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CASE REPORT

Effective Use of External Collaborators to Address Mental Health Needs of Long-Term Care Residents: Composite Case Reports

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ABSTRACT

Background. Long-term care facilities are experiencing rapid increases in the number of residents with serious persistent mental illnesses (SPMI) and substance use disorders (SUD).

Aims. The purpose of this paper is to propose a new model for long-term care, the Collaborative Care Model, to bring expert mental health care to these residents more effectively.

Methods. Two composite case studies of long-term care residents, one with serious persistent mental illnesses, the other with substance use disorder, are presented. One represents the traditional model of expert external consultation, the other represents the use of the Collaborative Care Model. The cases are analyzed in terms of the similarities and differences in the problem presented and the approach used, as well as interpretation of the outcomes of these long-term care stays.

Results. The most striking differences between the two approaches to obtaining external expert guidance were 1) the multifaceted nature of the Collaborative Care Model, which included staff education, consultation with the facility pharmacist, discussions with both the resident and family members, and meetings with the staff and management of the facility, and 2) improved outcomes for the residents

Conclusions. The Collaborative Care Model promises to offer a more person-oriented, interdisciplinary approach to obtaining expert mental health care for a resident in need of it. The model should be subjected to rigorous testing to evaluate the effect of its use on long-term care resident outcomes.

Keywords: psychosocial and behavioral expression, severe mental illness, substance use disorder, long-term care, nursing home residents, Collaborative Care Model

Introduction

Worldwide, approximately 15% of adults 60 and older have a mental illness[1]. This is reflected in the increasing number of long-term care residents with serious persistent mental illness (SPMI). SPMI can be defined as chronic mental health disorders that substantially impact a person's functioning. SPMI includes individuals with schizophrenia, bipolar disorder, and severe major depressive disorder[2,3]. The proportion of long-term care residents with a mental illness has grown steadily, tripling from 11% in 1995 to 31% in 2015[4-6]. The resulting case mix of residents who are frail, with increased acuity and a complex mix of comorbid conditions, with those who have cognitive impairment, and with those who have serious persistent mental illness, and/or substance use disorder (SUD), requires tailored interventions that challenge existing providers who are not yet well-equipped to manage their care. A 2021 survey[7] noted that a substantial portion of facilities reported that behavioral health services (including family support, group therapy, and substance use counseling) were not available at their facility. Furthermore, one-third of the facilities surveyed responded that they were not able to meet the mental health and behavioral needs of their residents. More than half reported that their staff needed training to provide this care, a situation researchers called "troubling"[8].

Of particular concern is that most long-term care facility staff are not prepared to care for residents with serious persistent mental illnesses or substance use disorders, nor for the corresponding impact of behavioral expressions on themselves or others. Younger residents may also have psychosocial or behavioral expression needs that differ from those of older residents. Further, residents with SPMI tend to have more acute or comorbid conditions that require higher levels of care[4]. The combination of acuity and behavioral expressions impacting others, including staff, leads to increased operational challenges such as staff retention, regulatory compliance, and surveyor citations[4, 9, 10]. These long-term care facilities may also have fewer staff and higher turnover, raising additional concerns about resident safety and care quality[11].

This change in long-term resident case mix is a complex problem that will require action on multiple fronts, from better training of staff to faster recognition and assessment of resident psychosocial needs to the creation of crisis response teams ready to quickly de-escalate situations that may lead to resident-staff and resident-resident verbal and physical aggression. The purpose of this paper is to examine the potential use of the Collaborative Care Model in today's long-term care facilities.

Collaborative Care Model

The Collaborative Care Model is a strategy for treating behavioral health needs through integrated care management and psychiatric consultation. Having begun in primary care and now thoroughly tested in numerous randomized clinical trials, the use of the Collaborative Care Model has been found to be more effective and cost-efficient than usual care for common mental illnesses[12, 13]. Startup costs, however, may be significant. Use of the Collaborative Care Model (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn) in mental health and behavioral health has also been shown to reduce mental health inequalities in racial and ethnic populations[14] and improve quality care and behavioral and psychological symptoms of dementia in persons with Alzheimer's disease[12, 15]. There is considerable evidence indicating that the Collaborative Care Model has yielded improvement in symptom management and in the quality of care when implemented by primary care providers (leading the effort) in collaboration with mental health providers[13]. With an increasing population of adults with SPMI and SUD in long-term care and the lack of evidence supporting the use of the Collaborative Care Model in this setting and with this population, there are significant reasons to explore the potential implementation of the Collaborative Care Model in long-term care. Implementation of the Collaborative Care Model may foster close working relationships, improve communication, and improve care for residents. A typical Collaborative Care Model team would include a mental health provider, primary care provider, administrator, nurses, pharmacist, residents, and families.

Method

A composite case study or narrative is employed when concern for maintaining anonymity and preventing breaches in confidentiality is very high[16, 17] but there is a need to compose an accessible, compelling narrative that is a trustworthy reflection of the experience of a set of individuals[18, 19]. For example, Samenow and colleagues[20] employed a composite case study to illustrate the application of a set of principles to a program for physicians displaying disruptive behaviors. Cruz and colleagues[21] triangulated caregiver and client therapy records to create a composite case study of unaccompanied Latin immigrant youth and the traumas they had experienced over their lives. Other sources of data for the development of a composite narrative or case have included case files, clinical journals, transcribed interviews, clinical findings, and individual narratives.

The steps taken to develop a composite case study may differ somewhat in relation to the sources used. For example, a large set of relevant quotes could be created from interviews conducted with involved individuals, or separate accounts of individuals' experiences may be developed to begin the process (the latter was the source of the composite cases presented in this paper). This information becomes the building blocks of the composite case study. The next step, perhaps the most important and often the most difficult, is to create the narrative thread for the composite case, a thread that synthesizes the experiences of the individuals of interest and becomes the backbone of the composite case. The narrative or story is built upon this narrative thread to produce a coherent, compelling narrative, one that is concise but compelling to read, an amalgamation of the individuals' experiences, reflecting the typically complex, multifaceted accounts of each individual but at the same time protecting confidentiality and preserving anonymity[18, 19].

For our purposes, two expository clinical cases were composed, one that is representative of the features of the Collaborative Care Model (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn), the other representative of the traditional consultation model[22]. The cases are designed to accurately reflect the common features of the situation of interest, while remaining authentic to the experiences of the individuals[23]. To create an illustrative composite, the following steps were taken[17]:

- Specify the focus of the composite case.
- Select 5 cases that exemplify this focus.
- Identify the aspects of each case that are most illustrative of the focus.
- Blend these features into a single composite case.
- Construct a coherent composite case.

Each of the composite cases presented has been based on five clinical cases.

Results

Composite Case Study 1: Traditional Psychiatric Consultation Model: Resident with Physical Illness, Substance Use Disorder, and Behavioral Challenges

Mr. L.K. is a 54-year-old divorced male who was admitted to the facility from acute care for continued treatment of sepsis related to an infected PICC (Peripherally Inserted Central Catheter) line. Hospital staff had noted in his medical record that he frequently manually manipulated his PICC line. Mr. L. K. has a long history of opioid use disorder, particularly fentanyl, as well as polysubstance use disorder involving cannabis, alcohol, and cocaine. His history includes Post-Traumatic Stress Disorder (PTSD), schizoaffective disorder, recurrent pneumonia, diabetes, obesity, and chronic abdominal pain from prior trauma.

Mr. L.K. is estranged from his family due to years of drug-seeking activities. He has experienced periods of homelessness. He was alert but often appeared withdrawn, anxious, and mistrustful of others, reporting feelings of isolation. He uses recreational marijuana to manage anxiety and believes it helps him sleep.

On admission from the hospital, Mr. L.K. had a PICC line for IV antibiotics and was on Suboxone as part of his medication-assisted treatment (MAT) for opioid use disorder. He was underweight and needed help with wound care but often refused it as well as refusing meals. He insisted on receiving pain medications only through his IV line and became angry when staff offered oral medicines. He believed oral medications were ineffective and accused staff of withholding his treatment.

Staff noted he had a poor appetite, stayed up all night, was frequently angry, and refused to bathe. When he left the facility for community appointments, he often returned smelling of alcohol or marijuana. When his belongings were checked, and staff found drug paraphernalia, he became defensive and threatened to sue the staff for violation of his privacy. On one occasion, he fell asleep while smoking in his room, burning the sleeve of shirt.

Mr. L.K. also displayed sexually inappropriate behaviors toward female staff, including masturbating openly and making lewd comments, which he continued despite multiple redirections and psychotropic interventions (Geodon, Ativan). He refused to take his prescribed antipsychotics and mood stabilizers, which he said made him “feel like a zombie”.

The interdisciplinary care team, including nursing, social work, psychology, occupational therapy, and administration, met several times to review his care plan. He refused to attend care conferences or allow screening for drugs. Behavioral contracts, mental health consults, and 1:1 supervision were used, but his behavior remained erratic.

Staff became increasingly frustrated and concerned for everyone’s safety. They complained about feeling untrained and unsupported in managing these complex behavioral and substance use issues. When called upon for help, the consulting psychiatrist prescribed anti-anxiety and antipsychotic medications, but Mr. L.K. refused to take them. Ultimately, the facility administrator determined that the facility could no longer safely or effectively meet Mr. L.K.’s complex needs. With assistance from social services, a discharge plan was developed to transfer him to a psychiatric facility better prepared to implement behavioral stabilization and SUD treatment. The facility staff and administration felt they had failed Mr. L. K., but did not know what they could have done better.

Composite Case Study II: Collaborative Care Model: Resident with SPMI, Bipolar I Disorder, Anxiety, and Medication Mismanagement

G.H., a 63-year-old, was admitted to the facility after hospitalization for mania. G. H. had a history of bipolar I disorder, anxiety, and poor medication management. She also had inpatient psychiatric admissions for mania three times over the last nine months. Since arriving at the facility, she had become manic three times. Each time this escalated to sending nude photos to male residents and increasing symptoms of paranoia, such as believing that the staff was giving her the wrong medications, so she would not take them (she based her decision to take medication on the color of the pill). She also had symptoms of rapid, tangential speech, racing thoughts, restlessness, difficulty focusing, risky behaviors, decreased need for sleep, irritability, significant increases in activity, and impulsivity. The staff reported they were not sure how to provide the best care for her because she became very accusatory, and they were afraid she might harm them or another resident.

The administrator of the facility was seeing more residents with serious persistent mental illness being admitted and increasingly hearing verbalized concerns about feeling unprepared to care for them from all levels of facility staff. Responding to this concern, the administrator sought to hire an expert from outside the facility. After interviewing several potential candidates, the administrator hired a mental health provider who would be responsible for the coordination of care of assigned residents with the interdisciplinary team (mental health provider, primary care provider, administrator, nursing staff, social worker, resident, plus family if

available). The administrator decided to start this new strategy with G.H. because she was frequently experiencing mania. The new mental health provider met with the facility administrator and nursing staff to understand the problems staff had experienced when caring for G.H. Identified issues from staff were a lack of knowledge of how to care for persons with bipolar disorder and determining if she was taking the appropriate mood stabilizer and/or antipsychotic medications.

The interdisciplinary team, led by the mental health provider, included a behavioral health manager, primary care provider, pharmacist, administrator, and nursing staff, all empowered to contribute to shared decision-making with G.H. (when she was not in mania) and her sister, who G.H. agreed could be one of her decision-makers. The Collaborative Care Model team held meetings once a week to address the needs of G.H. and, eventually, several other residents with SPMI. These discussions contributed to the education of facility staff as well as to planning the care provided to G.H. Procedures were put in place to identify early symptoms of mania as well as to treat behavioral and psychological symptoms of bipolar disorder, and consider additional appropriate non-pharmacological approaches. For example, it was important that nurses watch G.H. take her medication because, in the past, they would give her the pills and leave the room. Because of her paranoia, G.H. would put the pills in the drawer and not take them, which led to her episodes of mania.

Timely and effective communication was essential, so the mental health provider and administrator agreed to not only have the weekly meetings but also to use text messaging in between meetings unless it was urgent, in which case a phone call was needed. Collaborative care for this resident's SPMI improved the quality of care. The nurses reported being more comfortable in caring for G.H. and other persons with serious persistent mental illness. The pharmacist appreciated being involved in pharmacological shared decision-making. The administrator witnessed the benefits of the Collaborative Care Model and has decided to continue the program.

Discussion

Residents with SPMI and/or SUD present a challenge to the majority of long-term facilities, whose staff and providers have been focused upon, and are experts in, providing care to older adults with primarily physical limitations and/or cognitive impairments.

The composite case studies present the unique challenges related to caring for residents with SPMI and SUD in long-term care facilities and two different models for organizing their care. In summary, care teams using the Collaborative Care Model were more informed and had a better ability to provide quality care to residents with SPMI or SUD. The Collaborative Care Model is one of the strategies that long-term care facilities can adapt to help them meet the complex needs of these residents. As it has done in primary care, use of the Collaborative Care Model may improve the quality of care in a cost-efficient manner once it is in place.

Case Similarities

The greatest similarities in the two clinical cases were the many care challenges that facility staff encountered. In both cases, they clearly articulated their concerns about safety when disruptive behavior occurred. They felt unprepared to care for their residents with serious persistent mental illness (SPMI) and substance use disorder (SUD). In addition, both cases included issues related to medications, which affected the residents' mental health status. The resident with SPMI believed the nursing staff were not giving her the right medications. The resident with SUD wanted his medications given through the PICC line, but staff declined to do that, which was upsetting for him.

Case Differences

Notably, the differences between these two composite case studies were primarily related to the mode of care planning and care team function employed. In the traditional psychiatric consultation care, the mental health provider prescribed the medications without input from the team members, including the pharmacist. In this case, those caring for the resident did not have a shared set of understandings of what was happening to the resident. In contrast, when operating within the Collaborative Care Model, residents tended to respond more to the staff and were more involved in the decision-making. In addition, the staff seemed to better understand their roles and responsibilities.

Traditional psychiatric consultations are proving to be inadequate to address the multiple intersecting needs of residents with SPMI and SUD. They often are focused primarily upon medication and secondarily, may include a recommendation for counseling. They frequently do not include educating staff, working with pharmacists, and other providers, individualizing a medication regimen, consultation with family members, or therapeutic sessions with residents, and specialized treatment programs such as Alcoholics Anonymous.

On the other hand, the Collaborative Care Model is an interdisciplinary, person-centered approach to care of residents with SPMI, SUD, or a combination of the two that may include the following:

- Mental health (psychiatrically prepared) providers lead/coordinate the development of the resident's plan of care and its implementation.
- Discussions or counseling sessions with the resident and family.
- Input from point of care (direct care) staff from CNAs to recreational therapists, family members, and external care/service resources (e.g., Medication-Assisted Treatment programs, Alcoholics Anonymous).
- Individualized plan of care for the resident that may include the family.
- Mental health provider maintains contact with facility staff and management regarding resident status.

Implications for Practice

Employing the Collaborative Care Model in long-term care settings, particularly for residents with serious and persistent mental illness (SPMI) and substance use

disorders (SUDs), has significant implications for clinical practice. The Collaborative Care Model supports person-centered care, enhanced care integration by promoting early detection, strategic care planning, and individualized interventions for residents experiencing mental health conditions such as depression, anxiety, mania, or substance use-related behaviors. It also offers the potential to improve healthcare outcomes, streamline system operations, and strengthen interdisciplinary team dynamics.

Utilizing the Collaborative Care Model for managing complex cases involving SPMI and SUDs may also encourage greater resident engagement in care planning, which can enhance treatment adherence and resident satisfaction. Moreover, the Collaborative Care Model emphasizes the ongoing communication and coordination between facility staff (e.g., nurses, social workers, case managers, administrators) and external mental health professionals (e.g., psychiatrists, psychologists, and psychiatric nurse practitioners). Successful implementation requires both staff training and leadership support to define and reinforce team roles.

As one study [24] noted, using terms such as "insanity" or "addicted" can create emotional and psychological barriers to treatment. Instead, adopting person-first language, such as "a person with substance use disorder" or "a person struggling with substance use," respects individual dignity and supports a collaborative environment. Such mindful language use fosters trust and promotes recovery in long-term care populations with serious persistent mental illness and substance use disorders, most of whom present with long-standing problems that have resisted resolution in the past. Competencies such as motivational interviewing are essential, especially when addressing sensitive topics.

Another important consideration is reimbursement for collaborative care services. Some states offer reimbursement for collaborative care management. Coverage may include the development of the initial psychiatric collaborative care management plan and subsequent psychiatric collaborative care management team meetings. This is important not only to improve clinical outcomes, but also to enhance the healthcare workforce to improve the mental health of the residents. While the Collaborative Care Model is eligible for reimbursement under the U.S. CMS Behavioral Health Integration (BHI) codes, billing frameworks may require adaptations. Collaborative care is billed separately from the Prospective Payment System (PPS) and is not included in Pay-for-Service Alternative Payment Models (PPS-APMs)[25]. For example, code 99494 can be used for behavioral health integration services. Additional codes are available for psychiatric care provided by psychiatrists or mental health nurse practitioners providing care within a Collaborative Care Model framework.

The Collaborative Care Model is potentially one of the many strategies facilities can employ to more effectively meet the needs of residents with serious persistent mental illness and substance use disorders. With adequate preparation, long-term care staff are able to care for this increasing proportion of the older residential population.

Implications for Future Research

There is a substantial literature on the increase in long-term care residents with SPMI, SUD, or a combination of the two. The residents with these problems and the issues that have arisen related to providing the care they need are well characterized in these reports. However, reports of evidence-based interventions, particularly non-pharmacological interventions or health services research on new models for care in long-term care are very limited [6] and should be a priority in addressing the needs of this population[5]. Well-designed, rigorous studies are essential to guide both clinical and administrative decisions regarding best practices for providing high-quality care for these residents. The implementation of effective strategies to deliver high-quality, effective care to those with serious persistent mental illness and substance use disorders in long-term care is far behind that developed for residents with dementia, despite the growing number of residents affected by these conditions[12]. The scarcity of studies about residents with serious persistent mental illness and substance use disorders in long-term care necessitates an urgent call for further research.

Conclusion

The Collaborative Care Model offers a potentially more comprehensive, person-oriented, integrated, interdisciplinary approach to addressing the needs of long-term care residents with severe persistent mental illness and/or substance use disorder. Rigorous testing in long-term care settings to objectively evaluate its effect on resident outcomes is needed to establish its potential effectiveness.

Conflict of Interest Statement: The authors have no conflicts of interest to declare.

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