



STATE OF MINNESOTA
**OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH
AND MENTAL RETARDATION**

Ste 420, Metro Square Bldg., St. Paul, MN 55101

Voice: 651-296-3848 Toll Free: 1-800-657-3506 Fax: 651-296-1021

Website: <http://www.ombudmhm.state.mn.us> e-mail: ombudsman.mhmr@state.mn.us

Mental Health - A System in Crisis

The Office of Ombudsman presents this discussion paper with the understanding that many of these items would require funding which is not currently available. However, we present them so that policy decision-makers will know what is needed in this system. Perhaps redirecting funds or planning for times when funding is available can be done. In addition, while funding is and remains a critical issue, not every problem requires additional funding but may require removing barriers by changes in laws and rules, along with creativity, altering assumptions and modifying out of date or overly bureaucratic practices. It is the Ombudsman's goal to raise the issues for discussion and hope to inspire that action is taken.

Minnesota's mental health system is a system in crisis. Often children and adults with mental illness must wait until they or their loved ones are in crisis before they can receive the help they need. What we have is a revolving door system that provides crisis treatment and stabilization and very little service or huge gaps in services in-between crisis periods. Crisis-only treatment is the most expensive method, is the least humane, and can actually be counter therapeutic. It comes at a time when patients may be least receptive to treatment due to impairment of their illness. At that time securing treatment may require intervention of the courts adding to delays in treatment and costs to the system.

Minnesota's current in-patient psychiatric bed crisis is indicative of a system beginning to fall apart and in desperate need of **fundamental reform**. While the Ombudsman for Mental Health and Mental Retardation strongly believes that the State must commit adequate resources to serve the needs of this vulnerable population, the State along with the Federal Government are spending millions of dollars to provide the current patchwork of services. Is it a factor that we are not spending enough or is it a factor of spending it in the wrong places? It is probably both but until there is fundamental reform, we will never know. However, it is the opinion of the ombudsman that the entire children's mental health system is severely under funded to serve the children who need services. There are many good professionals working to improve the lives of persons with Mental Illness who have their hands tied and their time used up by conflicting public programs, policies and difficult to understand federal, state and local services rules.

Is this a supply problem or a demand problem? It is both; we have had a shortage of services that is significantly compounded by a rapidly increasing demand as evidenced in the MHHP study. Is this about enforcement of existing laws or creation of new laws? It is both; many current laws about the service delivery are not currently enforced and need to be. Others need to be looked at to remove artificial barriers or request waivers from Federal rules. The current maze of services often defies common sense.

Current Problems and Contributing Factors*

- No inpatient psychiatric beds available when a patient is in crisis and in need of hospitalization.
- Long waits in ER (10 – 72 Hours).
- Transfers from the presenting hospital to available beds hundreds of miles away (even Canada and bordering states).
- Counties refusing to pay for hold orders at hospitals outside their area if the only reason sent there is due to the bed shortage.
- Problem even worse for children where we often apply adult system process. A regular in patient hospital bed is not necessarily the best place for a child but there is a critical lack of crisis services for children.
- Parents of children with mental health needs are treated like it is their problem and counties deny services without demonstrating reasonable or proven alternatives.
- No family or community support when a patient is sent to a hospital so far away from home.
- Voluntary patients put on hold orders.
- Abuse of Hold Orders to get law enforcement to transport.
- Patients receiving high ambulance billings for transportation that are denied by their insurance plans.
- Discharged patients have no transportation home and no funding to get home.
- MI patients sometimes are put in ICU beds.
- No follow up care after discharge from hospital that can lead to repeated crisis and use of ERs.
- Patients end up in detention settings.
- Concerns rose that some patients are being discharged to the street due to lack of beds despite the persons need for inpatient hospitalization.
- Hospitals closing down MH units, both adolescent and adult.
- Reimbursement rates not sufficient for hospitals to continue to provide the service.
- Federal Regulations that govern Emergency Rooms that can lead to uncompensated care (EMTALA).
- Nursing shortages and contracts that allow nurses to shut down units when staffing not adequate.
- Lack of access to psychiatrists to allow patients to quickly deal with needs for medication adjustments or negative reaction to medication (2-4 month waits).
- Discharged patients not provided sufficient supply of medication to use until can arrange to see a community psychiatrist.
- Some HMOs will not cover medication prescriptions if written by an out of network provider even though getting into a network provider is not possible or practical.

- Reimbursement rates for MH both public and private programs often driven by Medicaid rates which are set by the Legislature with recommendations from the Commissioner of Human Services. Service system funded at the lowest common denominator.
- Current beds filled with committed patients waiting for an RTC bed to become available and who are receiving little or no treatment while they wait.
- Patients provided services they don't need because the services they do need are not available.
- Lack of appropriate services for co-occurring disorders.
- RTC's not able to discharge quickly enough due to lack of available transitional and permanent housing and community options for patients ready for discharge. These patients take up expensive beds when not in need of treatment, which causes those in need of treatment to wait at their local hospital in an even more expensive bed, and treatment is not initiated because the patient is going to be transferred to a different treatment professional.
- When patients transferred get a new psychiatrist they can end up with a different diagnosis and change in medications. Everything seems to start over again. This is true if they even change units within the same facility.
- Lack of community infrastructure to provide adequate supports to persons with mental illness based on their level of need to prevent the need for acute hospitalization.
- Failure of Counties and the State to develop adequate services for the number of persons who require them as is outlined in the State Mental Health Act (County CSSA plans).
- County case managers with high case loads; the State does not hold counties and case managers accountable to requirements of the State of Minnesota's case management rules.
- The state approves but does not monitor CSSA plans nor does it step in when the county fails to plan for and provide for the services as is outlined in the CSSA plan.
- Failure of health plans to have adequate MH services to meet the needs of their enrolled populations.
- Providers lack the clout or fail to negotiate adequate rates with the insurers.
- Over reliance on Medication and Medical/Insurance Model as the quick solution to problems that have long term social support components to them.
- Liability issues for providers causing them to keep patients longer than needed or restrict patient's liberty for fear of lawsuits over harm to self or others.
- HMO, Insurance, and Medicare regulations and paperwork cause psychiatrists to not want to do hospital practice (see Minnesota Psychiatric Association Report).
- Lack of community and family education on what to do in a crisis.
- Lack of respect and support for families who are trying to help their MI children including adult children.

- CD citizens who request services voluntarily are told the only way to get help is to “go out and get drunk” and go to detox so they can get a CD assessment which could open the door to treatment often then done through expensive involuntary means, are more expensive, are not humane and encourage people to engage in dangerous behavior.
- MI citizens in need of services are often advised they are not sick enough to receive services or in some cases put on waiting lists until such time that they decompensate and then are in crisis that results in ER visits, loss of employment or loss of family/friend social support system. They then enter at the most expensive end of the system and take longer to stabilize and return to functioning.
- Parents are told to call the police when a child with serious emotional disturbance is in crisis, often having them end up in the Juvenile Justice system as a way to access treatment via court order.
- Patients who have to wait until they deteriorate to the level where civil commitment is necessary often the experience so abusive that when they need help in the future, they will not seek help in the future or will not reveal the existence of certain symptoms like hearing voices, etc.
- Lack of communication between MH providers and the patients support network (families, friends, community providers and primary care practitioners).
- Data Privacy often used as a way not to deal with families/social supports in ways that defy common sense, are not helpful to the client and are not even consistent with intent of the law.
- Changes in the commitment act that have eased requirements, triggered by overly narrow interpretation by some of the term ‘imminent harm,’ and the impact this has on client rights.
- Providers using the commitment act as a source of guaranteed payment because the law says that court ordered treatment is considered to meet the criteria for “medically necessary treatment”.
- Problems with voluntary patients being denied admission to RTCs.
- Surgeon General’s report on Mental Health making more people aware and less afraid to ask for treatment has increased demand while at the same time, stigma causes people to wait too long before asking for help leading to more expensive care.

Ideas & Strategies*

- Increase MA reimbursement rates to reasonably reflect the true actuarial cost of care and insure it is comparable to cost of other hospital based medical care such as cardiac or orthopedic care. Some hospitals reported that they did not even know what their true cost of care was for MH units; they simply accept the negotiated rates.
- Establish a capital improvement grant fund for use by hospitals for one time costs to create or increase MI beds with emphasis on geographic distribution, smaller settings and community based.
- Increase the use of Psychiatric Clinical Nurse Specialists (CNS) and Advance Practice Nurses (APN) to increase patient access to psychiatric services, medication management and follow up care. Provide incentives for nurses to pursue APN or CNS certification for psychiatric specialties.

- Assure reimbursement for CNS and APN services at a level that leverages the psychiatrist's time allowing additional patients to be seen in a timelier manner.
- Establish incentives for medical students to pursue psychiatry, especially rural psychiatry, as a specialty practice similar to the UMD Rural Family Practice Program.
- Encourage primary care clinics to more fully integrate mental health into services provided at the clinic including use of psychologists and consulting psychiatrists. Allows people to get help in a familiar setting that is less stigmatizing.
- Increase use of telemedicine to allow rural areas to have access to expertise throughout the state and allow for payment reimbursements for these services.
- Require medical schools to include more initial education on mental illness and its relationship to other illness for all medical students and especially family practitioners.
- Consideration of allowing psychologists to prescribe certain classes of psychotropic medications under supervision of an MD.
- Eliminate behavioral health carve outs.
- Integrate MI and CD funding and services.
- Incent the development of integrated dual diagnosis programs instead of making them go through two different programs each poorly equipped to handle the patient's comprehensive needs.
- Allow flexibility in funding streams so that case managers are able to do what makes sense for the client and not just make clients fit into what programs are funded.
- Create a fund that MH patients could access to continue medication treatment until seen by a psychiatrist for medication adjustment or refilling.
- Increase reimbursements for social rehab options to attract more private providers.
- Modify the Social Rehab Option to allow DHS State Operated Services to provide services where no private or non-profit service provider can be found, especially for the most difficult to serve clients.
- Establish Regional Mental Health Courts with common understandings, standards, forms and consistent time lines so that all parties will be operating with clear knowledge of expectations, standards and time lines. Have costs associated with the civil commitment process handled by this court. This should improve efficiency and shorten delays in access to treatment which will also be most cost effective.
- Provide incentives or tax credits to landlords and developers who will actively include and reach out to the mentally ill as part of their target market for housing options.
- Develop a spectrum of housing options from total independent living to assisted living with an array of options in between.
- Take advantage of the President's New Freedom Initiative to provide creative ways of using federal funds to achieve independence and community based options.

- Develop short stay facilities for crisis intervention, stabilization, assessment, and treatment plan development that divert people away from hospital emergency rooms like the Psych Under 21 Hospital for Children and Crisis Foster Care Facilities for Adults.
- Reallocate State Operated Services so that beds and intensive quality services are located in communities in smaller settings, closer to where a person lives and receives social and community support, rather than having to travel to a distant institutional setting far from friends and families.
- Ensure that Bridges has sufficient funding to prevent the loss of housing while persons are hospitalized.
- Develop post discharge housing options similar to DHS SOS's Como Avenue and Bloomington apartment building with staff on site.
- Expand the use and funding of Youth Service Bureau (YSB) programs that exist in communities to help emotionally disturbed children with a number of stress issues including programs like the ACE program in Ramsey County, or the Truancy Program provided by the YSB in Washington County.
- Use YSBs or similar programs in schools so that issues can be dealt with professionally in the schools while freeing up education professionals to provide education.
- Expand and fund the role of Community Mental Health Centers as a community based resource to help the MI stay out of the hospital.
- Provide tax credits or other incentives so the private sector employment market will hire and work to accommodate employees with mental illness.
- Work with counties to deal with the negative incentive for placement of children because of the counties' share of room and board costs.
- Eliminate the counties' use of CHIPs petitions as a requirement for providing mental health treatment services to children.
- Provide for a program where counties who are doing good things are rewarded and encouraged to share those successes and practices with other counties.

Neither the problem list nor the strategies list is intended to be all inclusive. The lists are intended to provide a window into a system that needs reform to provide services in a cost effective way in the community rather than the more expensive hospital settings.

The Office of Ombudsman is charged under MN Stat. 245.91-.97 with promoting the highest attainable standards of treatment, competency, efficiency and justice for persons receiving services for Mental Illness, Developmental Disabilities, Chemical Dependency, and Emotional Disturbance. Through the work of the in death and serious injury review, direct client assistance and complaint review, the agency is able to view the system both what is working and where the gaps are. We have a view of the system and the way it works, not in policy, but in practice for real citizens. We see that the laws, rules, policies and practice do not always reflect the true needs of the citizens served and that implementation and system intent do not always match.