NAMI
National Alliance on Mental Illness
MINNESOTA

January 26, 2021

Dear Members of the Behavioral Health Policy Division:

There is so much information to share with you on the topic of inpatient psychiatric care that I wanted to provide you with a letter in addition to the testimony I will give on Wednesday.

The discrimination that children and adults face in accessing mental health is great and truly overwhelming to those of us who either live with a mental illness or have a family member. Not being able to access care leads to poor outcomes such as the mental illness becoming more disabling, people dropping out of school or becoming unemployed, people ending up homeless or in jail, or people dying by suicide.

The crisis in our mental health system is long standing. State institutions were not a mental health system, so we have never had a community mental health system where people with mental illnesses have been able to access the right care, at the right time, at the right place. With more Minnesotans struggling with their mental health during the pandemic, and as Minnesotans with serious mental illnesses experience an increase in their symptoms, we are very concerned that the fragile mental health system we have will implode.

While the focus today is on inpatient hospital care, the committee needs to understand that this is also a "front door" and "back door" issue. We need to look at what we can do to prevent people from needing to enter the "front door" of a hospital and what we can do to make sure people can be safely discharged out the "back door" of a hospital into an appropriate level of care.

With 50% of all mental illnesses emerging by the age of 14 this means we need to expand access in our children's mental health system. This includes early childhood mental health consultation, school-linked mental health programs, day treatment, residential treatment, Psychiatric Residential Treatment Facilities, Youth ACT, in-home services and more. For adults we need to expand and fund programs such as supportive and affordable housing, employment programs, clubhouses or drop-in centers, ACT teams, in-home services and more.

For both children and adults, it means ensuring timely access to basic care such as psychiatry and therapy. Waiting three months to see someone when you're hearing voices, are deeply depressed or manic is unconscionable. Mental health crisis services are extremely effective in preventing hospitalizations and yet are not funded at a level to respond when needed. Crisis homes are a good alternative for people who need help but don't need hospital level of care – but please note we have no crisis homes for children.

Funding tertiary prevention programs is key - where we cannot prevent the illness, but we can prevent it from becoming a disabling condition. We know that first episode programs for psychosis and mood disorders can change the trajectory of a young person's life in a positive way. We also need to implement the voluntary engagement in treatment section of the new commitment law, so we people don't languish until they are a danger to themselves or others.

Building our community mental health system will help decrease the need for hospitalizations, but not eliminate the need. Once someone needs hospital level of care – despite early intervention, despite easy access to treatment – then you should not have to wait. You should not have to wait for 4 hours, or 8

hours, or 12 hours or days. You should not have to travel to North Dakota from Minneapolis or Duluth for an open bed. You should not be released without receiving any treatment.

Using 2018 data, there are roughly 1,345 psych beds in Minnesota out of about 16,600 licensed beds. About 4,800 of the total licensed hospital beds are not being used – they are what we refer to as "banked beds." Not every hospital has unused beds, but many do.

This means that right now, today, hospitals could add beds without going through the public review process connected to the hospital moratorium. So why aren't hospitals adding beds when clearly there is a need? A need established by their own community needs assessment that nearly always places mental health in the top three priorities – with MHealth Fairview's most recent assessment ranking mental health as their number one need?

It's about money. Medicaid and Medicare pay less, below costs, for inpatient mental health care - often several thousand dollars per patient. Because it is a loss leader, health systems are not interested in adding beds.

While there are not many things you can do, we would suggest the following:

- Do not allow health systems that close psych beds to keep them (bank them)
- Allow any health system to add psych beds without going through the moratorium process
- Address workforce shortages, especially recruitment of BIPOC mental health professionals
- Increase Medicaid rates for inpatient care and for all community-based services
- Expand psychiatric ERs in hospitals (not separate crisis centers but ones integrated and co-located in hospitals).
- Expand Urgent Cares to treat mental health issues
- Expand crisis teams and homes
- Expand all community mental health services
- Enforce mental health and substance use disorder parity laws

Every year NAMI and the MHLN come to the capitol with recommendations for how to continue to build the mental health system. You have a significant role to play – as do others. Hospital and health care systems are required to assess and meet the needs of the community –and they need to meet those identified needs by adding more beds and not closing beds. Health plans must start paying for the very community services that address the front and back door issues - especially IRTS facilities and PRTFs, and finally embracing mental health and substance use parity laws.

Please act this session, before the crisis worsens. Please act to end this discrimination against children and adults with mental illnesses.

Sincerely,

Sue Abderholden, MPH
Executive Director

*Please note: Do not reference the Treatment Advocacy Center study on hospital beds per state. They only counted state-run hospital beds, not the psychiatric beds in community hospitals. In some states their state-run hospitals provide acute care, but not in Minnesota.*