BESPOKE PSYCHIATRY

Substance Abuse in ALF Setting

Date: 06/09/2026

Presented by Dr Jacob Fyda MD CMD

Poll Question

Who is in the room today?

Poll Question

What substances are a problem in your building?

Dr Jacob Fyda MD CMD

- Board Certified Psychiatrist, CEO Bespoke Psychiatry
- Co-Founder/Owner of Bespoke Psychiatry
- Certified Medical Director in LTC
- Psych Medical directorships at several LTC Facilities
- Membership:
  - American Psychiatric Association
  - PALTmed: Post-Acute and LTC Medical Association

PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY® ABPN 1934

Objectives

- **Differentiate and Define Clinical Substance Use Terms**
  Identify and distinguish between clinical definitions of substance abuse, misuse, addiction, tolerance, physical dependence, and psychological dependence across major substance classes (including alcohol, opioids, sedatives, stimulants, and nicotine).
- **Analyze the Regulatory and Clinical "Double Bind" in Long-Term Care**
  Evaluate the operational challenges long-term care operators face in balancing the mandate to prevent resident drug overdoses while simultaneously complying with legal requirements to admit and provide medication-assisted treatment (MAT/MOUD) for residents with substance use disorders.
- **Implement Effective Management and Intervention Strategies**
  Apply evidence-based pharmacological treatments (such as Naltrexone, Buprenorphine, and combination Nicotine Replacement Therapy) and multi-stakeholder management techniques to safely intervene and care for assisted living residents exhibiting clinically significant substance use.

Outline

Context
Addiction in Post-Acute Care

Magnitude
Scope of the Problem in General

Definitions
Addiction vs. Abuse vs. Intoxication

Specific Disorders:

local_barAlcohol use disorder

medical_servicesOpiate use disorder

medicationSedative use disorder

boltMethamphetamine use disorder

layersCocaine use disorder

smoking_roomsNicotine use disorder

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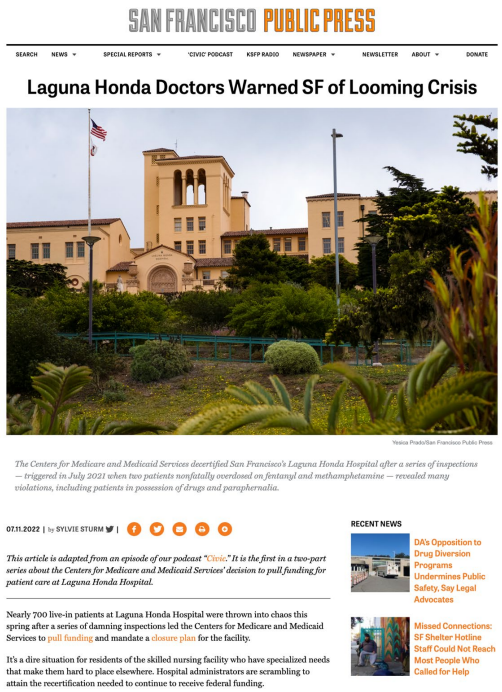
Scope of the Problem: overdoses

Laguna Honda's current troubles began last July, after two patients overdosed on illegal drugs and recovered. That report triggered the state visit in October, after which inspectors found the facility out of compliance That led to the recommendation that CMS end its contract with Laguna Honda on April 14 if the nursing home was still out of compliance.



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SEARCH NEWS SPECIAL REPORTS 'CIVIC' PODCAST KSFP RADIO NEWSPAPER NEWSLETTER ABOUT DONATE

Laguna Honda Doctors Warned SF of Looming Crisis

Yesica Prado/San Francisco Public Press

The Centers for Medicare and Medicaid Services decertified San Francisco's Laguna Honda Hospital after a series of inspections — triggered in July 2021 when two patients nonfatally overdosed on fentanyl and methamphetamine — revealed many violations, including patients in possession of drugs and paraphernalia.

07.11.2022 | by SYLVIE STURM |

This article is adapted from an episode of our podcast "Civic." It is the first in a two-part series about the Centers for Medicare and Medicaid Services' decision to pull funding for patient care at Laguna Honda Hospital.

Nearly 700 live-in patients at Laguna Honda Hospital were thrown into chaos this spring after a series of damning inspections led the Centers for Medicare and Medicaid Services to pull funding and mandate a closure plan for the facility.

It's a dire situation for residents of the skilled nursing facility who have specialized needs that make them hard to place elsewhere. Hospital administrators are scrambling to attain the recertification needed to continue to receive federal funding.

RECENT NEWS

DA's Opposition to Drug Diversion Programs Undermines Public Safety, Say Legal Advocates

Missed Connections: SF Shelter Hotline Staff Could Not Reach Most People Who Called for Help

St. Louis Post-Dispatch

https://www.stltoday.com › health-med-fit › health › staf...

[Staffing shortages are widespread in Missouri, Illinois ...]

Aug 18, 2018 — Between May 31 and June 7 at Northview Village in St. Louis, **three residents overdosed on illegal drugs**, including one who died in the facility.

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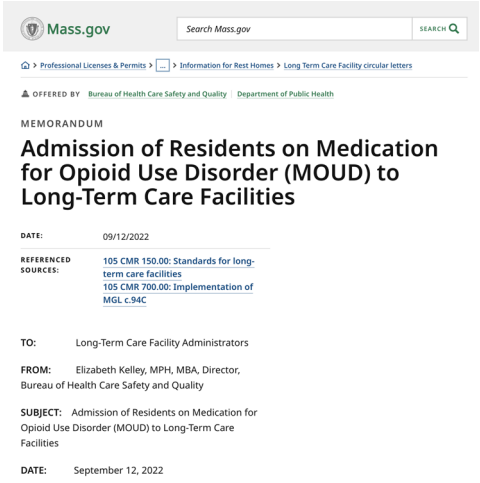
Scope of the Problem: not having treatment

In an effort to combat this confusion, the Massachusetts Department of Public Health in 2016 issued guidance for nursing facilities caring for patients who take medicines for addiction. The state's circular letter asserted that care facilities must provide medication-assisted treatment for people who are already on it, and who otherwise are eligible for admission. A spokesperson said that the department addresses any concerns related to the topic that are brought to its attention, and that it reviews a facility's policies and procedures when conducting a nursing home on-site visit. But the agency has not tracked complaints about addiction-related admission denials.



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OFFERED BY Bureau of Health Care Safety and Quality | Department of Public Health

MEMORANDUM

Admission of Residents on Medication for Opioid Use Disorder (MOUD) to Long-Term Care Facilities

DATE: 09/12/2022

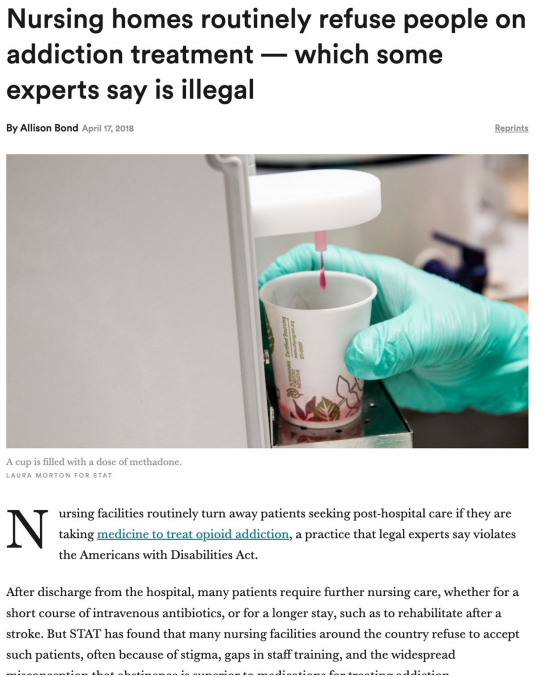
REFERENCED SOURCES: 105 CMR 150.00: Standards for long-term care facilities
105 CMR 700.00: Implementation of MGL c.94C

TO: Long-Term Care Facility Administrators

FROM: Elizabeth Kelley, MPH, MBA, Director, Bureau of Health Care Safety and Quality

SUBJECT: Admission of Residents on Medication for Opioid Use Disorder (MOUD) to Long-Term Care Facilities

DATE: September 12, 2022



Nursing homes routinely refuse people on addiction treatment — which some experts say is illegal

By Allison Bond April 17, 2018 Reprints

A cup is filled with a dose of methadone.
LAURA MORTON FOR STAT

Nursing facilities routinely turn away patients seeking post-hospital care if they are taking medicine to treat opioid addiction, a practice that legal experts say violates the Americans with Disabilities Act.

After discharge from the hospital, many patients require further nursing care, whether for a short course of intravenous antibiotics, or for a longer stay, such as to rehabilitate after a stroke. But STAT has found that many nursing facilities around the country refuse to accept such patients, often because of stigma, gaps in staff training, and the widespread misconception that abstinence is superior to medications for treating addiction

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Double Bind

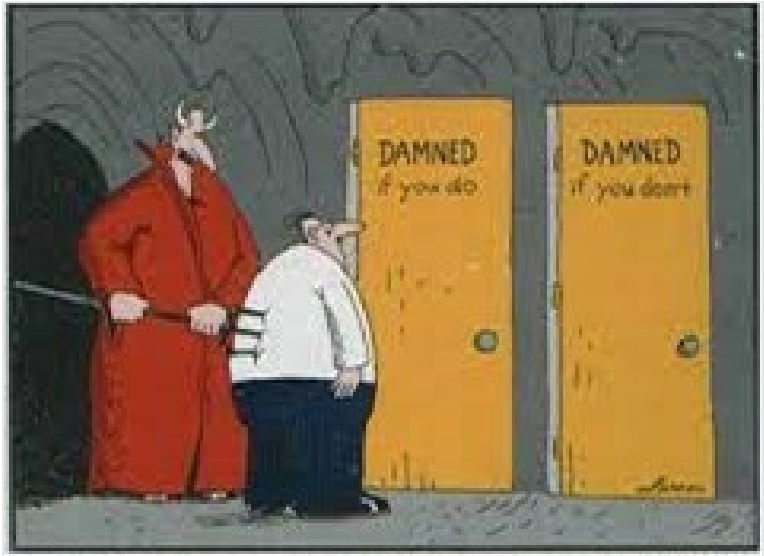
The Conflict

We are receiving two reciprocally conflicting messages:

- Must not have overdoses of drugs
- Must care for folks with SUDs

The Path Forward

Solution: Comprehensive Treatment



"C'mon c'mon - it's either one or the other".

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Positive Examples:

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Growing Crisis

Diagnosis & Treatment

Substance abuse in older adults often goes **underdiagnosed**. Even when identified, it is frequently **undertreated**.

Hospital Impact

Older adults with addiction account for **more than twice** the number of hospital readmissions compared to peers without addiction.

Medical Illnesses

Alcohol and Tobacco use are major contributors to a host of complex medical illnesses in this population.

Long-term Complications

Hepatitis C serves as a critical example of potential long-term complications from even brief drug use.

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Scope of the Problem in Post-Acute Care

Research Gap

Little literature exists on treating **Substance use disorders (SUDs)** in the post-acute care setting.

Prescription Focus

Most literature is focused on **escalating doses of prescribed opiates**.

Non-Prescribed Drug Scarcity

Little literature exists on non-prescribed drugs (i.e. **heroin, cocaine, methamphetamines, alcohol**) in post-acute care.

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What is an Addiction?

Addiction is a **treatable**, **chronic** medical disease involving **complex interactions** among:

- Brain circuits
- Genetics
- The environment
- An individual's life experiences

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Definitions

Abuse
The harmful use of a substance

Misuse
The use of a rx drug for other than accepted medical practice

Addiction
Characterized by impaired control over drug use, compulsive use, continued use despite harm, and craving

Physical Dependence
A state of adaptation that manifest as specific withdrawal syndrome

Psychological Dependence
The feeling of need for a substance for positive effects or to avoid negative effects of abstinence

Tolerance
Need for increasing amounts to obtain desired effect or lesser effect with continued use of same amount

Withdrawal
Substance-specific symptoms after cessation; can cause delirium, mood disturbance, sleep issues, or anxiety

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Treatment in General

Detox vs. Treatment

Detoxification alone does **not** constitute treatment of addiction. While mild abuse may resolve, most will not as addiction is a **chronic condition**.

Risk of Inaction

Failure to refer to treatment can **reinforce denial** of substance-related problems and enable continued addiction cycles.

Dual Diagnosis & Integrated Care

Patients with co-occurring psychiatric disorders have **significantly better outcomes** when:

- Both disorders are treated **simultaneously**.
- All stakeholders are fully invested in the recovery process.

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Alcohol Use Disorder

Nature of the Disease

Alcoholism is a **primary, chronic disease** influenced by genetic, psychological, and environmental factors. It is often **progressive and fatal**.

25%

of general hospital inpatients have alcohol related disorders.

Core Characteristics

- Impaired Control over drinking
- Preoccupation with alcohol
- Continued Use despite adverse consequences
- Thinking Distortions (notably denial)

Medical Comorbidities

GI: Gastritis, peptic ulcer, cirrhosis, hepatitis

Neuro: TBI, subdural hematoma, dementia, neuropathy

CV/Other: Cardiomyopathy, stroke, HTN, anemia, pneumonia, pancreatitis

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Alcohol Use Disorder: Treatment

Treatment Success Rates

33% stop drinking | **33%** improve | **33%** never achieve sobriety

Pharmacotherapy Options

Naltrexone

Reduces risk of relapse to heavy drinking.

SE: HA, nausea. Caution: Cannot be used with opioids.

Acamprosate

Aids in maintaining abstinence.

Dosing: Three times a day.

Gabapentin

Utilized as an adjunct or alternative treatment.

Antabuse (disulfiram)

Rarely used in modern clinical practice.

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Opioid Use Disorder

Mortality Trends

Deaths from heroin and synthetics are rising due to variations in purity and contaminants.

While initially driven by prescription misuse, heroin and synthetics now account for most fatalities.

Usage & Demographics

- IV use is most common nationally.
- Increased snorting among those concerned about HIV/HepC.
- Polysubstance use is common.

Common Clinical Complication: Chronic Constipation

Frequent in chronic users; can lead to recurrent abdominal pain and symptoms simulating intestinal obstruction.

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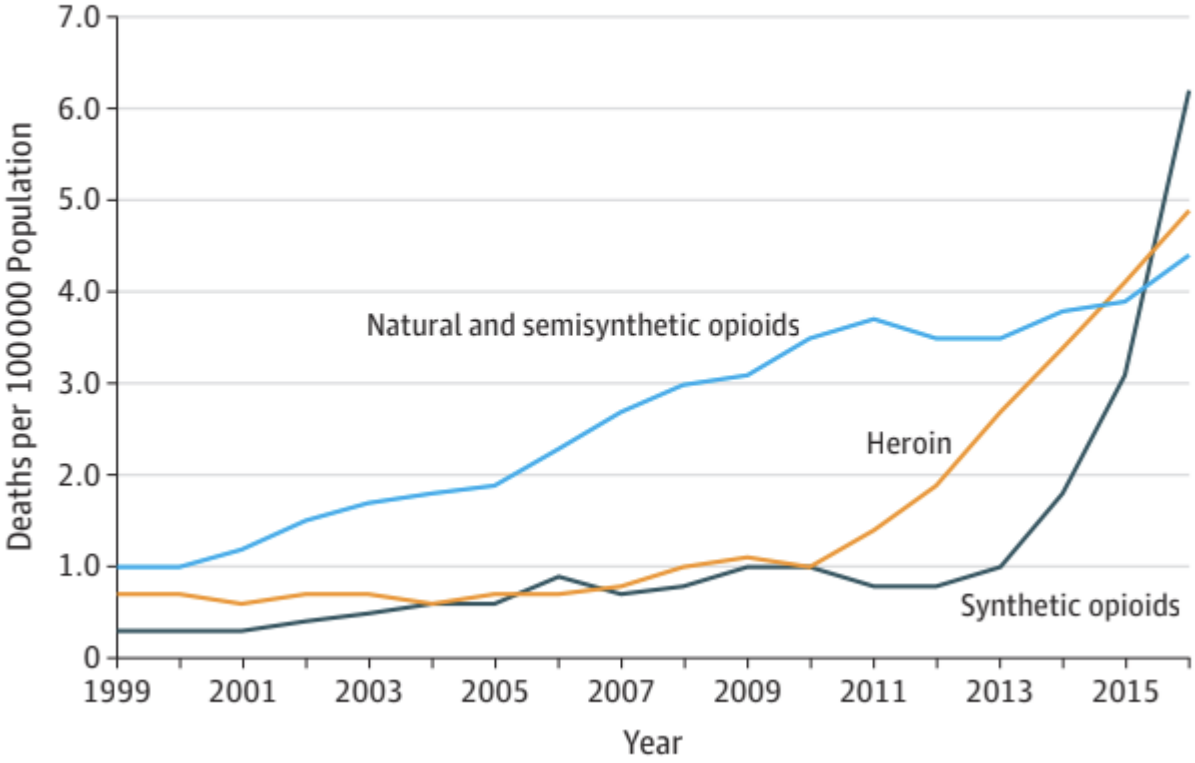
Figure 1. Three Waves of the Increase in Deaths Due to Opioid Overdose



How Opiates Work:

Mechanism of Action

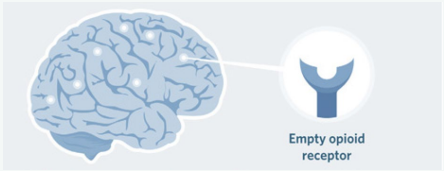
Opiates engage the endogenous opioid system, acting as agonists at the **Mu opioid receptor**.

This interaction is primarily responsible for analgesia and the rewarding effects associated with opioid use.

Receptor Localization

Concentrated in pain and reward circuits, and regions regulating emotions.

- Long-term use linked to depression and anxiety.
- Brainstem presence affects respiratory control.



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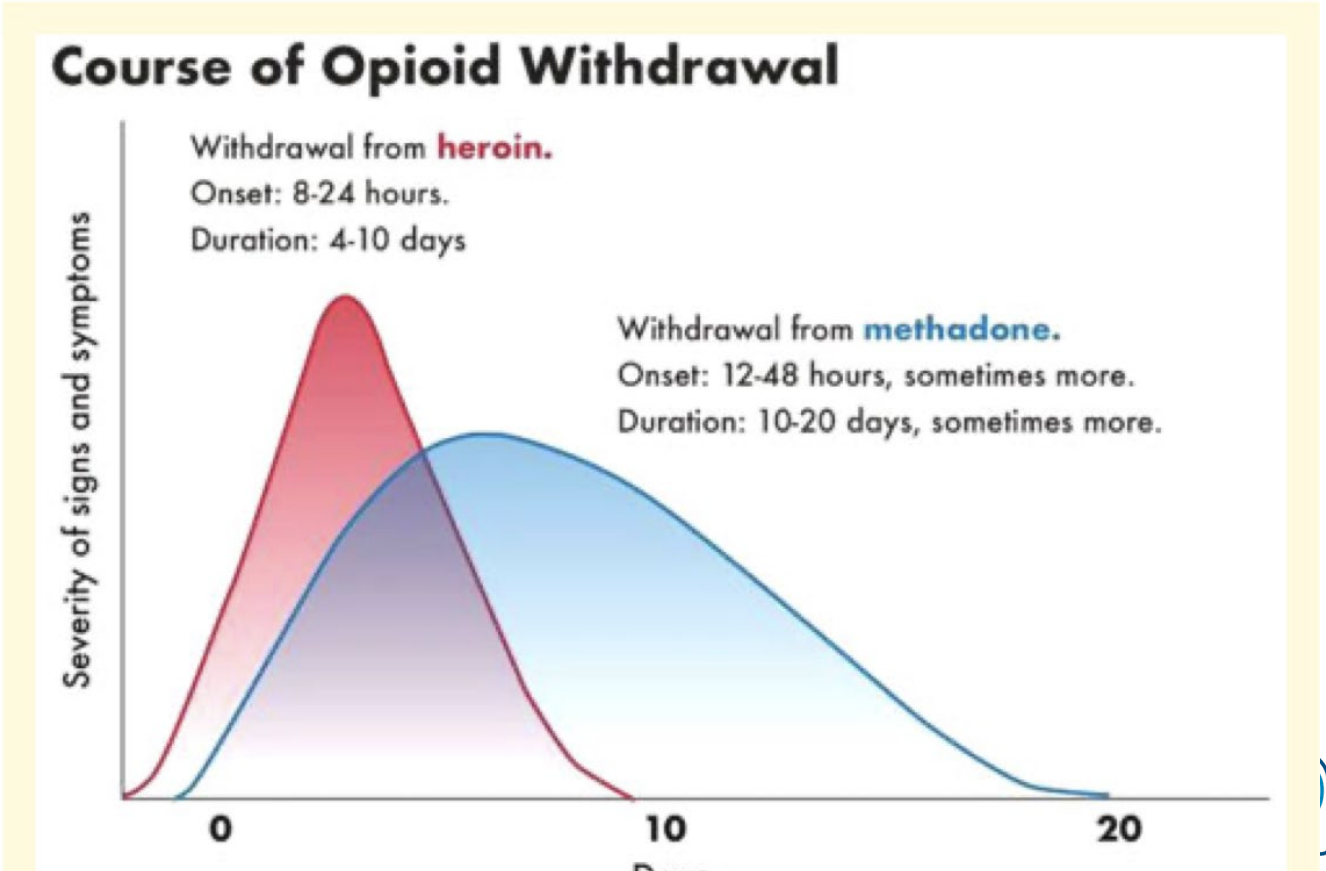
Opiate Half Lives: 2 diseases in 1



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Opiate Intoxication

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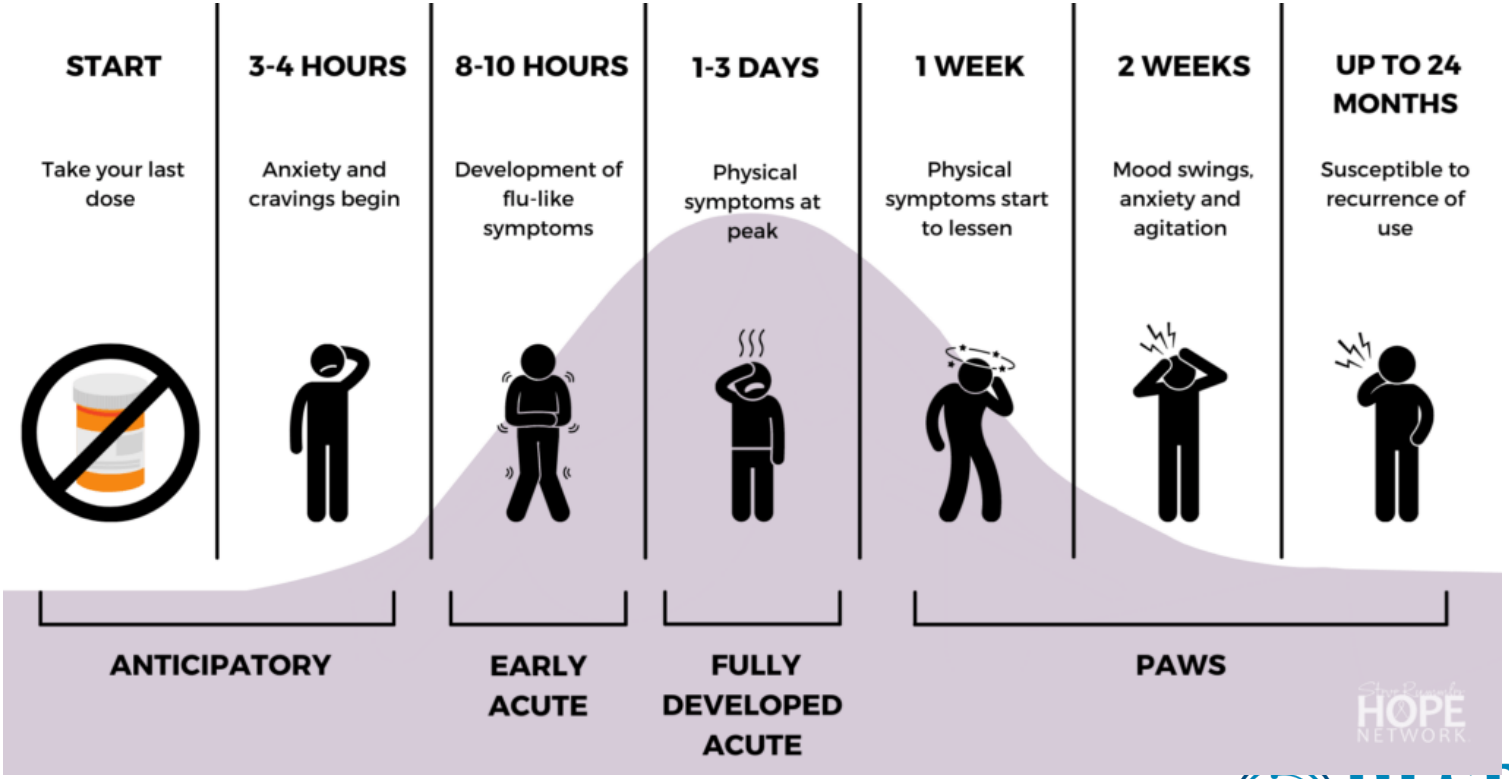
Opiate Withdrawl



Detox is Not a Long-Term Strategy

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CRITICAL CLINICAL INSIGHT

The Limitation

Detox is only a **temporary solution**. It addresses immediate physical withdrawal but does not treat the underlying chronic nature of addiction in Long-Term Care (LTC) settings.

Appropriate Use Case

Most appropriate for a resident who:

- Won’t stop using long-term.
- Requires a specific medical procedure.
- Will temporarily abstain specifically for that procedure.

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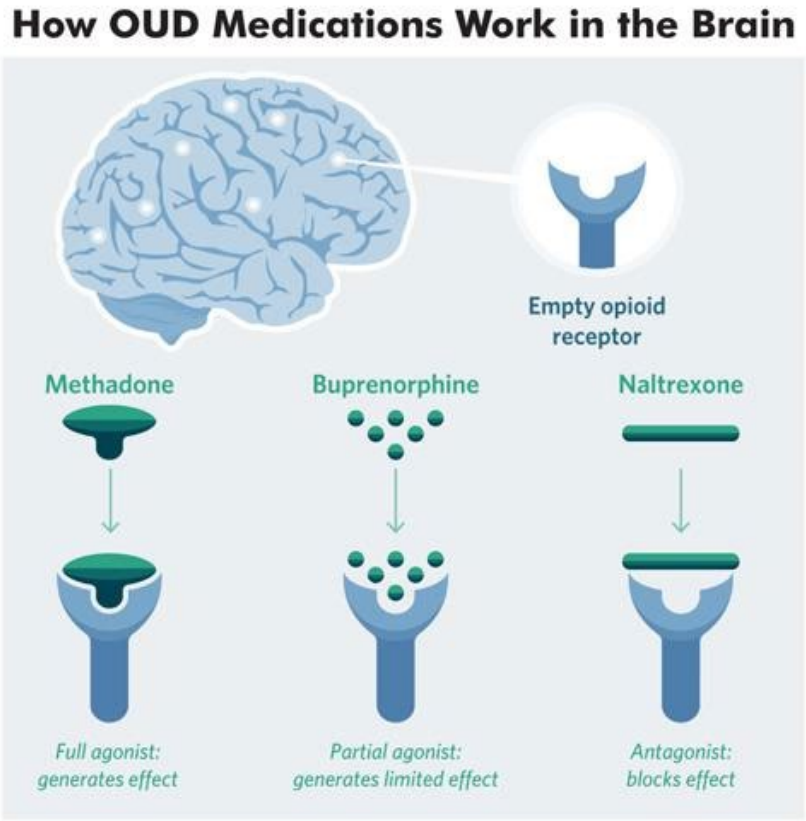
Opiate Use disorder: Treatment



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Agonist Maintenance: Methadone

Mechanism of Action

- Long half-life (24-26 hours) prevents extreme blood level fluctuations.
- Doses of 80mg blunt the euphoric response to heroin.
- Taken once daily, unlike heroin.

Therapeutic Goals

Enable patients to cease illegal activities, maintain employment, and fulfill family and social responsibilities.

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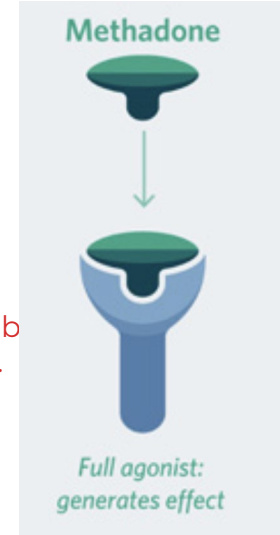
CLINICAL CONSIDERATIONS

Side Effects

- Sedation & mild euphoria
- Constipation
- Reduced sweating

Discontinuation

High risk of relapse if stopped ab
must be conducted very slowly.



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Buprenorphine

Mechanism of Action

- **Partial Agonist:** Buprenorphine is a partial agonist, providing a limited effect at the receptor site.
- **Receptor Affinity:** Stronger binding at receptor than full agonists; will displace them if present.

Suboxone Composition

- Given as **4:1 ratio** of Buprenorphine to Naloxone.
- Naloxone is added specifically to prevent diversion of the drug to injected use.

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CLINICAL CONSIDERATIONS

Precipitated Withdrawal

If a patient is currently on a full agonist, Buprenorphine will displace it and cause them to go into withdrawal.

Switching Protocols

This is why you cannot simply replace methadone with Suboxone or Buprenorphine without careful management.

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Naltrexone

Indications & Mechanism

- Used for alcohol use disorder and opiate use disorder.
- Reduces cravings and feelings of euphoria.
- LAI (Vivitrol) formulation is available.

Administration Timing

Cannot take until totally detoxified, otherwise can cause acute withdrawal symptoms.

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CLINICAL CONSIDERATIONS

Side Effects

- Headaches (HA) - most common
- Nausea/GI symptoms

Contraindications

Avoid use in patients with liver failure.

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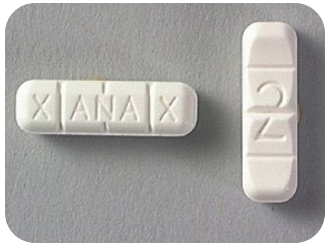
Sedative use disorder



Prescribing & Composition

- Widely prescribed for anxiety and insomnia.
- Includes benzodiazepines, z-drugs (ambien), and barbiturates.

Abuse & Presentation

- Abused for euphoria effects.
- Presents with dose escalation and early refill requests.

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CLINICAL CONSIDERATIONS

Monitoring Requirements

Clinicians must be alert for behavioral signs of misuse, including patterns of requesting medication before it is due.

Risk Profile

The addictive nature of these substances necessitates careful screening and strictly controlled prescribing protocols.

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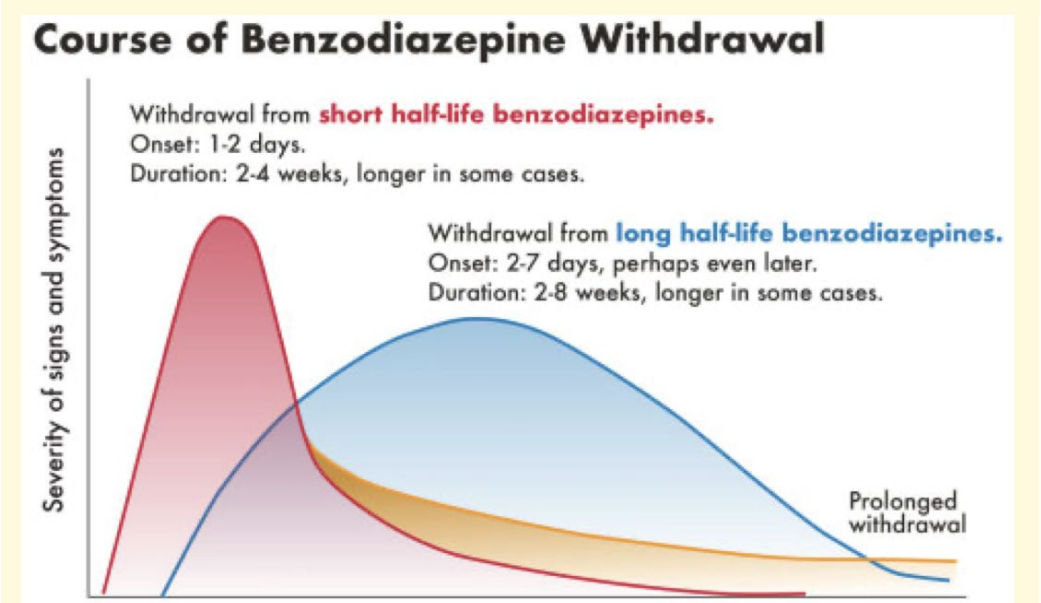
Sedative Use Disorder: Treatment

- Lorazepam 2mg = Xanax 1mg = Clonazepam 1mg



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Methamphetamine Use Disorder

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Mechanism & Properties

- Stimulant properties similar to cocaine.
- Causes catecholamine release (dopamine).
- Withdrawal produces a cocaine-like "crash".

Intoxication Presentation

Tachycardia, increased BP, pupillary dilation, agitation, elation, hypervigilance, and talkativeness.

CLINICAL RISKS & TOXICITY

Psychotic Features

Psychosis can resemble schizophrenia. Chronic users may exhibit prolonged psychosis due to toxicity.

Severe Toxicity

Critical complications include stroke, seizures, arrhythmias, comas, and death.

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Cocaine Use Disorder

Prevalence & Pattern

- 1.8 Million US users (1-month period).
- Often part of polysubstance use.

Mechanism of Action

- Blocks reuptake of dopamine, serotonin, and norepinephrine.
- Rapid tolerance to intense euphoric effects.

Intoxication & Use

- Features: Euphoria, hyperalertness, grandiosity, impaired judgement.
- Binges: Last a few hours to a few days.

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CLINICAL RISKS & TOXICITY

Physical Signs & Toxicity

Tachycardia, dilated pupils, increased BP, perspiration, chills, nausea/vomiting, VH and TH.

Critical Risks

- Cocaine + Alcohol -> Cardiotoxic cocaethylene.
- High doses/chronic use: Paranoia and psychosis.

Tx: Counseling, groups, and treating comorbid conditions.

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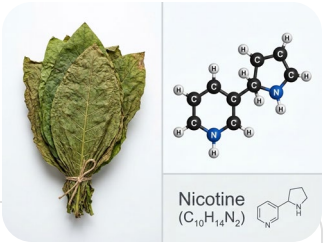
Nicotine Use Disorder



Public Health Impact

Tobacco addiction is the most preventable health problem in the US.

Psychoactive Properties

Nicotine is a psychoactive substance with euphoric and positive reinforcement properties, similar to those of cocaine and opiates.

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TOLERANCE & WITHDRAWAL

Physical Dependence

The individual develops tolerance to nicotine and experiences significant withdrawal symptoms.

Symptoms Include:

- Craving & Irritability
- Anxiety & Restlessness
- Difficulty Concentrating
- Decreased HR & Sleep Disturbance

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Nicotine Use Disorder: Treatment

Success Rates & Reality

- 5% success rate per attempt; 50% eventually stop.
- 95% of individuals stop without formal intervention.

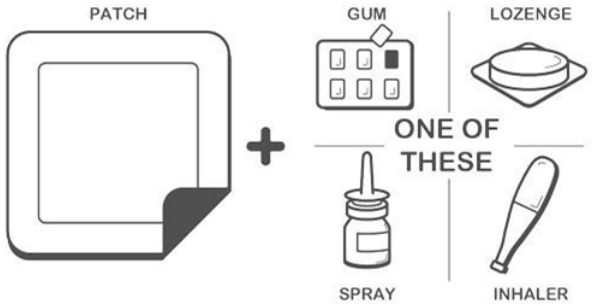
Pharmacotherapy

Nicotine Replacement (NRT)
Should be offered; safe to use while smoking.

Bupropion
Improves abstinence; Bupropion + patch is superior.

Varenicline (Chantix)
Used if NRT attempts have failed.

NRT OPTIONS: PATCH + BREAKTHROUGH



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How to Combine Quit Smoking Medicines

Español (Spanish) Print

There are seven medicines approved by the Food and Drug Administration (FDA) to help you quit. They work in different ways. All have been shown to be safe and effective for adults who smoke cigarettes.

These quit-smoking medicines include nicotine replacement medicines (the nicotine patch, lozenge, gum, oral inhaler, and nasal spray) and pill medicines (varenicline and bupropion SR).

Some other strategies, with or without medicines, can help you quit as well.

Select an FDA-approved medicine or a quitting strategy to learn more: Choose here

Combine Quit Smoking Medicines

You can use some quit-smoking medicines together for a better chance of staying quit. For example, long-acting nicotine patches can be used with shorter-acting nicotine gum OR lozenge to control withdrawal symptoms and the urge to smoke.

Using combination NRT starts with putting on a patch each morning to get a steady level of nicotine all day. Then you also use a nicotine medicine like the lozenge or gum that works more quickly to help deal with urges or cravings when you feel them coming on. You can also talk with your healthcare provider about other combinations of quit smoking medicines that may improve your chances of quitting for good.

How to Use | Quick Tips | Pros and Cons | Side Effects

- **You can use some quit-smoking medicines together for a better chance to quit smoking.** Quit-smoking medicines work in different ways to help ease withdrawal symptoms and lessen cravings. For example, you can use a long-acting nicotine replacement medicine together with a short-acting one:
  - **Long Acting**: The nicotine patch is referred to as "long acting" because it provides a slower, steady level of nicotine over a long period of time. It can be helpful by providing a steady state of nicotine throughout the day to help ease withdrawal symptoms.
  - **Short Acting**: The nicotine gum, lozenge, nasal spray, and oral are referred to as "short acting" because they give you

How to Combine Nicotine Replacement Therapies to Quit Smoking

Busting NRT Myths

Myth: Nicotine replacement therapy (NRT) doesn't work.
Truth: NRT works. NRT can double a smoker's chances of quitting smoking for good.

Myth: If I use one NRT product, I can't use others.

Truth: NRT products can be used safely together. For example, you might use long-acting NRT such as the patch with short-acting NRT such as a lozenge. Some people find both a long-acting patch and short-acting gum to be useful when cravings are high to handle withdrawal symptoms and fight off cravings.

Myth: Some people should not use NRT.

Truth: NRT has been available for more than 30 years. A great deal of research has been done on NRT. The research shows that NRT is safe and effective for almost all adults for quitting smoking. For most people, there is no need to talk to a doctor or health care provider before using NRT.

Pregnant women, teens, and people with serious health issues should talk to their doctor before using NRT. Serious health issues can include lung disease and heart problems. People with these problems still might be able to use NRT, but should talk to their doctor first.

THANK YOU!

Dr Jacob Fyda MD CMD

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