



Technical Assistance and Educational Needs of State Psychiatric Hospital Administrators

Federal FY 2020

By

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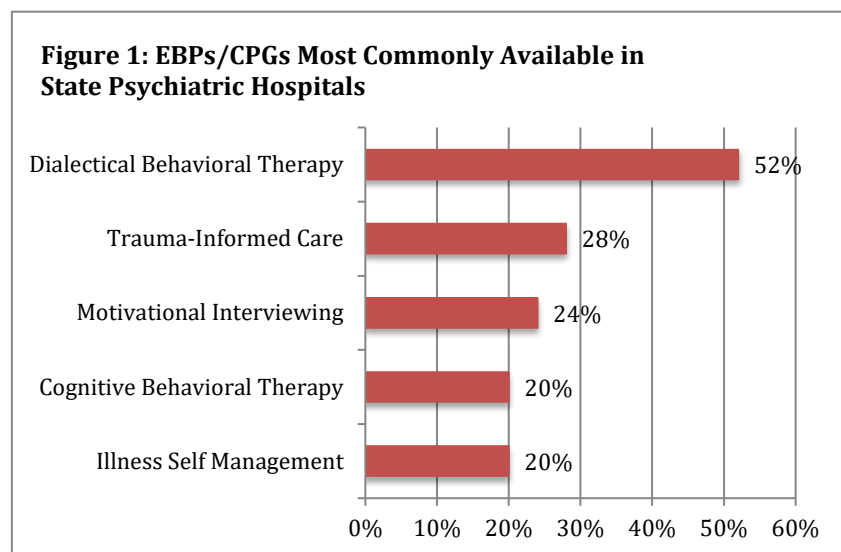
Introduction

During Federal FY 2020, researchers at NRI surveyed state psychiatric hospital administrators about their use of evidence-based practices (EBPs) and clinical practice guidelines (CPGs), and any related technical assistance needs they may have. Responses from 40 state psychiatric hospitals were received. Highlights from this survey are included in this summary.

Availability of EBPs

Seventy-three percent of state psychiatric hospital administrators indicated their facilities have implemented and adopted specific EBPs and/or CPGs for treatment and recovery of adults with SMI. The most common EBPs and CPGs adopted by state psychiatric hospitals are Dialectical Behavioral

Therapy, Trauma-Informed Care, Motivational Interviewing, Cognitive Behavioral Therapy, and Illness Self Management. See Figure 1. Other EBPs and CPGs provided in state psychiatric hospitals include Positive Behavioral Supports, Co-Occurring Psychiatric and Substance Use, Competency and Restoration, Integrated Dual Diagnosis Disorder Treatment, Person-Centered Thinking, and Social Learning. Eighty-one percent



of state psychiatric hospital administrators feel that appropriate EBPs and/or CPGs exist for the unique populations they serve. Eighty-nine percent feel their staff would benefit from a better understanding of the EBPs that are available in the community for clients post discharge. Those that would not find this training beneficial already have a system in place for state hospital staff to work with leadership at the community level to understand the service options for clients post discharge.

Workforce Challenges

State psychiatric hospital administrators find it difficult to recruit and retain talented staff. The biggest barrier identified to recruiting and retaining staff is the inability to offer

competitive salaries and benefits. Compassion fatigue is also a problem, especially when trying to retain nurses and social workers, as is the risk of aggression and violence. The positions most difficult to fill include nurses (both RNs and LPNs), psychiatrists, and masters-level social workers.

Psychiatric Advance Directives

Psychiatric Advance Directives (PADs) are legal documents that describe an individual's desired treatment should he or she be incapacitated or unable to express their desires for health care services. They specify an individual's desired service settings, stipulate which treatments they are willing to undergo, and designate a legal representative to make decisions on their behalf. Seventy-five percent of state psychiatric hospital administrators indicate that their hospitals offer clients the ability to construct a PAD if they do not already have one. Clinicians at 35% of state psychiatric hospitals are able to access a central repository for PADs when an individual is experiencing a crisis, and a nearly equal amount would like to have this ability. Only one state psychiatric hospital indicated they do not ask clients the status of their PADs at admission, nor do they offer the opportunity to construct a PAD. State psychiatric hospital administrators would like TA to help create a central repository for PADs.

Clozapine

Ninety-four percent of responding state psychiatric hospitals prescribe clozapine for clients with refractory psychosis. Of these, 65% follow CPGs in prescribing clozapine, and 10% rely on the clozapine REMS Program to help them make clinical decisions regarding the prescribing and use of clozapine.

More than one-third of responding state psychiatric hospital administrators indicated that prescribers in their facilities are reluctant to begin clozapine treatment for clients who may soon be discharged to the community. One indicated that this reluctance is because many patients return to county jails, which are reluctant to monitor blood levels. Another indicated that a patient who has started on clozapine would have their discharge date delayed until they were stabilized on a therapeutic dose. There is also uncertainty among prescribers in state psychiatric hospitals as to whether this treatment would be available in the community for continuity of care. Because of this, patients with a length of stay less than 72 hours will likely not be started on a clozapine regimen. State psychiatric hospital administrators who have not experienced reluctance to beginning a clozapine regimen noted that they do so with safe discharge plans in place, and some even work with discharged patients' community providers to ensure that patients are monitored after discharge and can continue to safely use clozapine.

Forty-one percent of responding state psychiatric hospital administrators indicated their facilities would benefit from additional training and guidance on the use of clozapine with refractory psychosis. This additional training would be useful to allow the providers to remain current and up to date on improvements and the use of clozapine, especially for facilities that rely on contracted psychiatrists who tend to turnover periodically. Specific requests for TA around clozapine include how to augment clozapine for refractory psychosis and changing psychiatrist and patient motivation/perception of clozapine's risks and benefits.

Additional TA Needs Identified by State Psychiatric Hospital Administrators

State psychiatric hospital administrators would most like TA related to dealing with the risks of aggression and violence (80%), followed by serving forensic populations (60%), serving individuals with co-morbid intellectual disabilities (60%), and suicide prevention and treatment (55%). Other needs identified include education around residential services for adults with SMI and digital technology to enhance patient care.

For Additional Information:

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