

Our MHTCs play a pivotal role!

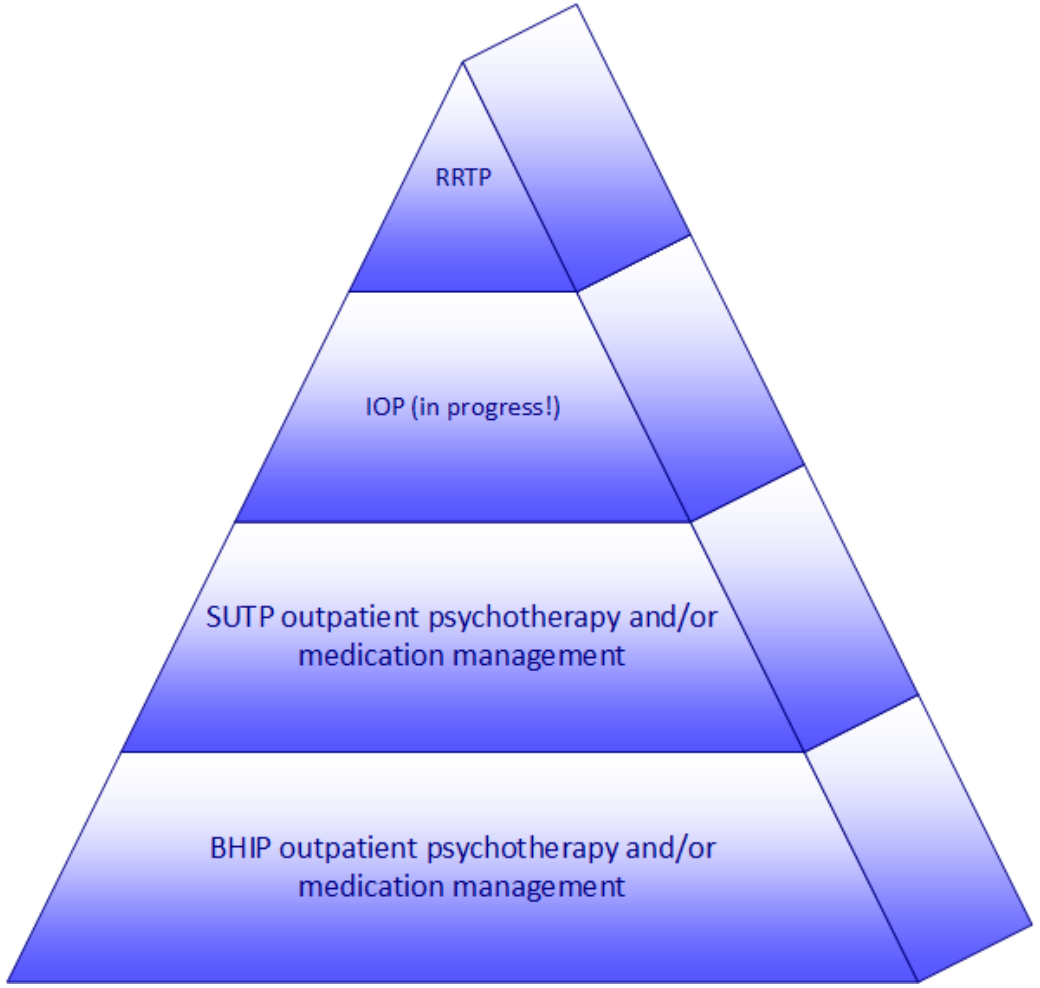
- MHTC are assigned during intake process (includes education and outreach)
- Care coordination can occur at multiple points
  - Direct communication between MHTC and veteran
  - BHIP team discussion
  - Another provider reaches out to MHTC
  - When veteran moves between different levels of care



West Texas VA: SUD treatment options

Veteran can move between levels depending on a number of factors including clinical acuity, access wait time, veteran preference, consolidation of care, etc.

MHTC is pivotal in this discussion!



West Texas VA: Care coordination between BHIP and SUD

- MHTCs are the primary liaisons between the teams
- SUTP and DOM representatives may be invited to BHIP team meetings
- Consults to SUTP/DOM may be placed from within BHIP (or from PCMHI)
- SUTP may confer with BHIP regarding transfer back to BHIP at any time, and/or can always refer to groups or other services for concurrent treatment
- MHTC is involved in discharge planning for DOM patients

Dedicated monthly meeting: "FLOW and Care coordination." Stakeholders of all teams are present and we work collaboratively to improve and update processes, as well as address any current issues. Many improvements have come out of this meeting!

The End!

- Questions?
- OMH BHIP-CCM Help Desk

VA | U.S. Department of Veterans Affairs

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Mental Health

Utilization of Peer Specialists in SUD Programs

Susan Lee, CPS

Erik Ontiveros, CPS

Patricia Sweeney, PsyD

February 27, 2025

Who are Peer Specialists in VHA?

- The peer specialist profession is a mental health care profession within VHA, not a program, and like other mental health professional disciplines, is dispersed throughout VHA services across the enterprise.

- Peer specialists are Veterans with other than dishonorable discharge who meet the 38 U.S. Code § 101 definition of Veteran.

- Peer specialists self-identify with living in recovery from a mental illness and/or substance use disorder for at least one year at the time of hiring. For this qualification requirement, "Successful recovery is exemplified by one who manages symptoms of illness and pursues a healthy lifestyle; lives independently; is employed or volunteers significant time approximating at least a part-time employment schedule; has meaningful relationships with family members and friends; and is socially involved in their community through clubs, hobby groups, civic organizations, or Veteran organizations in which the individual provides a service to others" (VHA Peer Support Services Toolkit, p. 23).

- They have prior experience through employment and/or volunteer work to meet the specialized experience requirement (ex. GS-6 peer specialist qualification =1 year/2,000 hours of specialized experience in a peer support service helping role).

- Peer specialists have obtained their full, current, and unrestricted VHA-approved peer specialist certification prior to their employment which they are required to maintain in order to remain employed in the peer specialist profession in VHA.

- Examples of topics covered in training courses for peer specialist certification:
  - ✓ How to effectively share one's personal recovery story
  - ✓ Effective communication skills
  - ✓ Advocacy skills
  - ✓ Group facilitation
  - ✓ Cultural competence
  - ✓ Crisis prevention and intervention

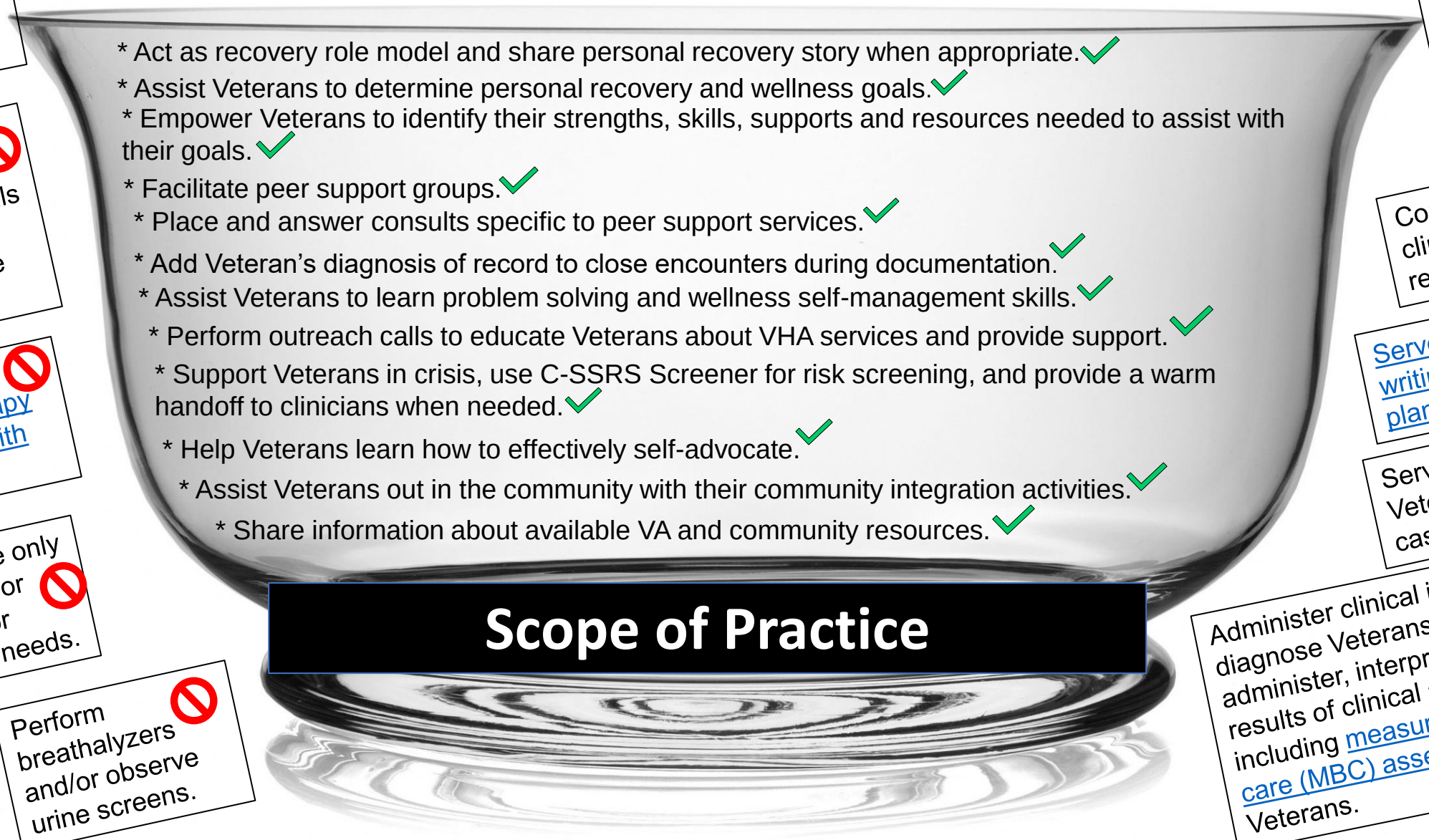
VA Peer Support
The Road to Recovery

VHA National Standards of Practice for Peer Specialists

- Assist Veterans to explore, identify, and make progress on their self-directed personal recovery and wellness goals.
- Be role models and share elements of their personal experience, including their recovery stories, coping techniques, and self-help strategies to be of service to others.
- Collaborate with Veterans and their treatment providers to identify and cultivate Veterans' skills and strengths that support their recovery goals.
- Help Veterans to learn new coping skills and self-help strategies to overcome fears and barriers that could inhibit the Veteran's personal recovery. This does not include facilitating psychotherapy protocols.
- Advocate for Veterans when needed and support Veterans in learning to self-advocate for their own needs and interests.
- Support Veterans in distress and collaborate with colleagues to connect Veterans with clinical providers' services and community services when needed.
- Assist Veterans to connect to available VA and community resources, including conducting outreach calls to educate and engage Veterans to connect with available VA services.
- Facilitate peer support groups as well as co-facilitate with clinicians other types of health and personal wellness groups. This does not include facilitating or co-facilitating psychotherapy groups.
- Assist Veterans with integration activities into their community, as consistent with Veterans' stated goals.

Note: When finalized, the national practice standards for peer specialists will be published as an appendix of VHA Directive 1900, VA National Standards of Practice. For further information, please refer to the VA National Standards of Practice SharePoint.

Scope of Practice for All Peer Specialists in VHA



* Act as recovery role model and share personal recovery story when appropriate.
* Assist Veterans to determine personal recovery and wellness goals.
* Empower Veterans to identify their strengths, skills, supports and resources needed to assist with their goals.
* Facilitate peer support groups.
* Place and answer consults specific to peer support services.
* Add Veteran's diagnosis of record to close encounters during documentation.
* Assist Veterans to learn problem solving and wellness self-management skills.
* Perform outreach calls to educate Veterans about VHA services and provide support.
* Support Veterans in crisis, use C-SSRS Screener for risk screening, and provide a warm handoff to clinicians when needed.
* Help Veterans learn how to effectively self-advocate.
* Assist Veterans out in the community with their community integration activities.
* Share information about available VA and community resources.

Scope of Practice

Place or answer consults for clinical services or equipment.

Complete required outreach calls for SMI Re-Engage Program.

Facilitate psychotherapy protocols with Veterans.

Serve as the only staff driver for Veterans' or program's needs.

Perform breathalyzers and/or observe urine screens.

Serve as the only or primary VHA health care professional providing health care services for any Veteran.

Complete clinical reminders.

Serve as lead in writing treatment plans.

Serve as a Veteran's case manager.

Administer clinical intakes, diagnose Veterans, and/or administer, interpret, or review results of clinical assessments, including measurement-based care (MBC) assessments, with Veterans.

Peer Specialist Role Do's and Don'ts During Transitions of Care

Do's	Don'ts
Peer specialists work as fully integrated members of interdisciplinary health care service teams.	Peer specialists cannot serve as the primary or only VHA health care professional providing health care services for any Veteran. If a Veteran wants to receive peer support services during a transition from completing clinical interventions in a treatment program, the Veteran must have clinical providers who are also continuing to be involved in the Veteran's care.
Peer specialists add a peer support service goal to a Veteran's existing treatment plan.	Peer specialists do not create a new treatment plan.
Peer specialists can place and respond to consults specifically for peer support services.	Peer specialists cannot place or respond to consults for clinical services or equipment in Veterans' electronic health records. If a peer specialist is assisting a Veteran who needs a consult for a clinical service or equipment, the peer specialist needs to coordinate with other members of the Veteran's health care service team to ensure that clinicians on the team have the information they need to place the consult for clinical services/equipment.
Peer specialists accept wherever a Veteran is at and start from there in assisting the Veteran to work on goals that the Veteran has identified and prioritized for themselves.	Peer support service interventions are not intended to be directive nor have a targeted goal to shape a Veteran's behavior in a particular way which some other types of interventions (ex. contingency management) strive to do.
The goal for peer support services must be specific and time-limited to address the current episode of care.	Providing a Veteran with "ongoing support" is not an appropriate goal for peer support services.

Peer Specialists and Naloxone

Below is the information about the OMH Peer Support Services Section's current position on whether peer specialists can carry naloxone for emergencies in their work with Veterans. It can be found in the FAQ about scope of practice which is located in the Frequently Asked Questions section of the VHA Peer Support Services SharePoint.

Can VHA peer support staff members carry naloxone as part of their work in case it is needed to help a Veteran?

No, not yet. The VHA Office of Mental Health Peer Support Services Section has received several questions about whether peer specialists can carry naloxone as part of their work to be able to assist a Veteran in the event of a potential overdose. The March 14, 2023 VHA Peer Specialist Webinar Series presentation addressed this topic. The OMH Peer Support Services Section is supportive of peer specialists being permitted to receive appropriate training and be able to carry naloxone only AFTER the national policy is published regarding non-licensed health care professionals being permitted to receive the relevant training and carry naloxone when appropriate and needed for their program work assignment (ex. community work in HUD-VASH). Dr. Elizabeth Oliva, the VHA National Opioid Overdose Education and Naloxone Distribution (OEND) Coordinator, and other colleagues are currently working to finalize and then publish VHA Directive 1651, the national directive pertaining to naloxone carrying.

Right now, peer specialists cannot carry naloxone as part of their work as peer specialists in VHA, but they will be permitted to carry naloxone only AFTER VHA Directive 1651, the national policy about naloxone carrying, is published and also only AFTER the peer specialists receive the needed training for carrying naloxone. The trainings that need to be completed will be indicated by Dr. Oliva's office when the national directive is published. Please note that staff members must not share their own personal prescription for naloxone with Veterans during the course of the staff member's work with the Veterans. VHA leadership does not approve this practice for staff. The anticipated publication date of VHA Directive 1651 is not yet known but is anticipated to occur near the end of 2025. For questions about national policies pertaining to naloxone, please contact Dr. Elizabeth Oliva at Elizabeth.Oliva@va.gov.

Peer Specialists and Syringe Services Programs (SSPs)

- Peer specialists can be involved in sharing information with Veterans about what the SSP is about and how Veterans can connect with the SSP.

- Peer specialists can also support Veterans to connect with staff involved with the SSP who can assist the Veterans further.

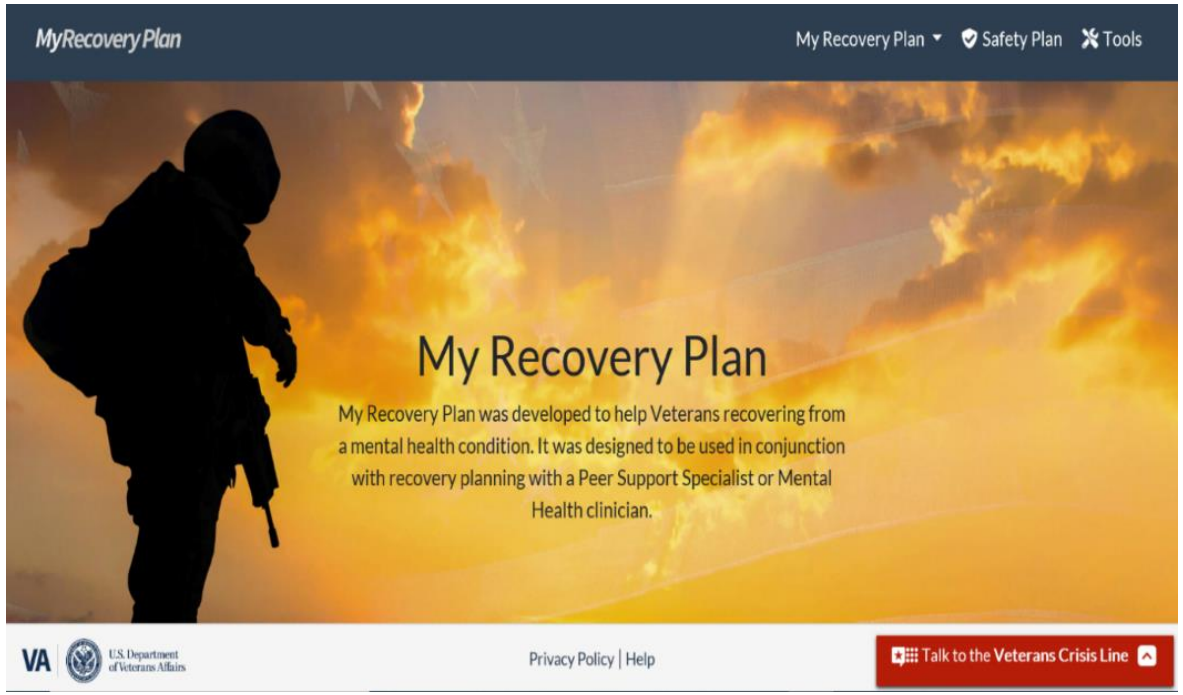
- With that said, peer specialists should not be involved in disseminating the syringes themselves for two reasons:

    1. It is outside of the training and scope of practice for peer specialists to answer technical questions that Veterans may have about using the syringes.

    2. Some peer specialists have used syringes as part of their past drug use and may potentially be triggered in being asked to handle dissemination of syringes for the SSP.

Examples of Approved Interventions Peer Specialists Use

- Share relevant aspects of their personal recovery story where appropriate—Expected of all peer support staff
- Wellness Recovery Action Plan (WRAP)
- Veteran X and Veteran Hope
- Honest Open Proud (HOP)
- Illness Management and Recovery (IMR)
- Social Skills Training
- Whole Health Tool:
  - Mission Aspiration or Purpose (MAP) and
  - Personal Health Inventory (PHI)
- Whole Health Groups:
  - Introduction to Whole Health
  - Taking Charge of My Life and Health
- Motivational Interviewing (MI)
- SMART Recovery
- VOICES Veterans Socials



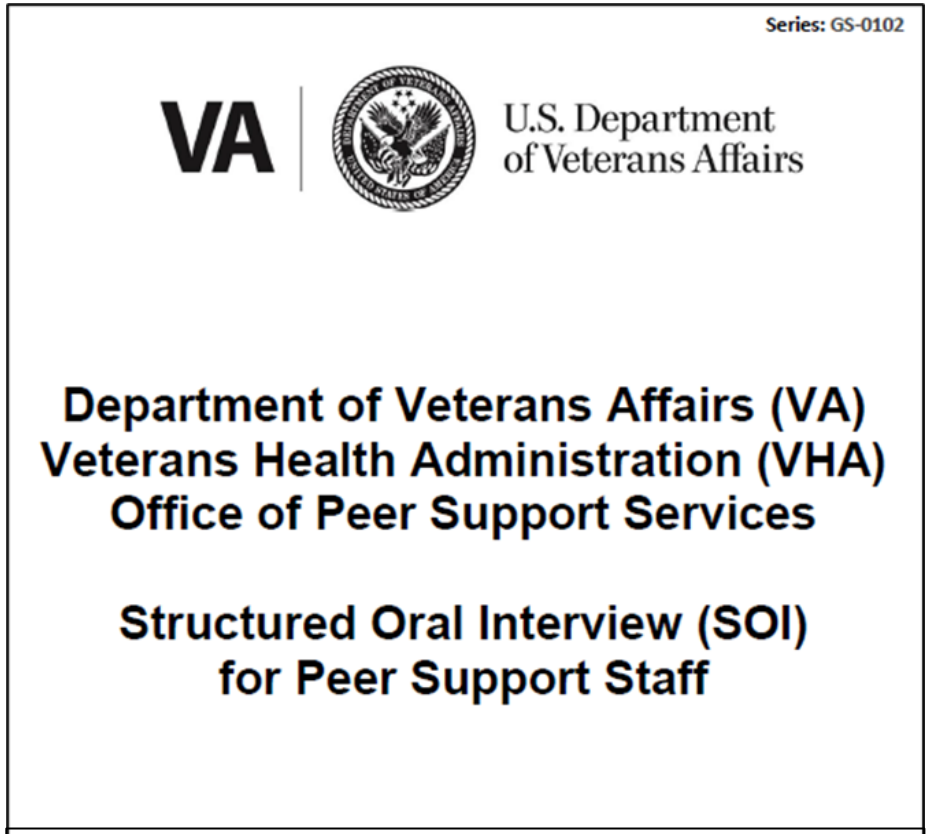
My Recovery Plan

Examples of Peer Specialists' Interventions for Veterans with Substance Use Disorders: Sue & Erik

Resources

Resources Related to Hiring Peer Support Staff

- Human Resources Guide
- Nationally standardized position descriptions:
  - Facility-based peer support staff PDs
  - Community-based peer support staff PDs
- Qualification standards* (Revision in development)
- Condition of Employment Form


Series: GS-0102

VA | U.S. Department of Veterans Affairs

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Office of Peer Support Services

Structured Oral Interview (SOI)
for Peer Support Staff

The Structured Oral Interview Guide is in the Human Resources section of the VHA Peer Support Services SharePoint and is accessible only to peer support supervisors who are part of the VHAPeerSupervisors@va.gov mail group.

Accepted Peer Specialist Certifications in VHA

Applicants not already onboard as peer specialists in VHA on August 1, 2022 must have the required **full, current, and unrestricted** peer specialist certification from one of the following sources to qualify:

1. The peer specialist certification training course and exam provided to peer support staff members by one of the VHA OMH-contracted peer specialist certification training vendors.
2. State-issued peer specialist certification that is active and maintained based on the specific state requirements. State-issued peer specialist certifications that VHA accepts are listed in the VHA-Approved Peer Specialist Certifications Guide. **Note: Provisional (temporary) state-issued peer specialist certifications do not meet VHA's peer specialist certification requirement. Veterans with provisional state-issued peer specialist certifications can only be hired as GS-5 peer support apprentices.**
3. *Certificate from the Depression Bipolar Support Alliance (DBSA) Peer Support Specialist Course (74-hour course) offered to the general public that was completed prior to August 1, 2022.
4. *Certificate from Recovery Innovations International (RI International or RI Consulting) Certified Peer Support Specialist Training also known as Peer Employment Training (approximately 72-hour course) offered to the general public that was completed prior to August 1, 2022.

*Effective August 1, 2022: Peer specialist certification training certificates showing a completion date after August 1, 2022 from DBSA's and RI International's peer specialist certification training courses offered to the general public will not be sufficient to meet the VHA peer specialist certification requirement. Applicants with either of these training certificates will also need to complete the additional steps required to obtain a state-issued peer specialist certification to qualify for employment as a peer specialist in VHA.

Condition of Employment Form

Condition of Employment Form for GS-5 Peer Support Apprentices

CONDITION OF EMPLOYMENT FOR PEER SUPPORT APPRENTICE

I, (Name), understand that I am being appointed as a Peer Support Apprentice under the condition that I obtain the required VA-approved peer specialist certification not later than (Date). Upon acquiring the VA-approved peer specialist certification, I understand that I must provide evidence of the peer specialist certification as described in the VA qualification standard for Peer Support Apprentice/Peer Specialist to officials of the Department of Veterans Affairs facility, (VA Facility). I understand that failure to become so certified in the specified time frame and to provide documentation of the VA-approved peer specialist certification may result in the termination of my employment. I also acknowledge that obtaining a VA-approved peer specialist certification is required for consideration for appointment to a Peer Specialist position and that the peer specialist certification must be maintained (including recertification if applicable) as a condition of employment for Peer Specialists.

Employee Signature Date

Supervisor Signature Date

Condition of Employment Form for GS-6/7/8/9 Peer Specialists, GS-10 Lead Peer Specialists, and GS-11 Supervisory Peer Specialists

CONDITION OF EMPLOYMENT FOR PEER SPECIALISTS, LEAD PEER SPECIALISTS, AND SUPERVISORY PEER SPECIALISTS

I, (Name), understand that I am being appointed as a Peer Specialist under the condition that I provide evidence of having a VA-approved peer specialist certification as described in the VA qualification standard for Peer Specialist to officials of the Department of Veterans Affairs facility, (VA Facility).

I acknowledge that the VA-approved peer specialist certification is required for consideration for appointment to a Peer Specialist position and that the VA-approved peer specialist certification must be maintained (including recertification if applicable) as a condition of employment. I understand that failure to provide documentation of a current VA-approved peer specialist certification may result in the termination of my employment.

Employee Signature (Date)

Supervisor Signature (Date)

Condition of Employment Forms

The purpose of the Condition of Employment Form is to document understanding of the peer support staff member's responsibility to first obtain and then maintain a VHA-approved peer specialist certification over time to remain employed. This form must be reviewed with the peer support staff member and signed as soon as the new peer support staff member is onboarded. The signed copy must be entered into the peer support staff member's employment file.

VHA-Contracted Peer Specialist Certification Course & Exam for GS-5 Peer Support Apprentices

- The peer specialist certification is critical, time-sensitive and mandated by law as a requirement for employment as a peer specialist in VHA.
- To register GS-5 peer support apprentices for the VHA-contracted peer specialist certification training course and certification exam, the peer support supervisor must send the following information to Rachel Breauchy, the ILEAD Project Manager (Rachel.Breauchy@va.gov), and Suzan Hoopengarner (Suzan.Hoopengarner@va.gov) for registration to occur in a timely manner:

1. Full name of the peer support apprentice
2. VISN number and facility name
3. Hire and expiration dates of appointment for the peer support apprentice
4. Full phone number (including area code) for the peer support apprentice
5. Best mailing address for the peer support apprentice to receive the materials
6. Email address for the peer support apprentice
7. Peer support supervisor's full name and email address

VHA-Contracted PS Certification Benefits

- ✓ Free tuition; content specific to VHA
- ✓ No certification renewal requirement (just need to meet VHA 12 hours per year continuing ed. requirements)
- ✓ Can move to another peer specialist role in VHA in another state and maintain the peer specialist certification (no in-state residency requirement).

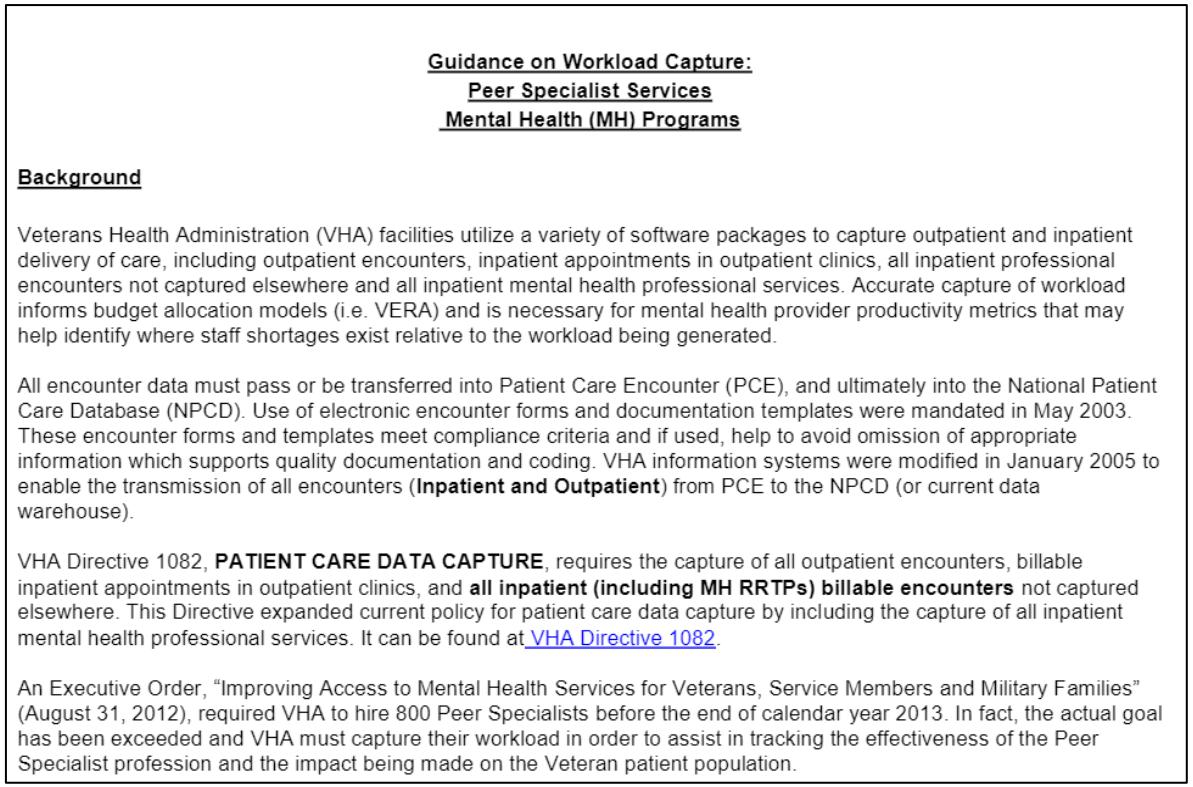
- Selected peer support apprentices and the peer support supervisors will be notified via email confirming the registration acceptance and the start date of the training course.
- Peer support supervisors must ensure that the peer support apprentice has protected time to focus solely on this training course and certification exam.
- While the Office of Mental Health funds the registration cost, the local facility provides the travel funding for the peer support apprentice to attend the VHA-contracted peer specialist certification training course and certification exam.

FYI about Recommended Content in Peer Specialist's First Meeting with Veterans

Joint Commission and other external reviewers ask how the informed consent process works for Veterans to determine whether they want to work with a peer specialist. This is handled in the first meeting that a peer support apprentice or peer specialist has with a Veteran as they discuss the Veteran's goals and reason for referral to work with the peer support staff member.

- The peer support staff member explains to the Veteran that the peer support staff member is a full member of the interdisciplinary treatment team in the program(s) where they are assigned to work.
- The peer support staff member informs the Veteran that, if the Veteran chooses to work with the peer support staff member, the peer support staff member will have access to the Veteran's electronic health record and will need to add the goal for peer support services to the Veteran's existing treatment plan as per the policy guidance in VHA Peer Support Services SharePoint - Guidance about Peer Specialists and Mental Health Suite 3-29-22.pdf - All Documents.
- The peer support staff member also explains the limits of confidentiality and that the peer support staff member is required to document all of their work with the Veteran in the Veteran's electronic health record. Additionally, the peer support staff member explains that they will coordinate with the other members of the Veteran's treatment team to support the Veteran's interests and goals being served, so they will talk with other members of the treatment team about the Veteran when needed to achieve these objectives.
- After hearing all of this in the first meeting, if the Veteran agrees to work with the peer support staff member going forward, then the Veteran has made an informed decision and agrees to the peer support staff member accessing needed information about the Veteran to be able to provide peer support services to the Veteran in an effective manner.
- The peer support staff member documents this discussion in the Veteran's electronic health record.

Peer Specialist Documentation Information



Guidance on Workload Capture:
Peer Specialist Services
Mental Health (MH) Programs

Background

Veterans Health Administration (VHA) 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. Accurate capture of workload informs budget allocation models (i.e. VERA) and is necessary for mental health provider productivity metrics that may help identify where staff shortages exist relative to the workload being generated.

All encounter data must pass or be transferred into Patient Care Encounter (PCE), and ultimately into the National Patient Care Database (NPCD). Use of electronic encounter forms and documentation templates were mandated in May 2003. These encounter forms and templates meet compliance criteria and if used, help to avoid omission of appropriate information which supports quality documentation and coding. VHA information systems were modified in January 2005 to enable the transmission of all encounters (**Inpatient and Outpatient**) from PCE to the NPCD (or current data warehouse).

VHA Directive 1082, **PATIENT CARE DATA CAPTURE**, requires the capture of all outpatient encounters, billable inpatient appointments in outpatient clinics, and **all inpatient (including MH RRTPs) billable encounters** not captured elsewhere. This Directive expanded current policy for patient care data capture by including the capture of all inpatient mental health professional services. It can be found at VHA Directive 1082.

An Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members and Military Families" (August 31, 2012), required VHA to hire 800 Peer Specialists before the end of calendar year 2013. In fact, the actual goal has been exceeded and VHA must capture their workload in order to assist in tracking the effectiveness of the Peer Specialist profession and the impact being made on the Veteran patient population.

Examples of progress notes are in the Documentation folder on the VHA Peer Support Services SharePoint. Clinic coding guidance for peer support staff's clinics can be found in the MH Coding Guidelines (sharepoint.com).

- VHA Directive 1163: All peer support staff must document their work with Veterans in the electronic health record (p. 73).
- Peer support staff's documentation does count toward VERA which is discussed in the MH Coding Guidelines.
- LP co-signature required for:
  - ✓ WOC peer support employees
  - ✓ GS-5 peer support apprentices
  - ✓ GS-6 peer specialists
  - ✓ GS-7,8,9 peer specialists: Co-signature is required during 1st year hired into peer specialist occupation in VHA at one of these GS levels. Afterward, it is a local facility decision whether the co-signature is required.
- **ALERT: As of May 6th, 2024, all peer support staff members use secondary stop code 183.** Please refer to the MH Coding Guidelines (sharepoint.com) for further details.

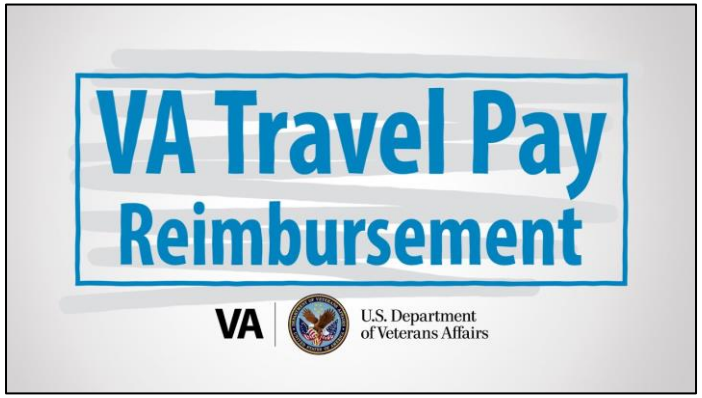
****ALERT: Peer specialists are NOT required to obtain a national provider identifier (NPI) number in order to document their work in CPRS or Cerner.** The NPI number is not needed for peer specialists. This has been verified with VHA national leadership. For further information, please refer to the response to Question #1 on pages 5-6 in the documentation section of the FAQs about Referrals, Clinic Coding, and Documentation.**

Supervision Requirements

- Supervision is required for all peer support staff members.
- Technical supervision of the peer support staff member's work with Veterans in a program must be provided by an appropriately credentialed health care professional (ex. licensed health care professional, GS-11 supervisory peer specialist, etc.).
- Technical supervision must be delivered in face-to-face individual supervision for a minimum of 1 hour per week for each GS-5 peer support apprentice and GS-6 peer specialist. The assigned supervisor must work on station with the peer support apprentices and GS-6 peer specialists.
- Technical supervision must be delivered in face-to-face individual supervision for a minimum of 1 hour per week for peer support technicians, GS-7/8/9 peer specialists, GS-10 lead peer specialists, and GS-11 supervisory peer specialists during their first year of entry into the peer specialist occupation in VHA and thereafter until the peer support staff member demonstrates the need for less frequent supervision based upon their experience and competencies.
- After their first year in the peer specialist occupation, at a minimum, technical supervision for the work of peer support technicians and peer specialists at the GS-7 level or above must be delivered in face-to-face individual supervision meetings no less than 1 hour per month.
- Group supervision, while encouraged as an additional resource for consultation and learning, does not substitute for the individual supervision requirement.
- In addition to the supervision meeting requirement, there must be an identified licensed practitioner who is available on-station for consultation when needed during the work hours of the paid peer support staff member or WOC peer support employee.
- If a peer specialist is teleworking for most of their schedule, face-to-face individual supervision must be delivered by one of the available video conferencing technologies (i.e., Microsoft Teams).
- Providing administrative supervision includes overseeing work schedules, leave requests, and performance appraisals for peer support staff members. Administrative supervision can be provided by the same supervisor who provides the technical supervision of the peer support staff member's work, or the administrative supervision can be provided by a different staff member who meets the requirements to serve as a supervisor of peer support staff.

FYI about Beneficiary Travel Pay for Peer Support Service Appointments

In the past few years, several peer specialists throughout VHA reported that Veterans experienced challenges in obtaining beneficiary travel pay for peer support service appointments. The Veterans Transportation Program within VHA Member Services sent the OMH Peer Support Services Section a message on 4/18/24 to verify that this issue is now resolved….

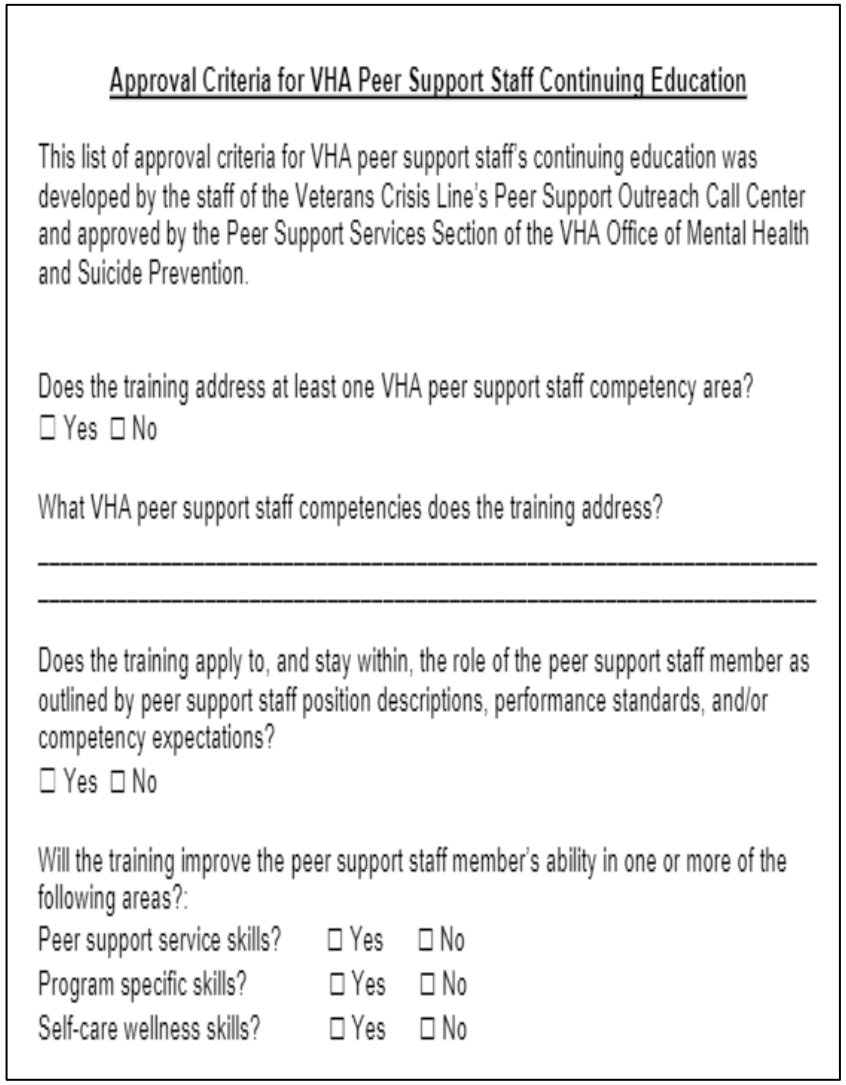


"On February 29, 2024, VHA's Healthcare Law Group ruled:

- "Peer specialists meet the Medical Benefits Package for healthcare professionals."
  - All peer support service appointments signed by peer specialists are eligible for beneficiary travel (BT) mileage, providing the Veteran meets BT eligibility. Unscheduled/walk-in appointments are paid one-way. Pre-scheduled appointments are paid round-trip.

- The Veteran Travel Program indicated that they are including this information in their updates for their VHA procedures guide for BT, and they are educating VISN and facility staff members involved with beneficiary travel approvals through their various national calls. Here is guidance that staff members can use when needed: (VAMC BT) Peer Support Services and Travel Benefits.

Education Information for Peer Specialists and Supervisors



Approval Criteria for VHA Peer Support Staff Continuing Education

This list of approval criteria for VHA peer support staff's continuing education was developed by the staff of the Veterans Crisis Line's Peer Support Outreach Call Center and approved by the Peer Support Services Section of the VHA Office of Mental Health and Suicide Prevention.

Does the training address at least one VHA peer support staff competency area?
☐ Yes ☐ No

What VHA peer support staff competencies does the training address?

_____

_____

Does the training apply to, and stay within, the role of the peer support staff member as outlined by peer support staff position descriptions, performance standards, and/or competency expectations?
☐ Yes ☐ No

Will the training improve the peer support staff member's ability in one or more of the following areas?:

Peer support service skills?	☐ Yes	☐ No
Program specific skills?	☐ Yes	☐ No
Self-care wellness skills?	☐ Yes	☐ No

VHA Peer Support Services Toolkit

- **VHA Directive 1163 Training Requirements for Peer Support Staff:**
  - ✓ Obtain required peer specialist certification
  - ✓ VHA requires minimum 12 hours of continuing education (CE) per year
  - ✓ State-certified peer specialists must meet state's requirements for certification renewal (fees, CE requirements, frequency of renewal) if applicable.

- **VHA-Approved Peer Specialist Certifications:**
  1. VHA OMH-funded training course for GS-5 peer support apprentices
  2. State-issued peer specialist certification:
     - ✓ Peer specialist certification focused on mental health for adults
     - ✓ Information usually found on state's website for Dept. of Mental Health, Dept. of Behavioral Health, or health care professional state credentialing board

- **CE-Accredited Webinar Series for Peer Support Staff and Peer Support Supervisors:**
  - ✓ **VHA Peer Specialist Webinar Series:** occurs bimonthly; Tuesdays from 2:00-3:30 PM ET
  - ✓ **VHA Peer Support Supervisor Webinar Series:** occurs quarterly; Wednesdays from 3:00-4:30 PM ET

Lists of Competencies

Archived Webinar Trainings

Communication System Related to Peer Support Services

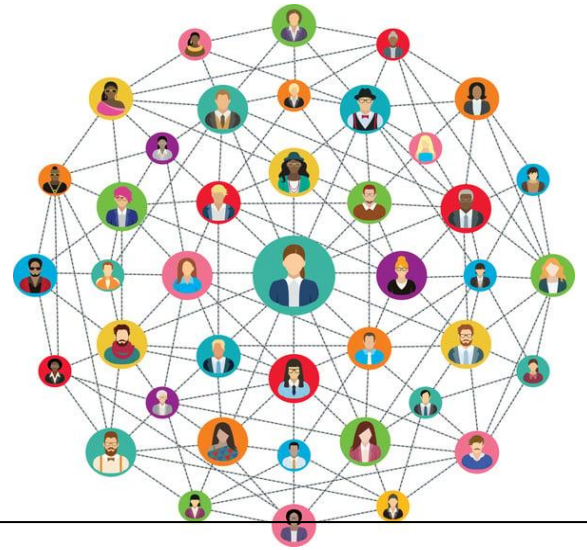
VISN Peer Support Points of Contact (POCs)

- VISN Peer Specialist(s) POC +
  VISN Peer Support Supervisor POC in each VISN
- Disseminate information between VHA OMH Peer Support Services Section and staff members working throughout the VISN
- Manage VISN-level mail group for peer support staff and peer support supervisors
- Answer questions, share national information, and facilitate conference calls with peer support staff members and peer support supervisors in the VISN.

List of VISN Peer Support POCs and
VISN Peer Support Mail Groups

National Mail Group for Peer Support Supervisors

- VHAPeerSupervisors@va.gov
- Peer support supervisors can be added to VHAPeerSupervisors@va.gov by contacting Suzan Hoopengarner who manages this national mail group: Suzan.Hoopengarner@va.gov



Additional Resources for Information

VHA Peer Support Services SharePoint:
VHA Peer Support Services SharePoint – Home

VHA Peer Support Services Toolkit:
VHA Peer Support Services SharePoint - VHA Peer Support Services Toolkit.pdf - All Documents

Answers to Frequently Asked Questions:
VHA Peer Support Services SharePoint - FAQs - All Documents

VHA OMH Peer Support Services Section Policy Page:
Peer Support Services (sharepoint.com)

Information Sheets about Peer Support Services:
How VHA Peer Specialists Can Help Veterans Info Sheet.pdf

Peer Support Services for Veterans Who Experienced MST.pdf

VISN Peer Specialist Points of Contact and VISN Peer Support Supervisor Points of Contact:
All VISNs Peer Support Points of Contact List.xlsx (sharepoint.com)

Office of Mental Health Peer Support Services Section Mail Group: VHA OMH Peer Support Services (VHAOMHPeerSupportServices@va.gov)

Presenter Contact Information

Susan Lee, CPS
Certified Peer Specialist
VISN 10 Peer Specialist Point of Contact
Wyoming VA Clinic
Wyoming, MI
Susan.Lee6@va.gov

Patricia Sweeney, Psy.D.
National Director, Peer Support Services Section
VHA Office of Mental Health
Patricia.Sweeney@va.gov

Erik Ontiveros, CPS
Lead Peer Specialist
VISN 21 Peer Specialist Point of Contact
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Livermore, CA
Erik.Ontiveros@va.gov

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Mental Health

VA | U.S. Department of Veterans Affairs

Cannabis Use Disorder

Deepak Cyril D'Souza, MD

Staff Psychiatrist, VA Connecticut Healthcare System

Director, Neuropsychiatry Firm, VA Connecticut Healthcare System

Vikram Sodhi Endowed Professor of Psychiatry, Yale University School of Medicine

Director, Yale Center for the Science of Cannabis and Cannabinoids (YC-SCAN^2)

Director, Schizophrenia Neuropharmacology Research Group at Yale (SNRGY)

February 27, 2025

Disclosures and Acknowledgements

- Dept. of Veterans Affairs
- Yale research funded by:
  - NIH: NIDA, NCATS, NIAAA, NIMH,
  - Industry: Boeheringer Ingelheim, Takeda, CH-TAC, Biogen
  - Foundations: Heffter Institute, Wallace Research Foundation
- Consultant: Abide, Jazz, BioHaven, Shulgin Institute, Atai, France Foundation

- **I am NOT paid by either:**
  - **cannabis producers/retailers/interest groups OR**
  - **opponents of legalization/commercialization.**

VA Policy on Cannabis

1. Veterans will not be denied VA benefits because of marijuana use.
2. Veterans are encouraged to discuss marijuana use with their VA providers.
3. VA health care providers will record marijuana use in the Veteran's VA medical record in order to have the information available in treatment planning. As with all clinical information, this is part of the confidential medical record and protected under patient privacy and confidentiality laws and regulations.
4. **VA clinicians may not recommend medical marijuana.**
5. VA clinicians may only prescribe medications that have been approved by the U.S. Food and Drug Administration (FDA) for medical use. At present most products containing tetrahydrocannabinol (THC), cannabidiol (CBD), or other cannabinoids are not approved for this purpose by the FDA.
6. **VA clinicians may not complete paperwork/forms required for Veteran patients to participate in state-approved marijuana programs.**

https://www.publichealth.va.gov/marijuana.asp

VA Policy on Cannabis

7. VA pharmacies may not fill prescriptions for medical marijuana.
8. **VA will not pay for medical marijuana prescriptions from any source.**
9. VA scientists may conduct research on marijuana benefits and risks, and potential for abuse, under regulatory approval.
10. The **use or possession of marijuana is prohibited** at all VA medical centers, locations and grounds. When you are on VA grounds it is federal law that is in force, not the laws of the state.
11. Veterans who are **VA employees are subject to drug testing** under the terms of employment.

https://www.publichealth.va.gov/marijuana.asp

Changing Landscape

Complicated Legal Status

Feds

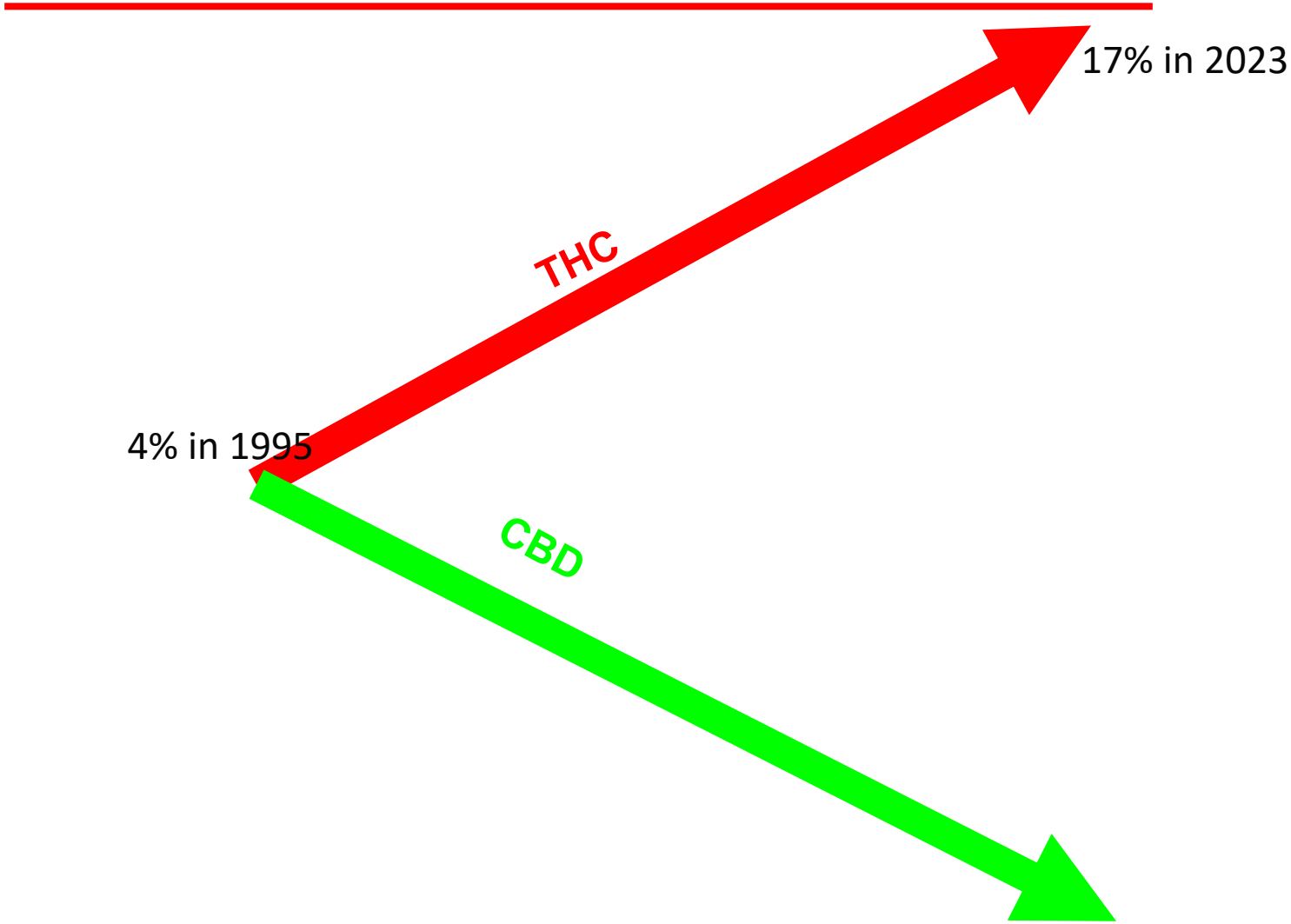
No medical purpose and high potential for abuse

States

√Medical (39/50)

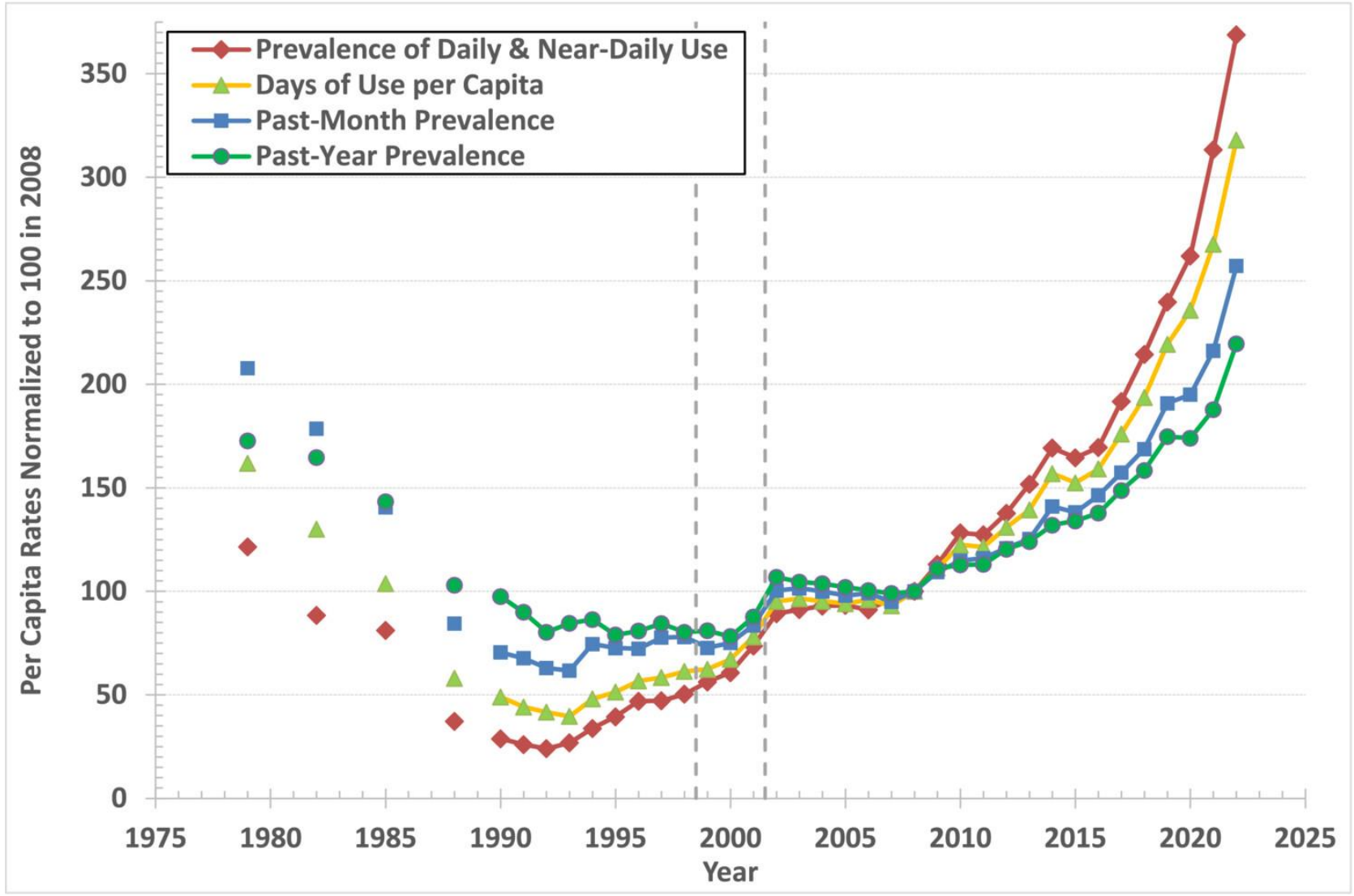
√Recreational (24/50)

The composition of cannabis has changed



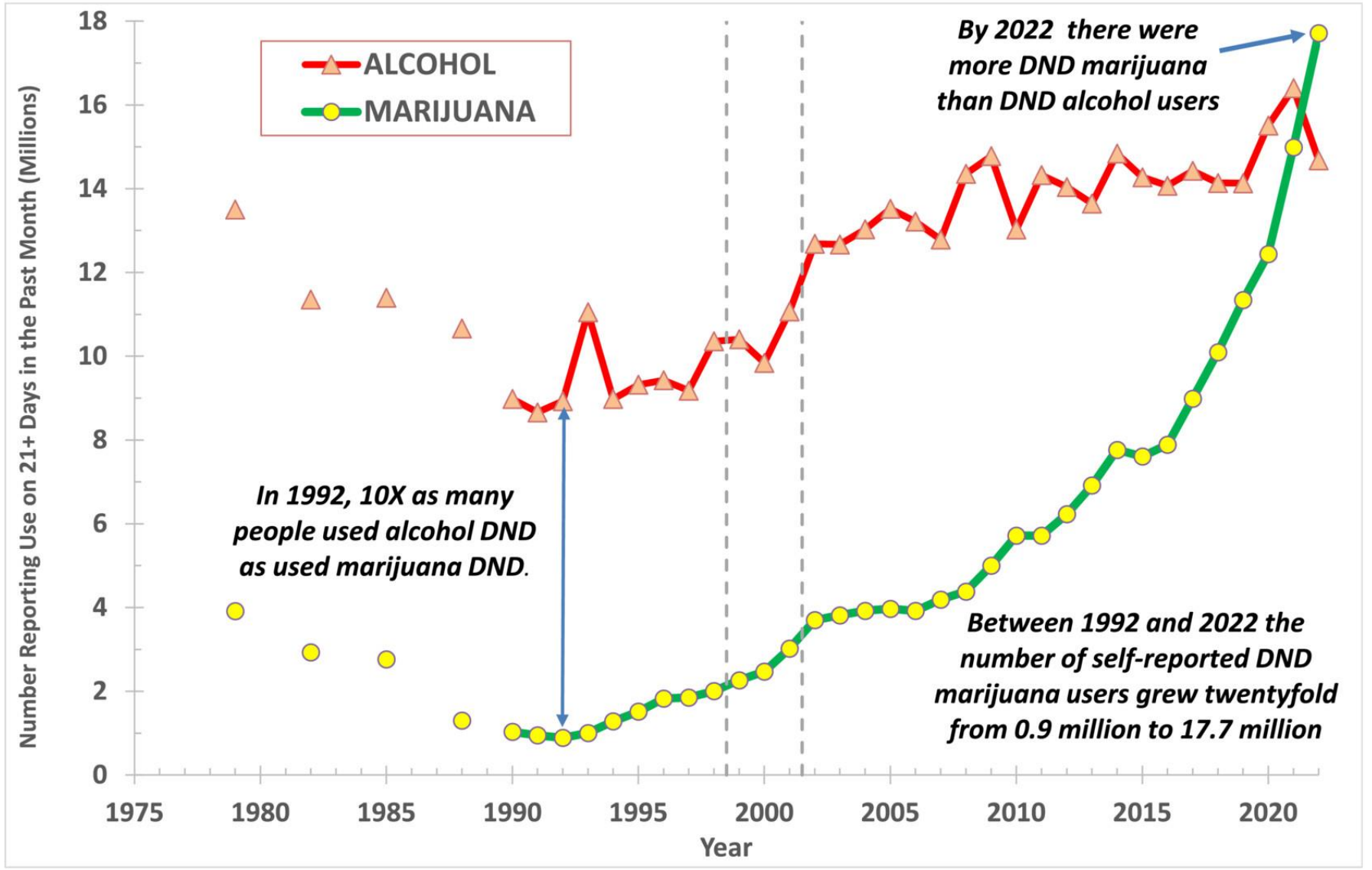
↑ Self-reported cannabis use in the US (1979 to 2022)

(All indexed to be 100 in 2008; Dashed lines indicate two major survey redesigns)



Addiction, Volume: 119, Issue: 9, Pages: 1648-1652, First published: 22 May 2024, DOI: (10.1111/add.16519)

Cannabis Use has overtaken Alcohol Use



Addiction, Volume: 119, Issue: 9, Pages: 1648-1652, First published: 22 May 2024, DOI: (10.1111/add.16519)

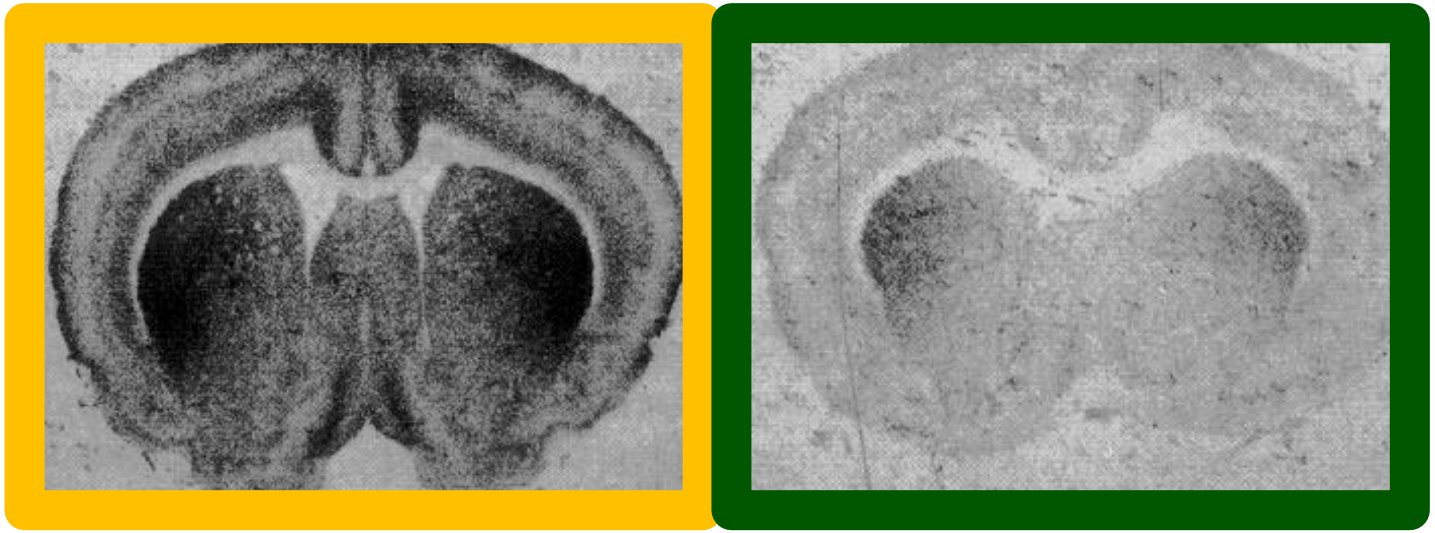
Is cannabis addictive?

Reinforcing effects in animals?

- DA release→ reinforcing effects
- Place conditioning? - dose
- Self-administration?
- Cue-induced reinstatement
- Intracranial self-stimulation (ICSS).

Reduced CB1R Receptor Density with Chronic THC Exposure

^{3}H-CP-55,940 Binding



Control **Chronic THC**

Tolerance: prolonged exposure to plant-derived, synthetic or endogenous cannabinoid agonists in animals is associated with the development of tolerance for most of their pharmacological effects

Cannabis Use Disorder: DSM

	DSM-IV Abuse[1]		DSM-IV Dependence[3]	
1. Hazardous Use (e.g., driving)	x	≥1 criterion	-	
2. Social or interpersonal problems related to use	x		-	
3. Neglected of roles	x		-	
4. Legal Problems	x		-	
5. Tolerance	-		X	≥3 criteria
6. Use of larger amounts or for longer	-		X	
7. Repeated attempts to quit or control use	-		X	
8. Much time spent using	-		X	
9. Physical or psychological problems related to use	-		X	
10. Activities given up in order to use	-		X	
11. Craving	-		-	
12. Withdrawal	-		-	

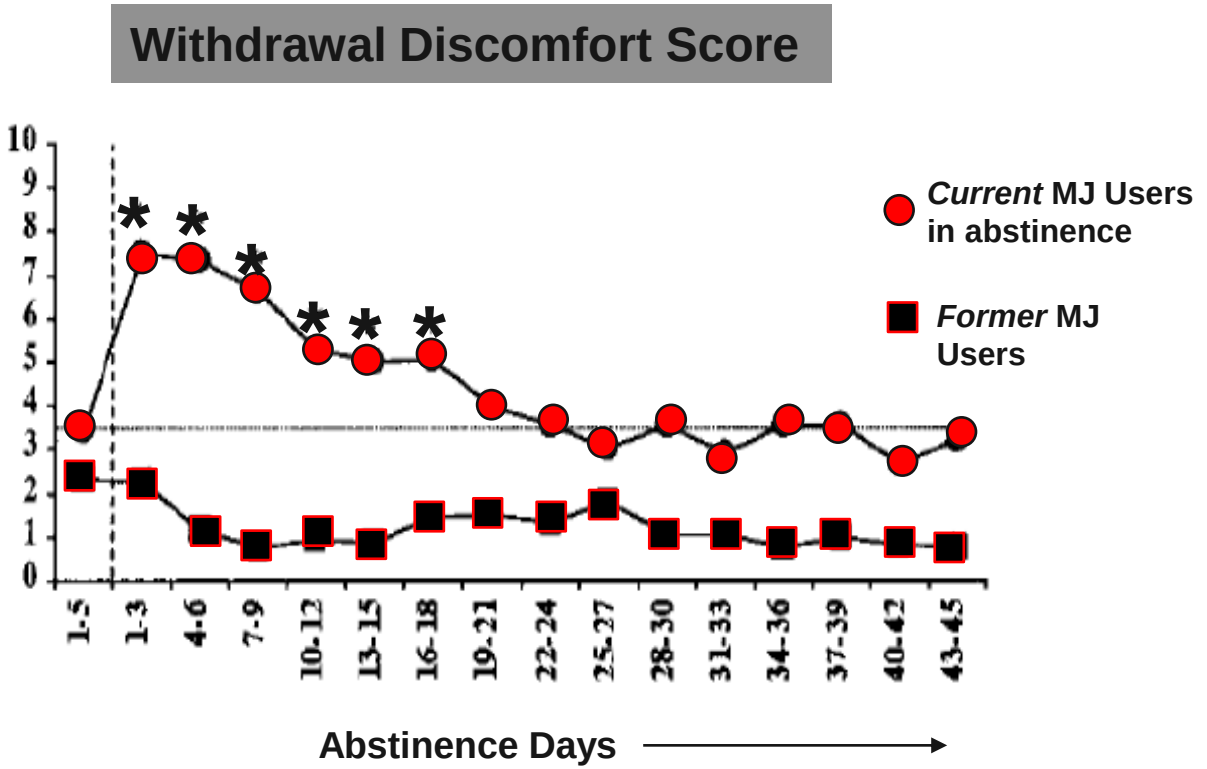
Withdrawal

- Rodents:
  - Spontaneous withdrawal:
    - subtle and can be hard to detect for THC
    - robust with full-agonists (WIN 55,212)
  - CB1 antagonist can precipitate a clear and abrupt withdrawal syndrome
    - scratching, face rubbing, licking, wet dog shakes, ataxia, myoclonic spasms

- NHP:
  - spontaneous withdrawal from THC: increased locomotion and aggression
  - CB1 antagonist precipitated withdrawal: head shaking and tachycardia

Cannabis Withdrawal

- Onset within the first 24–72 hours of cessation,
- Peak within the first week,
- Lasts ~1–2 weeks, but sleep difficulties may last > 30 days



Withdrawal Syndrome

- **Common:** appetite change, weight loss, aggression, irritability, anxiety, restlessness, altered sleep, strange dreams, cannabis craving and physical discomfort.
- **Less common:** chills, depressed mood, abdominal pain, headache, chills and sweating.

- CB withdrawal can be a negative reinforcer for relapse.
- CB withdrawal symptoms make it more difficult to maintain abstinence.
- Those who experience CB withdrawal symptoms may use cannabis to relieve or avoid withdrawal.

CUD Epidemiology

- Older studies: ~10% of users develop CUD *(Anthony et al., 1994)*

- NESARC (National Epidemiologic Survey on Alcohol and Related Conditions):
  - 33% of users develop DSM-IV CUD *(Hasin et al., 2015)*
  - 19.5% of users develop DSM-V CUD
    - 23% of them had severe CUD (⩾6 criteria).
    - ~ 50% encountered significant difficulties functioning within society (e.g., unemployment, lack of interpersonal relationships)

↑rates of cannabis use and CUD over the past decade among U.S. veterans.

National Health and Resilience in Veterans Study (NHRVS):

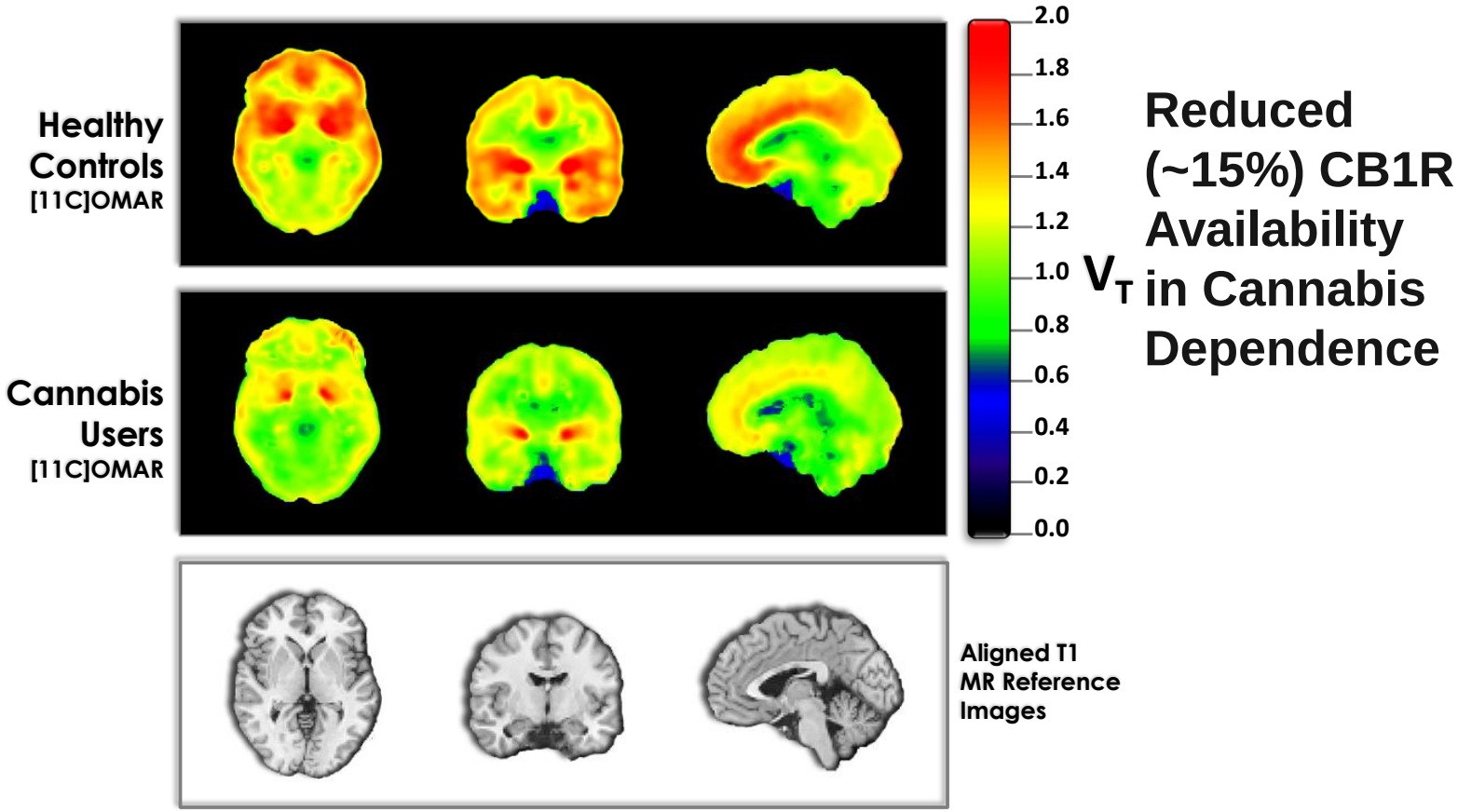
Between 2011 and 2019-2020

- Cannabis **use** prevalence: 21.9% to 26.3%
- **CUD** prevalence: 7.1% to 9.1%

Ashley Martin-Schnakenberg (unpublished)

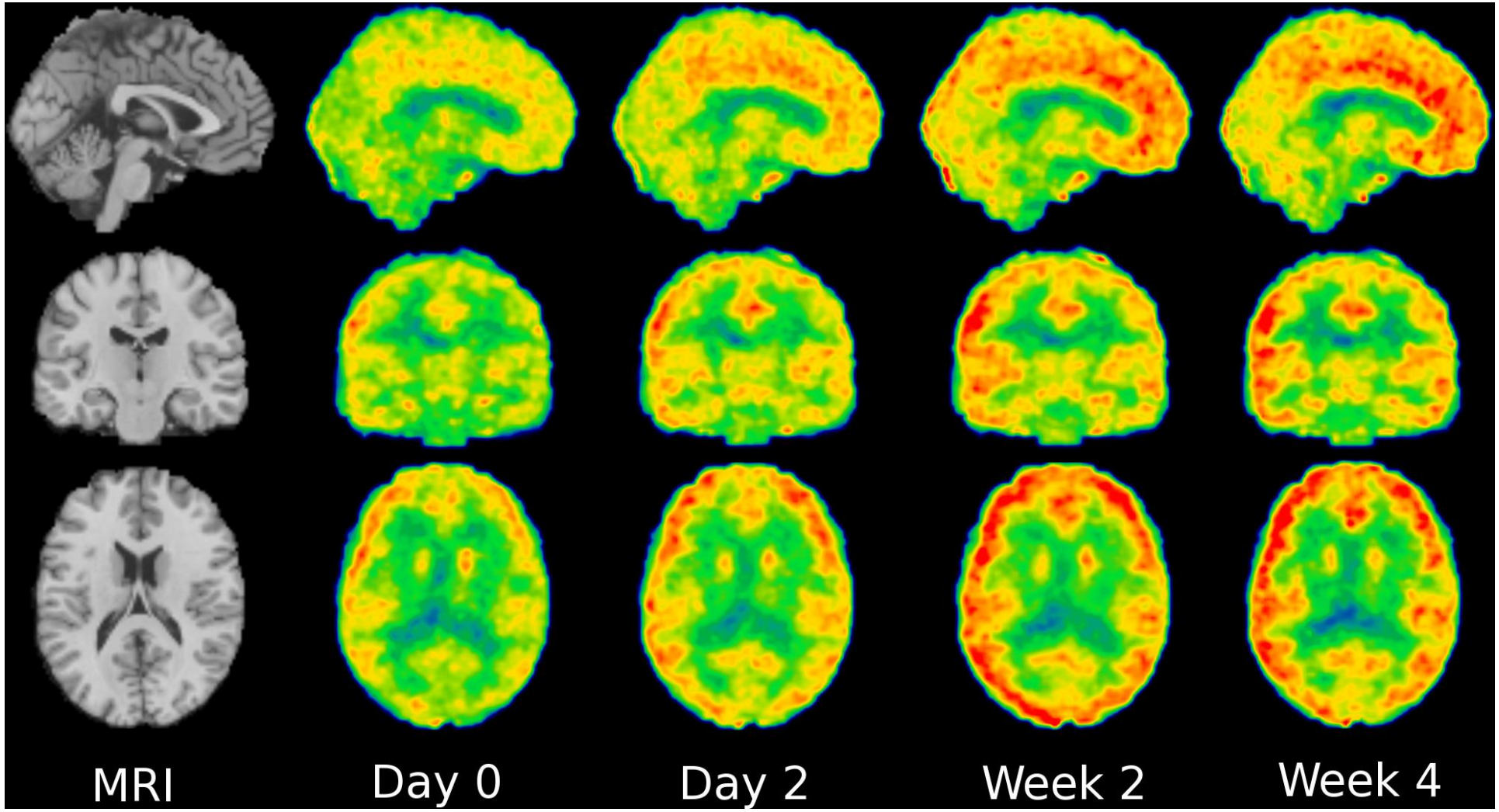
Biological Correlates/Consequences of CUD?

Reduced (~15%) Brain Cannabinoid Receptors in Cannabis Dependence



D'Souza et al., Biological Psychiatry (2016)

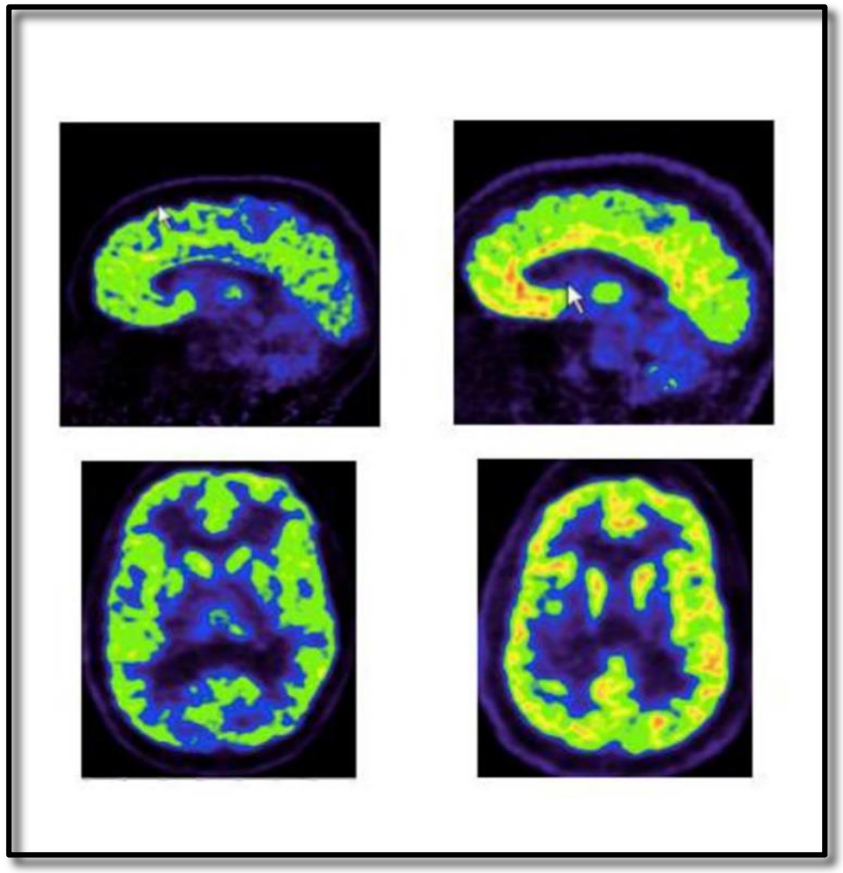
Normalization of CB1 Receptor Availability Over Time with Abstinence from Cannabis



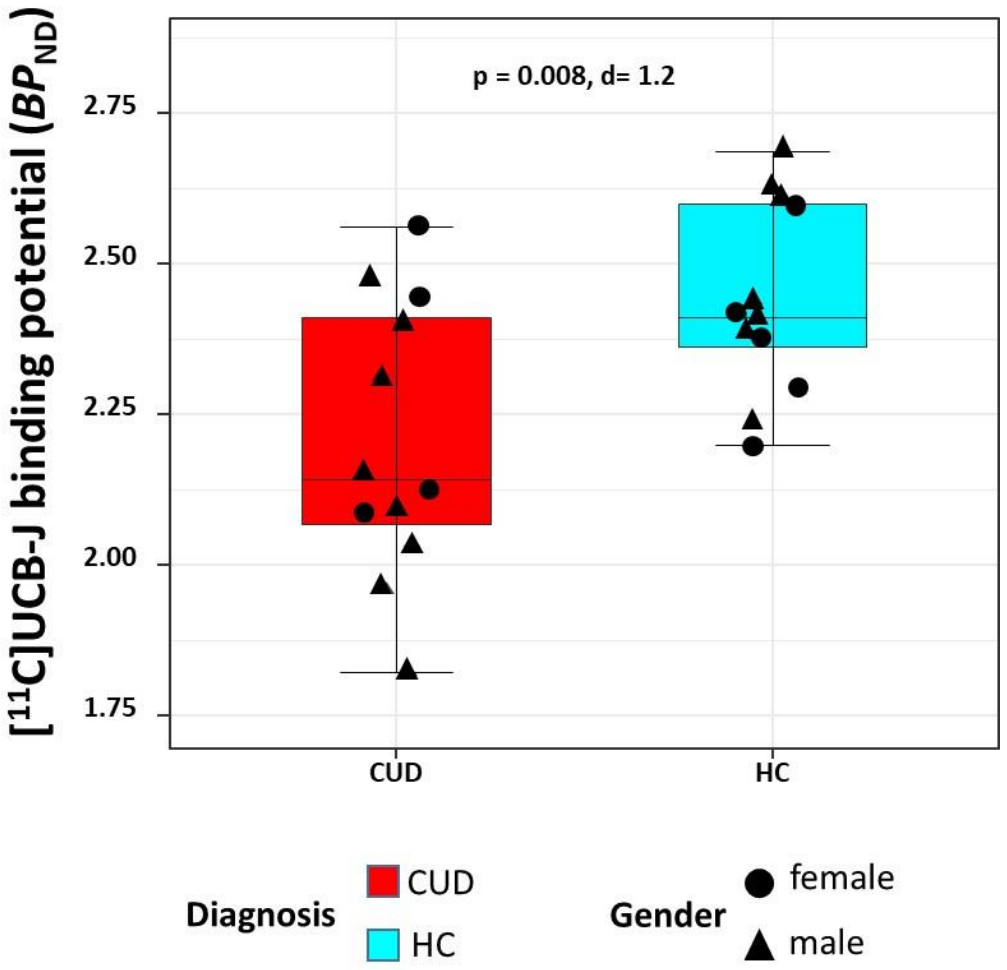
Effects of Chronic Cannabis Exposure on Glutamate Receptors (mGluR5)

chronic cannabis use is associated with *UPREGULATION* of postsynaptic metabotropic glutamate receptors (mGluR5)

Healthy Controls **Cannabis Users**



Reduced (~15%) Synapses in the Hippocampus in CUD



D'Souza & Radhakrishnan, *Mol. Psychiatry* (2020)

CUD: Genetics

- Estimated twin and family heritability about 50–70%.
- Genetic risk not deterministic
  - environmental factors also play a significant role.
- Distinction between genetic liability to cannabis **use** and CU**Disorder**
- Multiple genes are involved: combination of many genes, each contributing a small amount to the overall risk:
  - CNR1
  - CHRNA2
  - FOXP2
  - DRD2
  - ANKK1

CUD: Genetics

Genetic overlap between cannabis use disorder and:

- several mental health phenotypes (e.g., ADHD, schizophrenia),
- respiratory illnesses, and
- infectious diseases in the BioVU biobank

CUD: Risk Factors

- **Age:** younger age.
- **Genetics:** family history of SUD, including CUD.
- **Psychiatric conditions:** depression, anxiety, or psychosis
- **Environmental factors:** Easy access to cannabis, exposure to cannabis use by peers or family members, and stressful life events can increase the risk of developing CUD.
- **Frequency and potency of use:**
  - –frequency
  - –dose
  - –THC content

CUD: Treatment/s?

CUD: Targets of Tx

- Withdrawal:
  - Anxiety
  - Insomnia
- Reduced use
- Craving
- Relapse in those who become abstinent

Behavioral Treatments

Cognitive Behavioral Therapy (CBT):

- To identify and change negative thought patterns and behaviors associated with cannabis use.
- To focus on developing coping skills to manage triggers and prevent relapse.

Motivational Enhancement Therapy (MET):

- To increase their motivation to change their cannabis use.
- To build intrinsic motivation and setting realistic goals.

Contingency Management (CM):

- Rewards abstinence from cannabis use, as verified through drug testing.
- May promote short-term abstinence.

Family Therapy:

Medications Tested

- CB1R agonists: THC, Nabilone, Nabiximols
- Cannabidiol
- CB1R antagonists
- Opioid Antagonists
- Antidepressants: SSRIs, buproprion, nefazodone, lithium, atomoxetine, venlafaxine
- Buspirone
- Clonidine, N-acetylcysteine
- Varenicline
- Gabapentin, topiramate, baclofen
- Depakote, entacapone, lofexidine
- Quetiapine
- Zolpidem + Nabilone
- Guafacine
- rTMS

No FDA approved txs

Thank you!

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Mental Health

The Relationship of Spirituality in Substance Use Disorder Care

Chaplain Linda C. Conyers, MDiv., BCC-SUD,
Chief of Chaplain Service, VA Puget Sound HCS, Seattle, WA

Chaplain Neissha L. King, MDiv., MBA, BCC-SUD,
Chief of Chaplain Service, VA CCHCS, Fresno, CA

February 27, 2025

Objectives

1. Describe spiritual aspects of addiction and recovery
2. Examine evidence for integration of spirituality into SUD care
3. Discuss the role of the VA chaplain in SUD care
4. Explore value of interdisciplinary collaboration

Spirituality

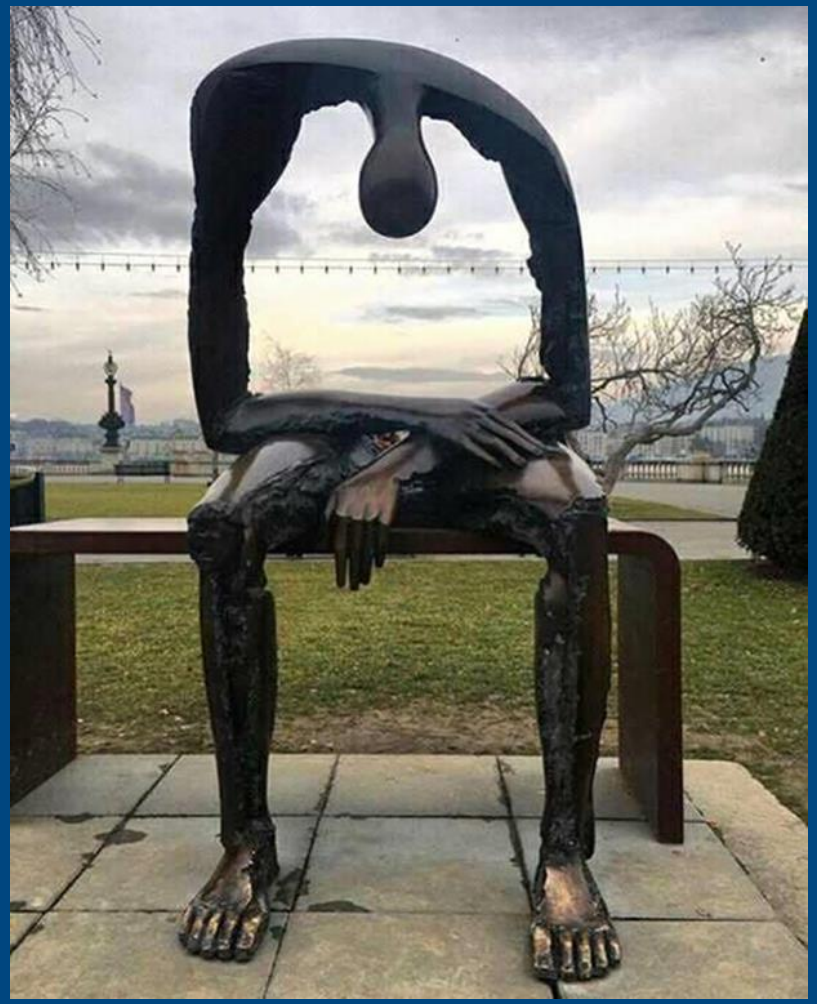
The **universal** aspect of humanity that refers to the way we seek and express **meaning** and **purpose** and the way we experience **connectedness and self-transcendence.**

We are "beyonding and betweening beings."

(Puchalski, 2009; Kurtz & White, 2015)

Image by Mohammed Nohasi on unsplash.com

Spirituality is expressed through ideas, beliefs, values, traditions and practices.



"Melancolie" by Albert György

A Holy Longing

"Our hearts are restless
until they find their rest in Thee."

St. Augustine, Confessions (397 – 400 CE)

"At the core of all addictions
there lies a spiritual void."

Gabor Mate, In the Realm of Hungry Ghosts (2010)

Framing Substance Use & Addiction in Spiritual Terms

- Seeking transcendence *(James, Jung)*
- Seeking belonging, connectedness *(Kurtz & Ketcham)*
- Seeking control, exercise of personal will *(Pollitt)*
- Narcotizing spiritual pain *(Ford, Horney)*
- Filling the existential vacuum, search for meaning *(Frankl, Mate)*
- Idolatry, attachment to a substitute *(May)*
- Spiritual bondage *(Waters)*

The Spiritual Pain of Addiction

Shame
Guilt
Alienation
Powerlessness
Lack of trust
Grief
Resentment
Loss of identity

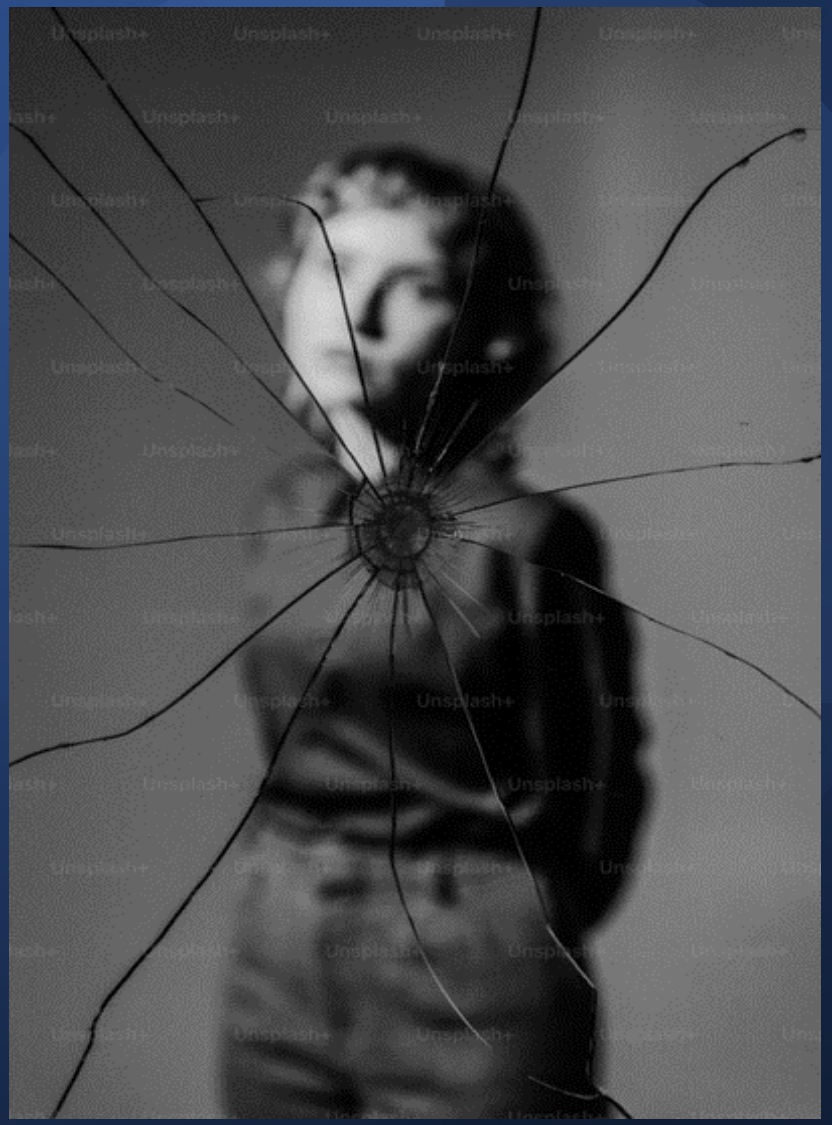


Photo by Nick Fancher on unsplash.com

Recovery: A Transformational Journey

An on-going process of:
Self-discovery
Healing
Growth

12-Step work is a spiritual path
Mindful Recovery is a spiritual path
SMART Recovery is a spiritual path
Integrated Recovery Model is a spiritual path

Photo by Nicolas Cool on unsplash.com

"Spiritual growth is the axis around which recovery must be centered." (Harold Doweiko)

Photo by Ahmed on unsplash.com

The Spiritual Work of Recovery

- Learning to be with life's complexity and pain
- Forming and nurturing relationships
- Reordering use of time
- Developing and practicing coping skills
- Processing losses related to use and recovery
- Re-examining values
- Recovering and learning from relapse
- Making meaning out of life experience
- Practicing acceptance and letting go

Evidence for Spirituality's Role in Treatment

2017 article*: systematic review of 14 studies (out of search of 457)

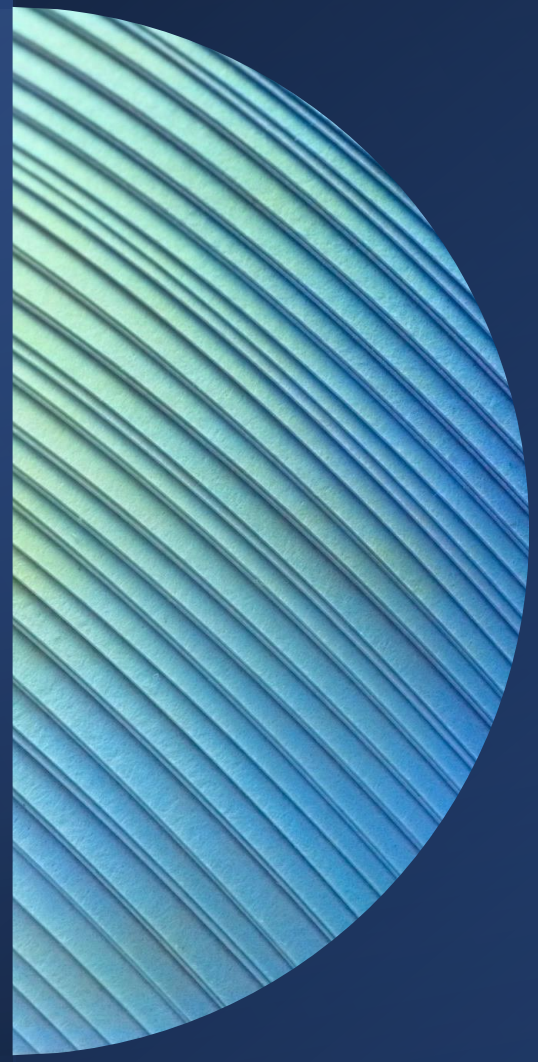
Objective: to examine how spirituality influences treatment outcomes for substance use disorders (SUD).

Result: spiritual treatments are not more effective, but high levels of spirituality and practice tend to reduce substance use and improve other areas of recovery.

*Santiago de Ossorno Garcia, Javier Martín Babarro, and María de la Paz Toldos

"When we are no longer able to change a situation, we are challenged to change ourselves."

Viktor Frankl



Integration of Spiritual Care in Clinical Practice

Integration of spirituality in SUD treatment remains limited beyond the 12-step tradition

<u>Begins with spiritual screening and/or assessment of needs</u>

Spiritual Screening – BAM-R, Q12

"Does your religion or spirituality help support your recovery?"

Another Available Tool

Screening for Spiritual Struggle Protocol (Fitchett & Risk)

In the Context of Therapeutic Conversation

Implicit spiritual assessment (Hodge)

Photo from Getty Images for unsplash+ on unsplash.com

The Role of the Chaplain

- Religion/Spirituality Subject Matter Expert
- Assess spiritual needs and resources
- Identify and address spiritual/religious injury
- Encourage recovery through use of spiritual/religious resources & practices
- Care is in alignment with person's own framework of understanding, values and beliefs
- Clinical chaplains do not proselytize!

Exploring Spirituality and SUD Care Through the Lens of Moral Injury

This section of the presentation explores the role of spirituality in Substance Use Disorder (SUD) care, highlighting key findings from a Moral Injury Group Intervention led by a VA chaplain and psychologist.

A Pilot Study of a Moral Injury Intervention Co-Facilitated by Chaplain and Psychologist (2021)

The Intersection of Spirituality, Moral Injury, and SUD in Veterans

Spirituality: Search for meaning, purpose, and connectedness.

Moral Injury: Engaging in perpetrating, witnessing, or learning about acts that transgress one's moral beliefs and expectations or as betrayal by an authority figure in a high-stakes situation.
(Litz et al., 2009; Shay, 2014)

Veterans with SUD often report experiences of betrayal or transgressions of moral values leading to feelings of guilt, shame, and betrayal.

Image from Getty Images on unsplash.com

Moral Injury Group Intervention

Two interventions targeting moral injury, Adaptive Disclosure (AD) and Acceptance and Commitment Therapy (ACT) have shown promising results (Gray et al., 2012; Farnsworth et al., 2017).

This study highlights the spiritual and psychological needs of Veterans by exploring 40 participants across seven cohorts who participated in a 12-week, 90-minute moral injury group (MIG) over 35 months.

MIG objective was to enhance functioning and self-compassion.

Intervention included a ceremony in which participants shared testimonies of their moral injury with the public.

Group Intervention Approach

MIG sessions provided information about moral injury to include topics on moral emotions, moral values, moral dilemmas, and moral disengagement.

MIG sessions also explored spiritual disciplines and spiritual dimensions of military and personal life. Integrated discussions on forgiveness, meaning, and value-based healing.

Sessions included guided reflections, mindfulness, and chaplain-led discussions.

MIG sought to normalize the moral pain from combat and emphasize that the onus of warfare does not lie solely with the veteran but also with the citizenry.

Photo by Linda Xu on unsplash.com

Depression-The Patient Health Questionnaire-9

Psychological Health-The Schwartz Outcome Scale-10

Self-Compassion-The Self-Compassion Scale-Short Form

Posttraumatic Growth-The Posttraumatic Growth Inventory-Short Form

Religious and Spiritual Struggles-The Religious and Spiritual Struggles Scale

Measures

Photo by Deniz Altindas on unsplash.com

Veterans experienced a reduction in depressive symptoms.

Many reported improved psychological functioning and greater self-compassion.

The intervention contributed to a decrease in religious and spiritual struggles.

Impact of the Intervention on Mental and Spiritual Well-Being

Photo by Alex Perez on unsplash.com

Interdisciplinary Spirituality Group Therapy

BSS: Building Spiritual Strength

(8/2-hour weekly sessions)

Point of Contact:
Dr. J. Irene Harris, Psychologist,
VA Maine HCS

Interdisciplinary Moral Injury Group Therapies

ACT MI: Acceptance and Commitment Therapy for Moral Injury
(10/90-minute weekly sessions)

AFT: Acceptance and Forgiveness Therapy
(10/90-minute weekly sessions)

REAL: Reclaiming Experiences And Loss
(12/90-minute weekly sessions)

Point of Contact:
Dr. Melissa Smigelsky, Psychologist,
MIRECC, DVAHCS

Adaptive Disclosure Addiction Treatment Center Group for Moral Injury (Pilot)

All group members previously completed a 4-week introductory Moral Injury group and requested more intensive support.

Eight weekly 90-minute sessions.

Group size: 4 to 6 participants.

Each group member was asked to share their source of strength, their current ability to cope with stress, and their goals for group participation.

Psychologist utilized the Subjective Units of Distress Scale (SUDS) to assess participants' distress levels pre and post intervention and instructed members to complete SUDS evaluations before and after homework assignments.

Detailed guidance on recounting morally injurious events, including sensory details, thoughts, and feelings.

Volunteers shared their experiences of moral injury. After each veteran's account was read, the group engaged in a guided compassionate care response.

Concluded the 8-week group with a candlelight ritual to honor reflection and healing.

Point of Contact: Dr. Anja Cotton, Psychologist, Addiction Treatment Center, VA Puget Sound HCS

Group Results:

Overall, participants experienced
a reduction in SUDs
and an increase in spiritual well-being.

Adaptive Disclosure Addiction Treatment Center Group for Moral Injury (Pilot)

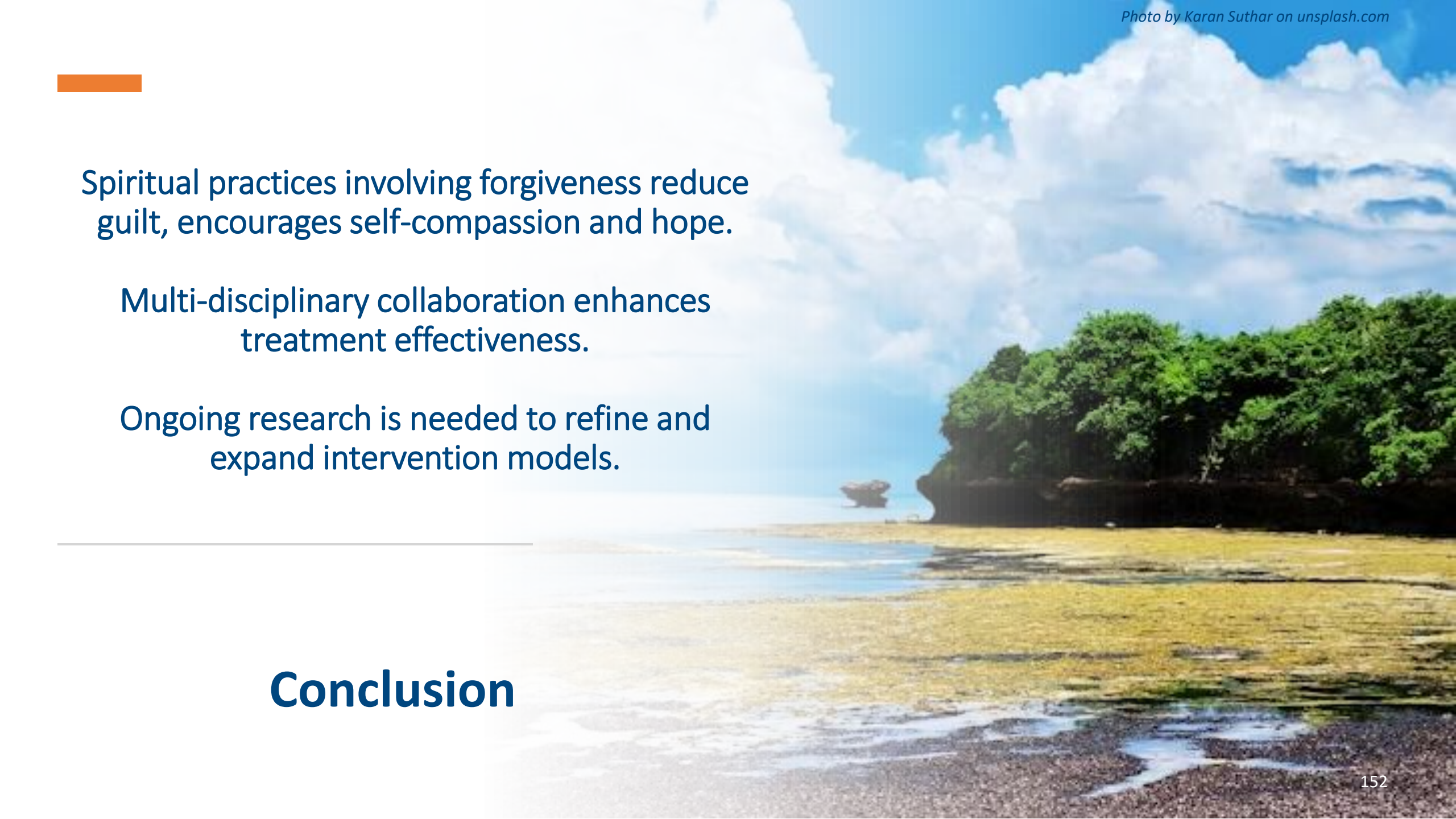


Photo by Karan Suthar on unsplash.com

Spiritual practices involving forgiveness reduce guilt, encourages self-compassion and hope.

Multi-disciplinary collaboration enhances treatment effectiveness.

Ongoing research is needed to refine and expand intervention models.

Conclusion

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Resources

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Mental Health

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Mental Health

SUD Treatment in the ED

Brian Fuehrlein, MD, PhD
Comilla Sasson, MD, PhD
Manuel Celedon, MD

February 27, 2025

Learning Objectives

- Explain the unique role of the emergency department (ED) in treating substance use disorders (SUD), with an emphasis on alcohol and opioids
- Identify the challenges associated with providing SUD care in the ED
- To recognize how common alcohol use is and know basic concepts such as standard drink sizes and blood alcohol level
- To apply fundamental clinical concepts to patient care for the acute management of alcohol withdrawal
- Briefly review ED stabilization of AWS and use of phenobarbital as monotherapy
- Introduce the various protocols for treating OUD in the ED (buprenorphine and methadone)
- Review available resources
- Introduce the VA Emergency Medicine Addiction Hotline (VEMAH)

Treating SUD in the ED

- Emergency Departments (ED) is often the first (and sometimes only) point of healthcare access for individuals with SUDs

- Patients present during crises:
  - Intoxication
  - Withdrawal
  - Overdose

- EDs are open 24/7/365
  - Opportunity to intervene during a critical moment in the addiction cycle

The ED Setting

- **Patient Acuity**
  - Manage the full spectrum of intoxication and withdrawal states from mild to severe
  - May have other co-occurring conditions (i.e., cellulitis, abscess, etc.)
- **Always Open for Unscheduled Care**
  - Constant influx of patients with diverse medical conditions

The ED Setting

- **Time Constraints**
  - “Sick” and ”unsick” patients must be “dispositioned” within 2 hours of ED arrival
    - All others within 4 hours of ED arrival

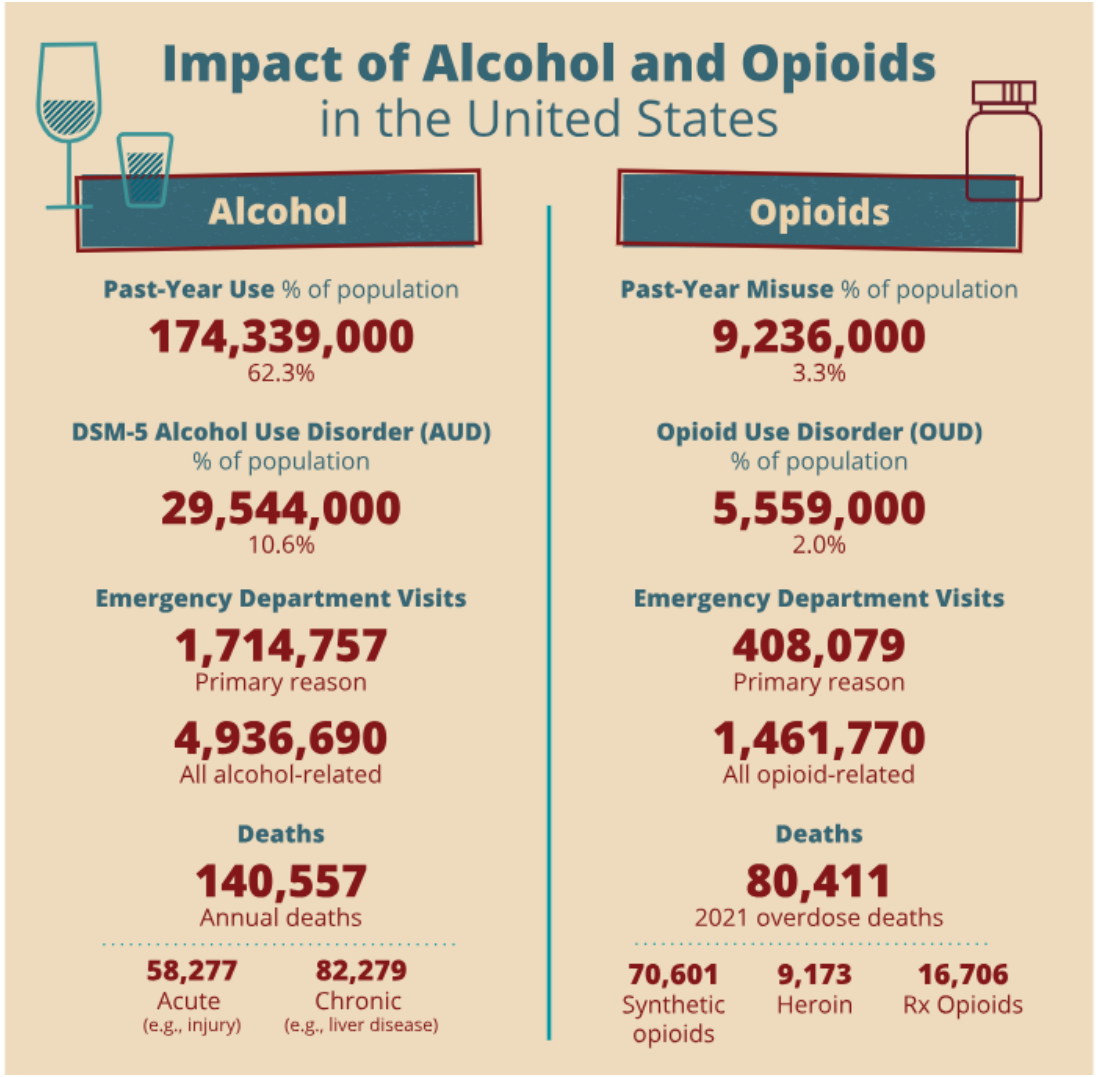
- **Follow-up and Continuity of Care**
  - No mechanism for longitudinal follow up
    - Preference for protocols that provide immediate and sustained symptom relief

Challenges of Managing SUD in the ED

- **Physician Perspective:**
  - Must stabilize patients quickly to free up resources for new arrivals
  - Treating SUD is often seen as secondary to managing life-threatening conditions in other patients
  - EDs lack longitudinal care structures, making it critical to provide effective, one-time treatments

- **Patient Perspective:**
  - EDs prioritize care by acuity, not arrival time.
  - Patients with acute withdrawal may not be triaged as high acuity
  - May leave ED prematurely if symptoms are not managed promptly or may feel ignored by the system

Alcohol is Common

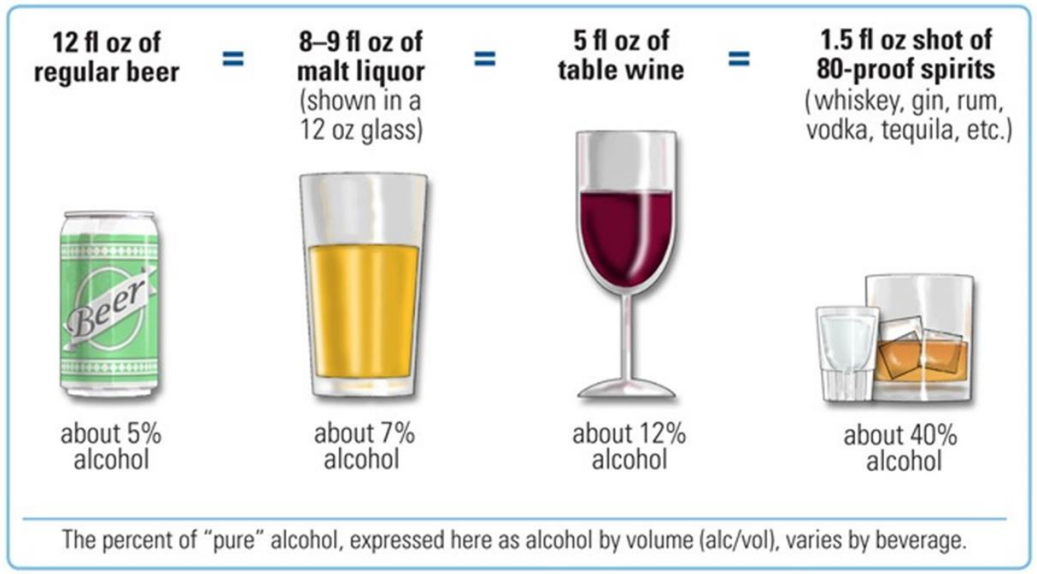


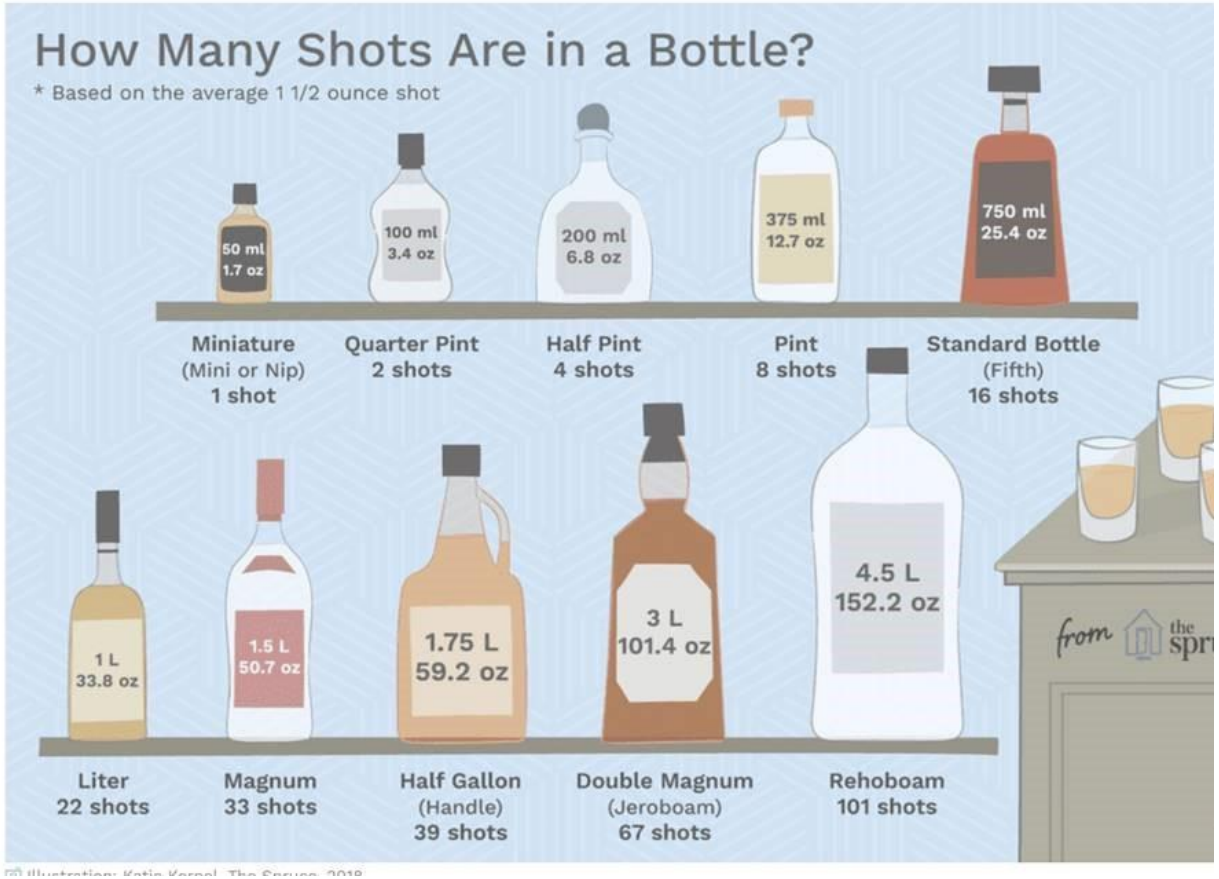
Standard Drinks

- **12 oz regular beer (5% alcohol)**
  - Light beer contains slightly less alcohol (4.2%)
  - Malt beverages contain approximately 7% alcohol
- **5 oz of table wine (12% alcohol)**
- **1.5 oz of 80 proof spirits (40% alcohol)**
- **14 grams of alcohol**

- **Remember 60 as an easy way to figure out drink size and percent**

Standard Drinks





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Impact on BAL

MEN

YOUR BAC AFTER ONE HOUR OF DRINKING

TOTAL NUMBER OF DRINKS	BODY WEIGHT (LBS) 120	140	160	180	200	220	240	260	280
1	.02	.01	.01	.01	.00	.00	.00	.00	.00
2	.05	.04	.03	.03	.02	.02	.02	.01	.01
3	.08	.06	.05	.05	.04	.04	.03	.03	.02
4	.11	.09	.08	.07	.06	.05	.05	.04	.04
5	.14	.12	.10	.09	.08	.07	.06	.06	.05
6	.17	.14	.12	.11	.10	.09	.08	.07	.06
7	.20	.17	.15	.13	.12	.10	.09	.08	.08
8	.23	.20	.17	.15	.13	.12	.11	.10	.09
9	.27	.23	.19	.17	.15	.14	.12	.11	.10
10	.30	.25	.22	.19	.17	.15	.14	.13	.12

WOMEN

YOUR BAC AFTER ONE HOUR OF DRINKING

TOTAL NUMBER OF DRINKS	BODY WEIGHT (LBS) 100	120	140	160	180	200	220	240	260
1	.03	.02	.02	.01	.01	.01	.00	.00	.00
2	.07	.06	.05	.04	.03	.03	.02	.02	.02
3	.12	.10	.08	.07	.06	.05	.05	.04	.04
4	.16	.13	.11	.10	.08	.07	.07	.06	.05
5	.21	.17	.14	.12	.11	.10	.09	.08	.07
6	.25	.21	.18	.15	.13	.12	.11	.10	.09
7	.30	.25	.21	.18	.16	.14	.13	.12	.11
8	.34	.28	.24	.21	.18	.16	.15	.13	.12
9	.39	.32	.27	.24	.21	.19	.17	.15	.14
10	.43	.36	.31	.27	.23	.21	.19	.17	.16

Alcohol limit recommendations

	Drinks per week	Drinks per day
Men	14	4
Women	7	3
Age >65	7	3
Pregnancy	0	0

Binge Drinking
Men – one time use of 5+ drinks
Women – one time use of 4+ drinks

Heavy Alcohol Use
Binge Drinking on
5+ days in the past month

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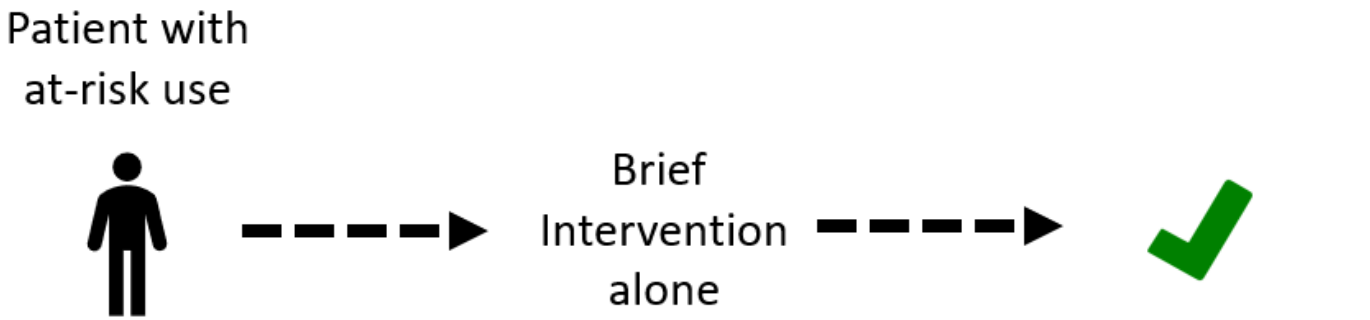
Screening, Brief Intervention and Referral to Treatment

- **Screen for risky drinking** (>3 drinks in one sitting or >7 drinks in one week for women and >4 drinks in one sitting or >14 drinks in one week for men) [criteria previous slide]
- **Brief Intervention**
- **Referral to Treatment**

Definitions from National Institute on Alcohol Abuse and Alcoholism

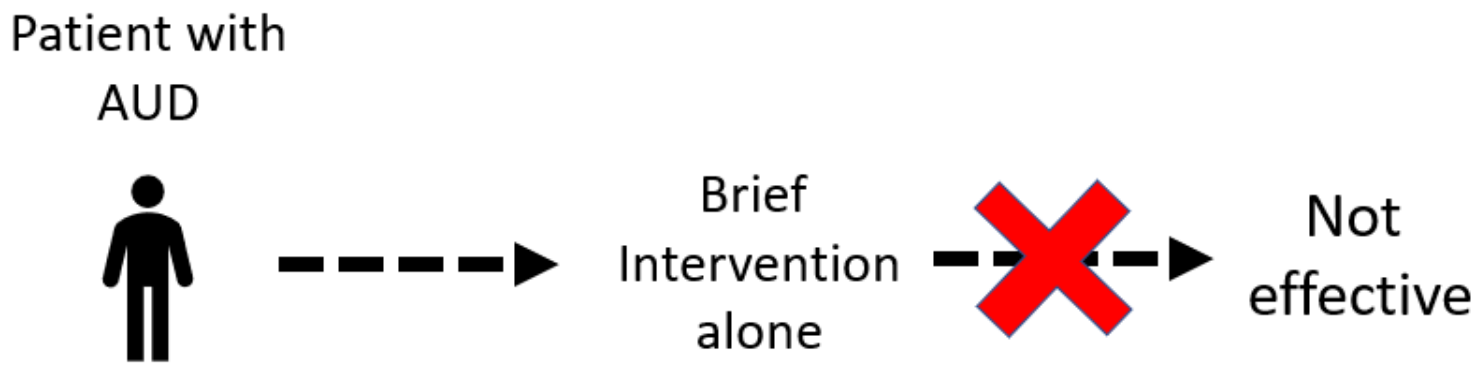
Connection to ongoing AUD treatment



Number needed to treat = 7
to have one patient return to recommended levels of drinking

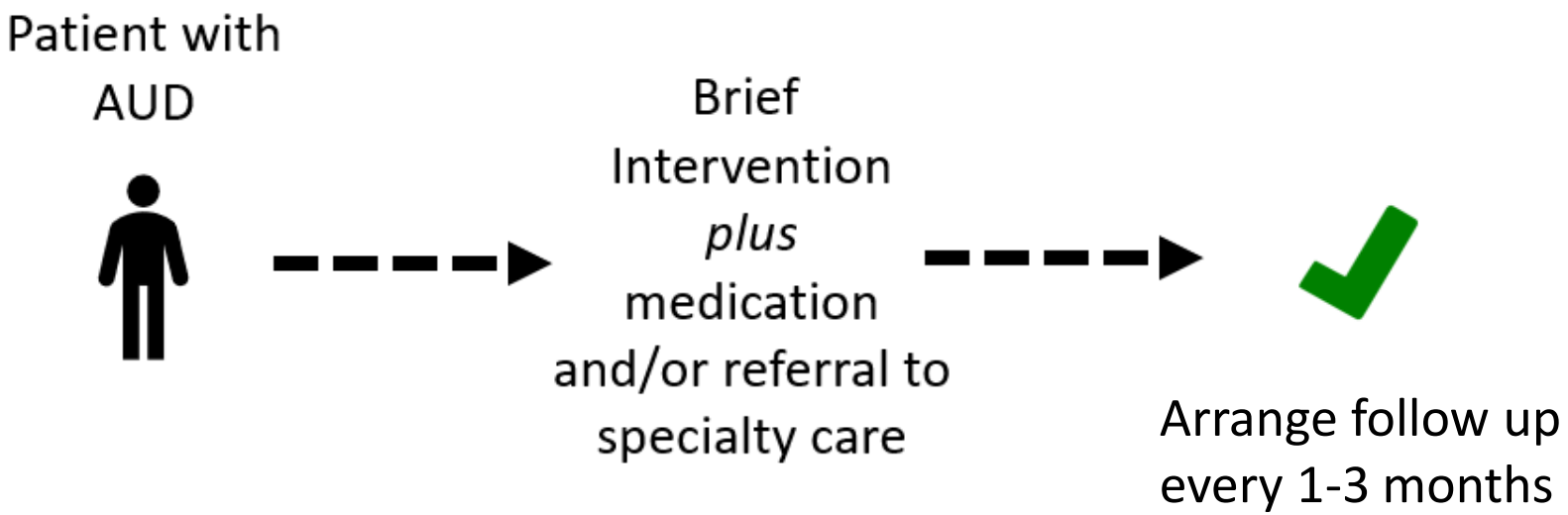
Slide credit: Dr. Paul Joudrey

Connection to ongoing AUD treatment



Slide credit: Dr. Paul Joudrey

Connection to ongoing AUD treatment



Slide credit: Dr. Paul Joudrey

Syndrome	Time after last drink	Symptoms/Characteristics
Stage 1: Initial withdrawal symptoms	6-8 hours	-Tachycardia -Anxiety -Hypertension -Tremulousness -Hyperthermia -Nausea/Vomiting -Diaphoresis -Headache -Insomnia
Stage 2: Alcoholic hallucinosis	12-24 hours	-7 to 8% of patients with AWS -Most commonly visual -Normal sensorium differentiates from delirium tremens
Stage 3: Withdrawal seizures	12-48 hours	-Generalized tonic-clonic -Shorter duration with little post-ictal period -1/3 of patients with withdrawal seizures progress to delirium tremens
Stage 4: Delirium tremens (DT)	3 to 5 days after initial withdrawal symptoms; lasting up to 8 days	-Rapid onset -Fluctuating disturbance of attention/cognition + alcohol withdrawal symptoms and autonomic instability -3-5% of patients hospitalized with AWS with a 1-4% mortality

Yancy, J. Alcohol Withdrawal Syndrome: Identification and Management. *EM Docs*, online publication, accessed 7/31/24 at emDOCs.net – Emergency Medicine EducationAlcohol Withdrawal Syndrome: Identification and Management - emDOCs.net - Emergency Medicine Education

Alcohol Metabolism

- On average, alcohol is metabolized ~ 0.02 per hour, or approximately one standard drink per hour
- Hence a BAL of 0.30 will take approximately 15 hours to reach 0
- People with tolerance develop withdrawal symptoms ~6 hours from the last drink
- At that point the BAL could still be well above 0

Approach to Alcohol Withdrawal Syndrome in the ED (click title for example algorithm)

1. Assess patient treatment goals and likelihood of developing alcohol withdrawal syndrome (AWS)
2. Quantify withdrawal severity and risk of severe / complicated AWS
3. Determine appropriate level of care
4. Formulate a treatment plan based on severity of AWS and patient risk profile
5. Connect to ongoing care & offer AUD pharmacotherapy

Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-Ar) scale

Clinical Institute Withdrawal Assessment for Alcohol revised	
Symptoms	**Range of scores**
Nausea or vomiting	0 (no nausea, no vomiting) –7 (constant nausea and/or vomiting)
Tremor	0 (no tremor) – 7 (severe tremors, even with arms not extended)
Paroxysmal sweats	0 (no sweat visible) – 7 (drenching sweats)
Anxiety	0 (no anxiety, at ease) – 7 (acute panic states)
Agitation	0 (normal activity) – 7 (constantly trashes about)
Tactile disturbances	0 (none) – 7 (continuous hallucinations)
Auditory disturbances	0 (not present) – 7 (continuous hallucinations)
Visual disturbances	0 (not present) – 7 (continuous hallucinations)
Headache	0 (not present) – 7 (extremely severe)
Orientation/clouding of sensorium	0 (orientated, can do serial additions) – 4 (Disorientated for place and/or person)

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al, 2015

Part A: Threshold Criteria:

("Y" or "N", no point)

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" BAL on admission? _____

IF the answer to either is YES, proceed with test:

Part B: Based on patient interview:

(1 point each)

1. Have you been recently intoxicated/drunk, within the last 30 days? _____
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? _____
   (i.e., in-patient or out-patient treatment programs or AA attendance)
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity? _____
4. Have you ever experienced blackouts? _____
5. Have you ever experienced alcohol withdrawal seizures? _____
6. Have you ever experienced delirium tremens or DT's? _____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days? _____
8. Have you combined alcohol with any other substance of abuse, during the last 90 days? _____

Part C: Based on clinical evidence:

(1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation ≥ 200? _____
10. Is there evidence of increased autonomic activity? _____
    (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea)

Total Score: _____

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS.

A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.

Revised Alcohol Withdrawal Guideline

WARNING: *There is no clear best practice for management of withdrawal and many mainstays of treatment such as symptom triggered therapy have not been well validated in inpatient settings. The one standard recommendation is to use benzodiazepines to induce* ***light sedation*** *for the purpose of avoiding delirium and seizures.* ***NOTE: If given too much sedation all patients will eventually become delirious due to the sedation itself.***

STEP ONE: Decision to admit to Medicine vs. PER. If patient has a CLEAR documented history of delirium, seizure or required ICU level care, or other acute reason for medical admission (eg, AKI), then they typically get admitted to medicine. NOTE: for patients that just recently relapsed they may need minimal "detox" if any.

STEP TWO: Decide whether to start standing dose benzodiazepine and what dosage.

Option A:** For patients who have had prior VACT Detox. ***Simply look up the past admissions and choose one that went well and approximate that regimen. This is *preferred for most of our patients*, although a patient's sedative requirement may be different depending on varied circumstances. Do NOT just review the last admission, but instead pick one that actually went well.

Option B: For patients, who have not been detoxed here, consider the VACT Risk Assessment Tool.

1. History of DTs (2pts)
2. History of Sz (2pts)
3. History of multiple withdrawals (2pts)
4. ≥20 servings of etoh/day (2pts)
5. C. 10 servings of etoh/day (1pt)
6. Age >55 y.o. (1pt)
7. Breathalyzer >200 or CIWA>8 (1pt)
8. Significant medical co-morbidity (1pt)
9. History of withdrawal hallucinosis (1pt)

≤ 4 Points	Low Risk Protocol, Consider PER or Outpatient **Ativan 1mg Q2hr prn**
5-7 Points	Moderate Risk Protocol **Ativan 1mg Q4hr and 1mg q2hr prn**
≥ 8 Points	High Risk Protocol, Consider SDU admit **Ativan 3mg Q3hr and 2mg q2hr prn**

Option C: For patients, who are "resistant to benzodiazepines" as defined by requiring an **Ativan drip of ≥2mg/hr,** consider admitting to the MICU for phenobarbital. For details of this MICU protocol, go to TOOLS→Clinical Resources→Guidelines and Protocols→Guidelines→Phenobarbital. Warning: Phenobarbital has a t1/2 of 3days, similar to chlordiazepoxide and should be used with caution.

Protocols

- For patients deemed higher risk, a front-loaded therapy with longer acting benzo is generally preferred to achieve more rapid control of alcohol withdrawal symptoms.
- Phenobarb mono therapy is also used to treat alcohol withdrawal symptoms in the ED

Stabilization of Alcohol Withdrawal in the ED

- Few established standards for ED setting (practice is variable)
- Undertreatment occurs more frequently than overtreatment
- Symptom-triggered dosing is preferred over scheduled dosing
  - "Front-loading" protocol until AWS is stabilized
- Most protocols recommend benzodiazepines as first-line therapy, but emerging interest in the use of phenobarbital (PB) as monotherapy for AWS in the ED

Sample Front-Loading Benzodiazepine Protocols for the ED Setting

Severity	Lorazepam	Diazepam
Mild AWS (1)	• 2–4 mg PO q1–2h until CIWA-Ar < 10	• 20–40 mg PO q1–2h until CIWA-Ar < 10
Moderate to Severe AWS (2)	• 2 mg IV q15-20m until RASS 0 to -1 • After 2 doses, consider doubling each subsequent dose	• 10 mg IV q5-10m until RASS 0 to -1 • After 2 doses, consider doubling each subsequent dose

- ASAM 2020 AWS CPG
- *No published peer-reviewed BZD dosing protocols for the ED setting that I am are aware of, this is my basic approach, and as informed by AAEM 2023 White Paper on AWS*

Phenobarbital for AWS in the ED

- Value in identifying alternative treatment regimens (benzo shortage)
- Limited direct evidence on the utility of PB for AWS in the ED
    - Available evidence, along with pharmacology and expert opinion, suggests it may be a reasonable approach
- The “self-tapering” effect of PB (long half-life) = well-suited for ED use (provides effective one-time treatment)
- Consider PB as first-line monotherapy in patients at risk for severe or complicated AWS (i.e., anticipate ICU-level of care)

Phenobarbital for AWS in the ED

Critical concepts:

1. Must confirm AWS diagnosis
2. Predictable dose-response relationship when used as monotherapy
3. Loading dose based on *ideal body weight*
4. PB load vs. PB titration
5. Monitor cumulative PB dose

GOAL:

- 10 mg/kg cumulative dose **OR** RASS -1

Methods of Administration:

- **PB Load:** infuse 10 mg/kg over 30 minutes
- **PB Titration:**
  - Moderate: 130 mg IV infused over ~3 minutes q30 minutes, **HOLD** for RASS -1 or lower
  - Severe: 260 mg IV infused over ~5 minutes q30 minutes, **HOLD** for RASS -1 or lower

Hospitalization or residential setting:

- May consider placing on CIWA protocol
- Some patients do not require further treatment for AWS after PB load

Discharge:

- No Phenobarbital!
- Medications for AUD
- Nutritional supplementation

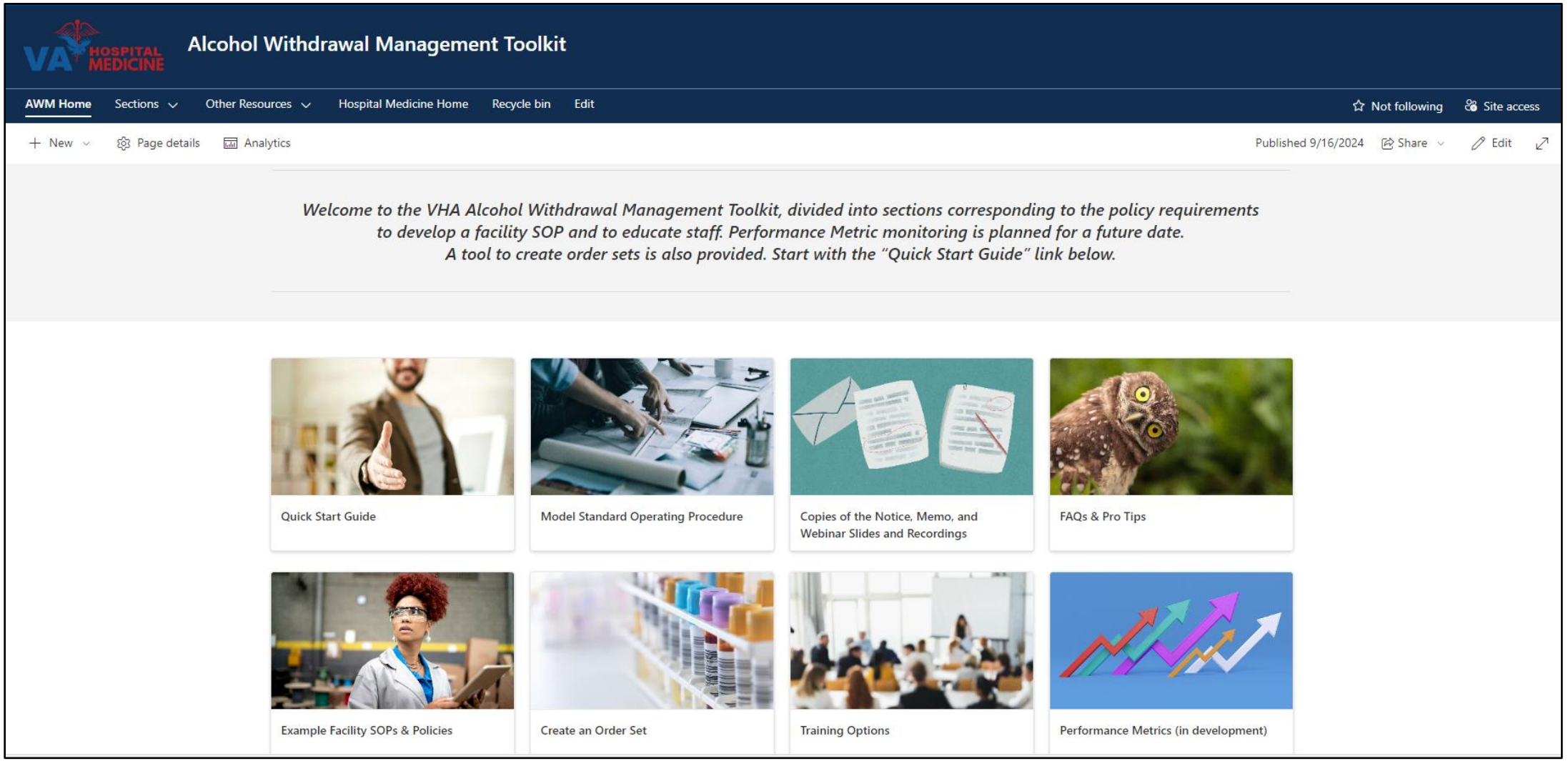
- Adapted and shared with permission from the Internet Book of Critical Care
- 10 mg/kg load based on Rosenson et al., 2012, also ASAM 2020 Alcohol Withdrawal Management Guideline
- Titration protocol based on Oks et al., 2020

Ongoing Care for Alcohol Use Disorder

- WM as a standalone intervention is not generally recommended.
- Individuals with AUD have improved outcomes when they participate in WM and subsequent treatment for AUD.
- Therefore, all WM protocols should include a plan for ongoing relapse prevention including:
  - **AUD pharmacotherapy** (i.e., naltrexone, acamprosate, etc.)
  - Psychosocial treatments and psychosocial support
  - Nutritional supplementation

Reference:

- ASAM 2020 AWS CPG
- Timko C, Below M, Schultz NR, Brief D, Cucciare MA. Patient and program factors that bridge the detoxification-treatment gap: a structured evidence review. J Subst Abuse Treat. 2015 May;52:31-9. doi: 10.1016/j.jsat.2014.11.009. Epub 2014 Dec 3. PMID: 25530425.
- Mutter R, Ali MM. Factors associated with completion of alcohol detoxification in residential settings. J Subst Abuse Treat. 2019 Mar;98:53-58. doi: 10.1016/j.jsat.2018.12.009. Epub 2018 Dec 26. PMID: 30665604.



[Alcohol Withdrawal Management Toolkit - Home (sharepoint.com)]

The Evolution of OUD Treatment in the ED

- **2015–2017: ED-Initiated Buprenorphine Gains Traction**
  - RCTs confirm ED-initiated buprenorphine improves treatment retention.
  - 2017: U.S. declares the opioid crisis a public health emergency.
- **2018–2020: Expanding Access to MOUD**
  - X-waiver revision allows more ED providers to prescribe buprenorphine.
  - A variety of ED protocols emerge to address fentanyl withdrawal (high-dose, low-dose, observed, unobserved initiations).
  - COVID-19 relaxes methadone rules, expands telemedicine for MOUD.
- **2023 – Present: Innovations in Treatment**
  - X-waiver eliminated → Any clinician can prescribe buprenorphine.
  - Brixadi (weekly/monthly injectable buprenorphine) approved.

OUD Treatment in the ED: A Case-Based Approach

- Follow a single patient through different stages of ED treatment and relapse to explore various interventions, including:
  - High-dose buprenorphine
  - Low-dose buprenorphine
  - Extended-release buprenorphine
  - Methadone

High-Dose Buprenorphine Initiation

- **Case Introduction:**
  A 32-year-old male presents to the ED with opioid withdrawal symptoms. He has a history of opioid use disorder (OUD) and has been using fentanyl daily for the past year. He expresses a desire to start treatment. His Clinical Opioid Withdrawal Scale (COWS) score is 12.

High-Dose Buprenorphine Initiation

- **Case Introduction:**
  A 32-year-old male presents to the ED with opioid withdrawal symptoms. He has a history of opioid use disorder (OUD) and has been using fentanyl daily for the past year. He expresses a desire to start treatment. His Clinical Opioid Withdrawal Scale (COWS) score is 12.

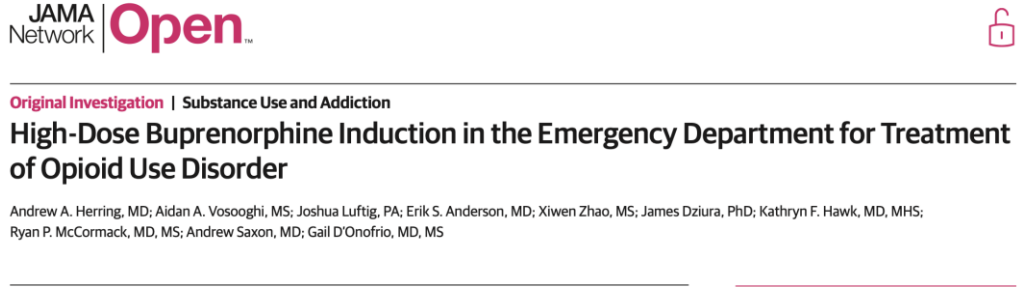
- **Plan:** Initiate high-dose buprenorphine following the CA-Bridge Buprenorphine in the ED protocol.
- **Rationale:** Traditional low-dose initiation may not be sufficient for patients with high fentanyl exposure. High-dose initiation can rapidly relieve withdrawal symptoms and provide stabilization.
- **Outcome:** The patient tolerates treatment well, is discharged with follow-up, and remains stable for 5 months.

High-Dose Buprenorphine Protocols

- **HDB protocols** defined by administration of **> 12 mg of bup SL** in episode of care
- **Pharmacologic Benefits**
  - Rapid MOR Occupancy
  - Respiratory depression ceiling effect
- **Clinical Efficacy**
  - HDB protocols enable faster stabilization, potentially improving patient retention and transition to outpatient care
- **Practical implementation in EDs**
  - HDB protocols minimize the need for complex dose titration (simple)
- **Relevance in Fentanyl Era**
  - Higher buprenorphine doses ensure sufficient receptor activation to counteract fentanyl’s potency and prolonged effects

High-Dose Buprenorphine in the Emergency Department

- Herring et al. (2021) found that HDB initiation in the ED was **safe and effective**
  - 579 ED visits without episodes of respiratory depression
  - Buprenorphine precipitated opioid withdrawal (BPOW) was rare (< 1%)

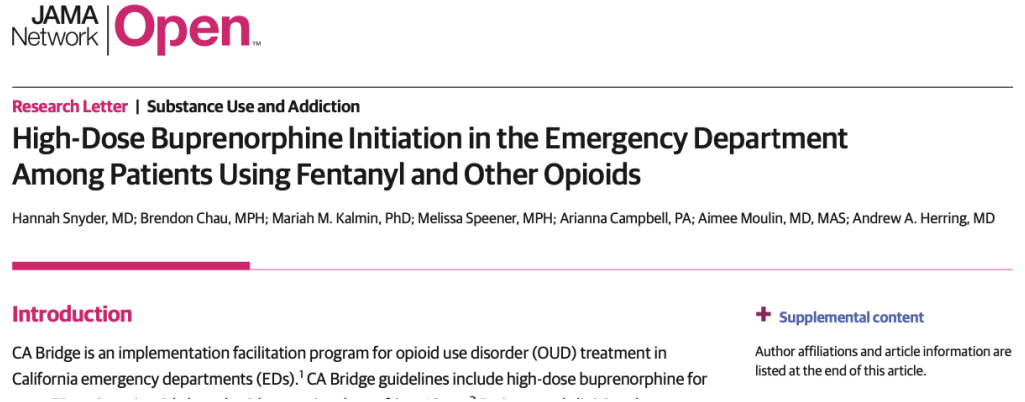

JAMA Network Open

Original Investigation | Substance Use and Addiction

High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder

Andrew A. Herring, MD; Aidan A. Vosooghi, MS; Joshua Luftig, PA; Erik S. Anderson, MD; Xiwen Zhao, MS; James Dziura, PhD; Kathryn F. Hawk, MD, MHS; Ryan P. McCormack, MD, MS; Andrew Saxon, MD; Gail D'Onofrio, MD, MS

- Snyder et al. (2023) found HDB effective across opioid types and low risk of adverse events (BPOW 1.6%)


JAMA Network Open

Research Letter | Substance Use and Addiction

High-Dose Buprenorphine Initiation in the Emergency Department Among Patients Using Fentanyl and Other Opioids

Hannah Snyder, MD; Brendon Chau, MPH; Mariah M. Kalmin, PhD; Melissa Speener, MPH; Arianna Campbell, PA; Aimee Moulin, MD, MAS; Andrew A. Herring, MD

Introduction

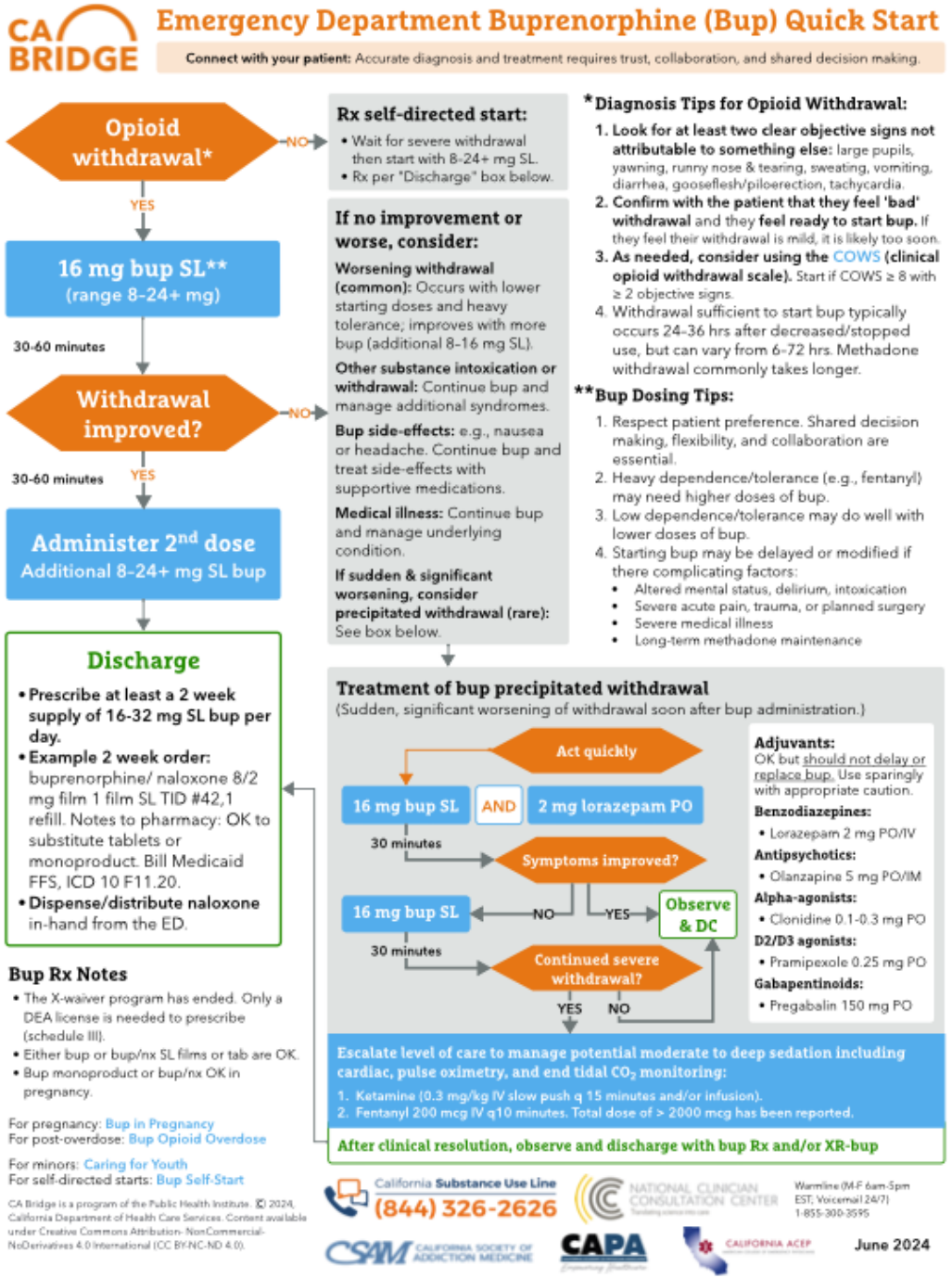
CA Bridge is an implementation facilitation program for opioid use disorder (OUD) treatment in California emergency departments (EDs).[1] CA Bridge guidelines include high-dose buprenorphine for

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

1. Herring AA, Vosooghi AA, Luftig J, et al. High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder. *JAMA Netw Open.* 2021;4(7):e2117128. doi:10.1001/jamanetworkopen.2021.17128
2. Snyder H, Chau B, Kalmin MM, et al. High-Dose Buprenorphine Initiation in the Emergency Department Among Patients Using Fentanyl and Other Opioids. *JAMA Netw Open.* 2023;6(3):e231572. doi:10.1001/jamanetworkopen.2023.1572

CA Bridge:
ED Buprenorphine Quick Start (HDB)



- https://bridgetotreatment.org/resource/buprenorphine-bup-hospital-quick-start/

Low-Dose Buprenorphine Initiation (LDBI)

- **Case Introduction:**
  The patient returns to the ED after a relapse. He has been using fentanyl daily (3g/day) for the past month but is not currently experiencing withdrawal (COWS = 0) as he used fentanyl just before arrival.

Low-Dose Buprenorphine Initiation (LDBI)

- **Case Introduction:**
  The patient returns to the ED after a relapse. He has been using fentanyl daily (3g/day) for the past month but is not currently experiencing withdrawal (COWS = 0) as he used fentanyl just before arrival. He is concerned about transitioning to buprenorphine and prefers a protocol that mitigates experiencing opioid withdrawal.

- **Plan:** Initiate an unobserved low-dose buprenorphine microdosing protocol to transition him without inducing withdrawal.
- **Rationale:** Low-dose initiation allows for a gradual transition to buprenorphine while minimizing withdrawal discomfort.
- **Outcome:** The patient attempts the protocol for 3 days but struggles with adherence, therefore is admitted to the hospital to complete the transition to buprenorphine.

Low-Dose Buprenorphine Initiation (LDBI)

- Also referred to as “micro-dosing” or cross tapering
- Multiple protocols with limited evidence basis in ED setting – no one “right” way to do it
- Typically used in the context of transitioning patients off prescribed long-term opioid therapy
- Sometimes used in patients with OUD reporting difficulty starting buprenorphine in the past (mitigates opioid withdrawal and discomfort with transition)
- Require a high degree of health literacy and medication adherence
- Generally, avoid LDBI protocols if patient is already in significant withdrawal

CA-Bridge: Low-Dose Buprenorphine Initiation (LDBI)

3-day Sublingual Cross Taper Start

Prescribe 2 mg buprenorphine films #6, 8 mg buprenorphine films #4 for 3 day supply)[4]

- Day 1: 0.5 mg (1/4 of 2mg strip) SL buprenorphine q3 hours (4 mg total daily dose), continue full opioid agonists
- Day 2: 1 mg (1/2 of 2 mg strip) SL buprenorphine q3 hours (8 mg total daily dose), continue full opioid agonists
- Day 3: 8-16 mg (1-2 8 mg strips) SL buprenorphine once daily and 4 mg SL q6h prn withdrawal (max 32 mg total daily dose), wean or stop full opioid agonists

7-day Sublingual Cross Taper Start

Prescribe 2 mg buprenorphine SL strips # 15, 8 mg buprenorphine SL strips #4 for 7 day supply

- Day 1: 0.5 mg (1/4 of 2 mg strip) buprenorphine SL daily (0.5 mg total daily dose), continue full opioid agonist
- Day 2: 0.5 mg (1/4 of 2 mg strip) buprenorphine SL BID (1 mg total daily dose), continue full opioid agonist
- Day 3: 1 mg (1/2 of 2 mg strip) buprenorphine SL BID (2 mg total daily dose), continue full opioid agonist
- Day 4: 2 mg buprenorphine SL BID (4 mg total daily dose), continue full opioid agonist
- Day 5: 3 mg (1+1/2 of 2 mg strip) buprenorphine SL BID (6 mg total daily dose), continue full opioid agonist
- Day 6: 4 mg (2 of 2 mg strip) buprenorphine SL BID (8 mg total daily dose), continue full opioid agonist
- Day 7: 6 mg (3 of 2 mg strip) buprenorphine SL BID (12 mg total daily dose), continue full opioid agonist
- Day 8: 16 mg (2 of 8 mg strip) buprenorphine qday and 4mg (1/2 of 8 mg strip) q6h prn withdrawal (max 32 mg total daily dose), wean or stop full opioid agonists

- Starting Buprenorphine with Microdosing and Cross Tapering - Bridge to Treatment

Extended-Release Buprenorphine Initiation (Brixadi)

- **Case Introduction:**
  The patient relapses after 1 year of stability, using fentanyl for the past 2 months. He reports issues with taking his buprenorphine as prescribed and had the medication stolen a few times in the past year. He is interested in OUD treatment, but is requesting support with medication management. He last used fentanyl 12 hours ago, with a COWS score of 5.

Extended-Release Buprenorphine Initiation (Brixadi)

- **Case Introduction:**
  The patient relapses after 1 year of stability, using fentanyl for the past 2 months. He reports issues with taking his buprenorphine as prescribed and had the medication stolen a few times in the past year. He is interested in OUD treatment, but is requesting support with medication management. He last used fentanyl 12 hours ago, with a COWS score of 5.

- **Plan:** Initiate Brixadi, a newly available extended-release buprenorphine formulation.
- **Rationale:** Extended-release buprenorphine reduces daily medication adherence issues and provides long-term stability.
- **Outcome:** The patient stabilizes and does well on Brixadi for 5 months.

ED-Brixadi Protocol (7-Day Extended-Release Dose)

- **Background:**
  - One barrier to sublingual buprenorphine (SL-BUP) initiation in the ED is that patient's must be experiencing sufficient opioid withdrawal (COWS ≥ 8) at the time of presentation to avoid buprenorphine precipitated opioid withdrawal (BPOW).
  - The slower rate of rise in plasma buprenorphine concentration of XR-BUP, reaching 1.6 ng/mL in 4 hours compared with 5.6 ng/mL in SL-BUP dosing, potentially permits buprenorphine initiation in patients with minimal to mild withdrawal (COWS 4-7).

- **Key Findings from Recent Studies:**
  - Feasibility & Safety (D'Onofrio et al., JAMA Network Open, 2024)
    - 100 patients with minimal to mild opioid withdrawal (COWS 0-7) received a 7-day extended-release buprenorphine injection (24 mg CAM2038).
    - Only 3.2% experienced precipitated withdrawal within 4 hours (COWS 4-7 group).
    - 73% remained engaged in OUD treatment at 7 days.
  - Early ED Experience (D'Onofrio et al., Acad Emerg Med, 2023)
    - 7-day XR-BUP provided continuous medication coverage, reducing treatment drop-off.
    - Minimal precipitated withdrawal even in fentanyl-exposed patients.
    - High patient satisfaction: improved privacy, eliminated daily medication burden, and facilitated transition to long-term treatment.

ED-Brixadi Protocol (7-Day Extended-Release Dose)

- **ED Protocol for Brixadi Initiation:**
  - **Eligibility:** Patients 18+ years old with opioid use disorder (OUD) and in at least mild withdrawal (COWS ≥4).
  - **Dosing:** Single 24 mg subcutaneous injection (Brixadi) administered in the abdomen, thigh, or gluteal area.
  - **Monitoring:** Patients observed for at least 2 hours post-injection for precipitated withdrawal or adverse effects.

- **Clinical Implications:**
  - Allows buprenorphine initiation in patients with mild withdrawal, expanding eligibility for ED treatment.
  - Eliminates need for SL-BUP lead-in, reducing delays in care.
  - Patients may also benefit from not having to make daily decisions regarding taking their medication or other circumstances such as having their medication lost, stolen, or confiscated; being unable to continue in short-term jail stays; or experiencing pressure to share, sell, divert, or misuse their medications.

Methadone Initiation

- **Case Introduction:**
  The patient is lost to follow-up and relapses again, using up to 5g of fentanyl per day for the past 4 months. He expresses concern that buprenorphine has not been sufficient for his cravings and wants to try methadone.

- **Plan:** Utilize the methadone "3-day rule" in the ED while facilitating rapid intake at the VA opioid treatment program (OTP) within 72 hours.
- **Outcome:** The patient starts methadone treatment and engages in long-term care.

- **Educational Blurb:**
  Methadone is a full agonist that is highly effective for severe OUD cases. The "3-day rule" allows ED providers to administer methadone for opioid withdrawal while arranging ongoing treatment in a licensed opioid treatment program.

Methadone Initiation

- **Case Introduction:**
  The patient is lost to follow-up and relapses again, using up to 5g of fentanyl per day for the past 4 months. He expresses concern that buprenorphine has not been sufficient for his cravings and wants to try methadone.

Methadone Regulations

- 21 CFR 1306.07 (one of two federal regulations guiding the use of methadone in OUD) as it applies to dispensing methadone for OUD in the ED:
  - *In two limited circumstances, DEA regulations allow hospitals to dispense methadone for OUD without an NTP registration. First, a physician or authorized hospital staff may, without being separately registered as an NTP, "administer or dispense narcotic drugs in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction." 21 CFR 1306.07(c). Second, a practitioner may dispense, but not prescribe, narcotic drugs "for the purpose of initiating maintenance treatment or detoxification treatment (or both)." 21 CFR 1306.07(b). In this scenario, a practitioner may dispense not more than a three-day supply of methadone to one person or for one person's use at one time while arrangements are being made for referral for treatment.*

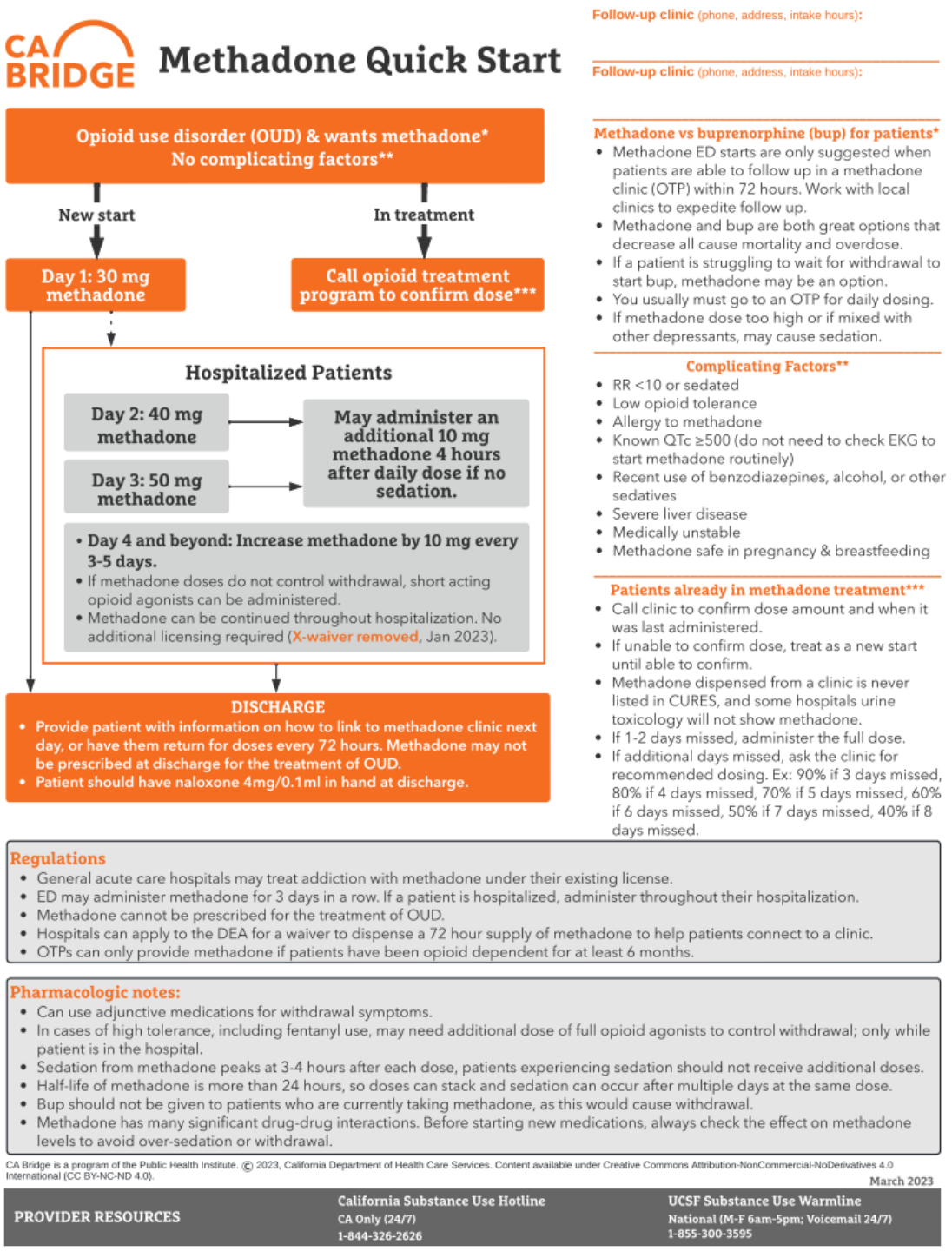
- Dispensing methadone for OUD in the ED must meet **either** of the following conditions:
  1. Methadone dosing is incidental to ED treatment for another emergent concern
  2. Methadone dosing is intended to commence longer-term methadone treatment or a detoxification course

CA-Bridge: Methadone

- Methadone ED starts are only suggested when patients are able to f/u in a methadone clinic (OTP).
  - If no VA OTP available, may work with local community clinics to expedite f/u.

- While not widely performed within VA, there are multiple models for ED-Methadone starts (i.e., Greater Los Angeles, Philadelphia, Northern California HCS, etc.)

- Methadone Hospital Quick Start - Bridge to Treatment



CA BRIDGE

Methadone Quick Start

Follow-up clinic (phone, address, intake hours):

Follow-up clinic (phone, address, intake hours):

**Opioid use disorder (OUD) & wants methadone*
No complicating factors****

New start → **Day 1: 30 mg methadone**

In treatment → **Call opioid treatment program to confirm dose*****

Hospitalized Patients

- **Day 2: 40 mg methadone**
- **Day 3: 50 mg methadone**

→ **May administer an additional 10 mg methadone 4 hours after daily dose if no sedation.**

- **Day 4 and beyond: Increase methadone by 10 mg every 3-5 days.**
- If methadone doses do not control withdrawal, short acting opioid agonists can be administered.
- Methadone can be continued throughout hospitalization. No additional licensing required (X-waiver removed, Jan 2023).

DISCHARGE

- **Provide patient with information on how to link to methadone clinic next day, or have them return for doses every 72 hours. Methadone may not be prescribed at discharge for the treatment of OUD.**
- **Patient should have naloxone 4mg/0.1ml in hand at discharge.**

Methadone vs buprenorphine (bup) for patients*

- Methadone ED starts are only suggested when patients are able to follow up in a methadone clinic (OTP) within 72 hours. Work with local clinics to expedite follow up.
- Methadone and bup are both great options that decrease all cause mortality and overdose.
- If a patient is struggling to wait for withdrawal to start bup, methadone may be an option.
- You usually must go to an OTP for daily dosing.
- If methadone dose too high or if mixed with other depressants, may cause sedation.

Complicating Factors**

- RR <10 or sedated
- Low opioid tolerance
- Allergy to methadone
- Known QTc ≥500 (do not need to check EKG to start methadone routinely)
- Recent use of benzodiazepines, alcohol, or other sedatives
- Severe liver disease
- Medically unstable
- Methadone safe in pregnancy & breastfeeding

Patients already in methadone treatment***

- Call clinic to confirm dose amount and when it was last administered.
- If unable to confirm dose, treat as a new start until able to confirm.
- Methadone dispensed from a clinic is never listed in CURES, and some hospitals urine toxicology will not show methadone.
- If 1-2 days missed, administer the full dose.
- If additional days missed, ask the clinic for recommended dosing. Ex: 90% if 3 days missed, 80% if 4 days missed, 70% if 5 days missed, 60% if 6 days missed, 50% if 7 days missed, 40% if 8 days missed.

Regulations

- General acute care hospitals may treat addiction with methadone under their existing license.
- ED may administer methadone for 3 days in a row. If a patient is hospitalized, administer throughout their hospitalization.
- Methadone cannot be prescribed for the treatment of OUD.
- Hospitals can apply to the DEA for a waiver to dispense a 72 hour supply of methadone to help patients connect to a clinic.
- OTPs can only provide methadone if patients have been opioid dependent for at least 6 months.

Pharmacologic notes:

- Can use adjunctive medications for withdrawal symptoms.
- In cases of high tolerance, including fentanyl use, may need additional dose of full opioid agonists to control withdrawal; only while patient is in the hospital.
- Sedation from methadone peaks at 3-4 hours after each dose, patients experiencing sedation should not receive additional doses.
- Half-life of methadone is more than 24 hours, so doses can stack and sedation can occur after multiple days at the same dose.
- Bup should not be given to patients who are currently taking methadone, as this would cause withdrawal.
- Methadone has many significant drug-drug interactions. Before starting new medications, always check the effect on methadone levels to avoid over-sedation or withdrawal.

March 2023

PROVIDER RESOURCES	California Substance Use Hotline CA Only (24/7) 1-844-326-2626	UCSF Substance Use Warmline National (M-F 6am-5pm; Voicemail 24/7) 1-855-300-3595

Treatment of OUD in the ED: Key Takeaways

1. Buprenorphine protocols available for observed (in the ED) or unobserved (at home) initiations.
2. High-dose buprenorphine is safe and effective for patients in acute opioid withdrawal (COWS ≥ 8).
3. Low-dose buprenorphine helps patients transition to buprenorphine by mitigating opioid withdrawal symptoms.
4. Extended-release buprenorphine (Brixadi) may be initiated in patients with minimal opioid withdrawal (COWS ≥ 4) and may improve adherence.
5. Methadone initiation is an option if patient is able to f/u in a methadone clinic within 72 hours.

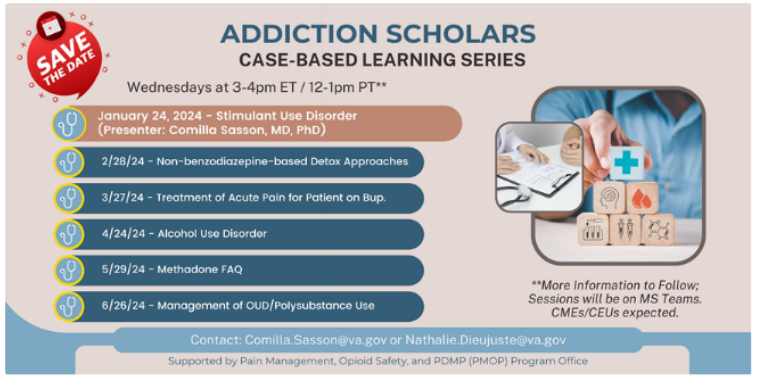
- Buprenorphine Self-Start - Bridge to Treatment

SUD Resources

- **VA:**
  - Substance Use Disorders in the ED SharePoint
  - ED Opioid Safety Initiative SharePoint
    - Documents
  - VA Emergency Medicine Addiction Hotline (VEMAH)
    - Virtual real-time clinician support service
  - Addiction Scholars Program (ASP)
    - 3-Day Mini-Fellowship for all VA providers
  - ASP Case-Based Learning Series
    - Monthly lectures for all VA providers
- **Non-VA:**
  - CA-Bridge

Substance Use Disorders in the Emergency Department

Smith, Jason P. (VISN 19)
Pharmacy Benefits Manager



NEW DEA REQUIREMENT: 8 HOURS OF SUD TRAINING PRIOR TO DEA RENEWAL BY JUNE 27, 2023

The Consolidated Appropriations Act, 2023 (H.R. 2617), signed into law December 29, 2022, eliminated the DATA-waiver (aka the X-waiver) program. However, there is a new DEA requirement to complete 8 hours of training in substance use disorder treatment prior to renewing your DEA registration on or after June 27, 2023. You will need to attest to completing these hours when you next renew your DEA on or after that date.

Below is a table of training programs through which you can meet this requirement. I want to highlight the excellent SUD 101 Core Curriculum offered by the Providers Clinical Support System, which consists of discrete modules you can chose from.

Note that the following are deemed to have already met the requirement: Practitioners who are board certified in addiction medicine or addiction psychiatry and recent graduates in the United States within five years of June 27, 2023 who successfully completed a comprehensive curriculum that included at least eight hours of training. Prior X-waiver training also meets the requirement.

TMS Training Programs for Renewal of DEA License

Training Title	Location/website	Accreditations	Contact Hours	Cost
Pain Management and Opioid Safety	TMS VA 31108	ACCME and ACCME-NP	2	FREE
Assessment and Treatment of Opioid Use Disorder	TMS NFED 4628389	ACCME/ACCME-NP ANCC/APA	1.25	FREE
Medication-Assisted Treatment for Opioid Use	TMS NFED 4628377	ACCME ANCC/APA	1.75	FREE

VA Emergency Medicine Addiction Hotline (VEMAH)

VA | U.S. Department of Veterans Affairs

Clinician Support Service for Treatment of SUD

1. Expand ED scope of practice through low-barrier access to addiction specialist
2. Provide real-time access to standardized SUD treatment protocols
3. Augment on-site staffing through telemedicine (hub and spoke)
4. Create ED-specific training resources
5. Leverage integrated healthcare system for improved care coordination

Barriers and Facilitators to SUD Treatment

Category	Description
Barriers	
Perceived Scope	ED clinicians feel M-OUD falls outside the ED's traditional scope, which focuses on acute care, not long-term management
Lack of Protocols	There is a noted lack of standardized protocols and follow-up procedures for M-OUD within EDs
Staffing Concerns	Insufficient staffing to manage M-OUD interventions effectively
Educational Gaps	Significant gaps in both clinician and patient education on M-OUD
Stigma	Persistent stigma associated with addiction treatment both among providers and patients
Systemic Issues	Logistical challenges like follow-up care and integration with broader health services
Facilitators	
Support Systems	Presence of peer support and integrated social work services
Technology	Utilization of electronic medical record (EMR) order sets and telehealth platforms
Training Availability	Access to comprehensive training and continuing education on addiction care

Brought to you by

- The Office of Mental Health
- National Emergency Medicine Office
- VISN 22 Tele-Emergency Care
- Pain Management, Opioid Safety, and PDMP (PMOP)

VA Emergency Medicine Addiction Hotline

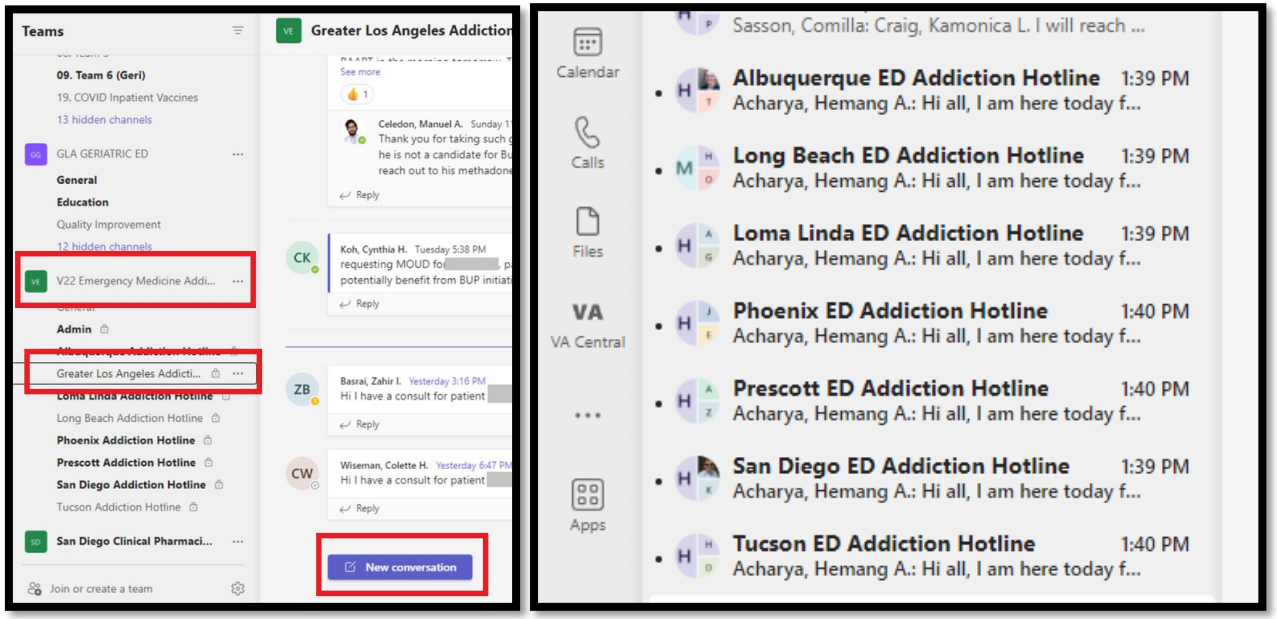
- Virtual real-time clinician support service for acute care providers
- Think Poison Control Line but for addiction medicine
- Staffed daily (including weekends and holidays) from 1 pm to 9 pm PST

Combination of Services

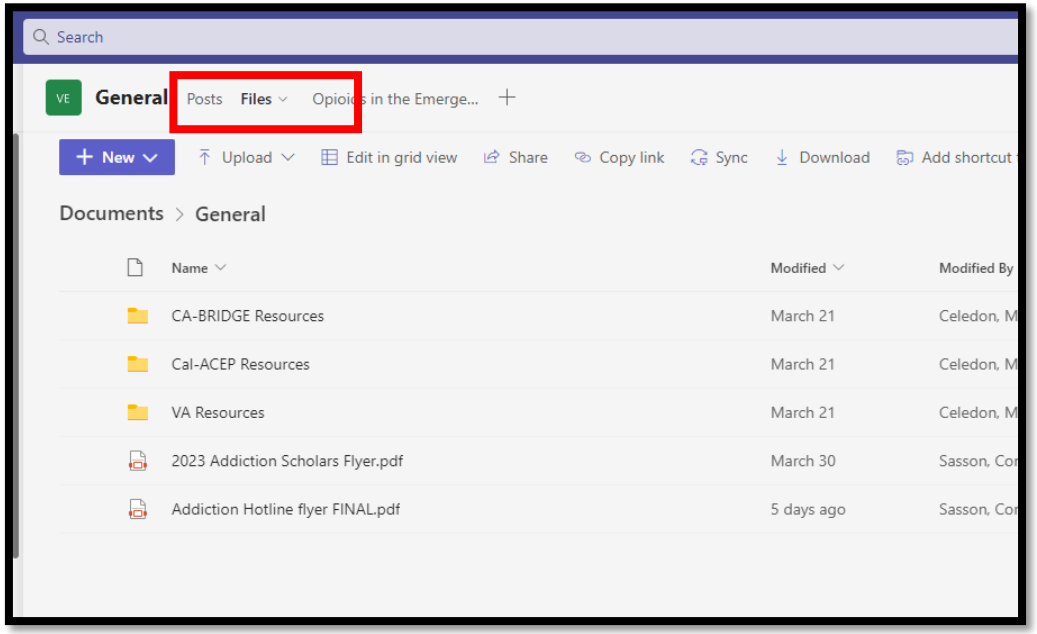
Poison Control Hotline + **UCSF Substance Use Warmline** + **CA-Bridge Substance Use Navigator** = **VA EMERGENCY ADDICTION HOTLINE (VEMAH)**

COMMUNICATION AND SHARING OF BEST PRACTICES

Encrypted Communication Between VA Providers



Acute Care SUD Resources



VA Emergency Addiction Hotline (VEMAH): MEET OUR TEAM

Comilla Sasson, MD, PhD

Emergency Medicine

Addiction Medicine

Manuel Celedon, MD

Emergency Medicine

Addiction Medicine

Cynthia Koh, MD

Emergency Medicine

Toxicology

Addiction Medicine

Zahir Basrai, MD

Emergency Medicine

Addiction Medicine

Ultrasound

Hemang Acharya, MD, MPH

Emergency Medicine

Addiction Medicine

Cullen Averill, MD

LLVA SUD Champion

Addiction Hotline Services

- **Provide low-barrier real-time case discussions from 1pm-9pm PST**
  - Review/responds off-tour messages asynchronously

- Support the assessment and treatment of SUDs (emphasis on opioid and alcohol use)
  - SUD intoxication and withdrawal syndromes

- Discuss treatment of acute pain and adjustments to opioid-based chronic pain regimens to reduce risk of misuse and harm
  - 9% of total VEMAH calls are pain-related

- Discuss Harm reduction and overdose prevention strategies

- On-demand ED provider education
  - Daily addiction pearls
  - CME – Addiction Scholars Program (3-day session every August)
  - Addiction and pain case-based learning sessions (throughout the year)

U.S. Department of Veterans Affairs

Veterans Health Administration

Office of Mental Health

Q&A and Conference Wrap Up

Please ensure you are REGISTERED in TMS, Please email Ainelda.Alfred@va.gov for any TMS questions

After the program: Complete the TMS evaluation and print certificate within *15* calendar days. CE credit will only be available *15* calendar days after today's course date (3/14/2025).