HENNEPIN COUNTY
MINNESOTA

Adult Mental Health

2019

System Review and Recommendations for Improving Community Stabilization

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Executive summary

Purpose

Hennepin County is actively working to expand local capacity to serve residents living with serious mental illness. Facilitating upstream access to community-based mental health services and supports is a critical strategy to prevent hospitalizations, civil commitments, homelessness, and the overrepresentation of people with serious mental illness in the criminal justice system.

Responsive supports help people with serious mental illness manage their symptoms, maintain engagement in treatment, and maintain community living so that they have fewer (or no) traumatic experiences of hospitalization, homelessness, detention, or civil commitment.

Community-based mental health services and supports are also critical to the functioning of the continuum of care, promoting timely discharges from state and local hospitals and freeing up capacity for others needing psychiatric stabilization services.

Hennepin County needs to continue to accelerate its efforts to develop a full range of community supports that can help people living with serious mental illness stabilize their symptoms and pursue recovery in the least restrictive settings that meet their needs.

Hennepin County currently spends millions of dollars annually in per-diem costs for residents with serious mental illness in state psychiatric hospitals. At the same time, there are significant numbers of people with serious mental illness who are cycling through crisis and deep-end venues. Both for improved resident well-being and for effective use of county resources, Hennepin County needs to continue to accelerate its efforts to develop a full range of community supports that can help people living with serious mental illness stabilize their symptoms and pursue recovery in the least restrictive settings that meet their needs.

Information requested

As a part of the 2019 budget process, the Hennepin County Board of Commissioners directed the County Administrator to conduct a review of the current adult mental health service system in Hennepin County to address capacity needs. The Board asked for a review to answer the following questions:

- What services are available within the entire spectrum of adult mental health in Hennepin County, including psychiatric, acute and treatment beds, community mental health supports, and supportive housing?
- How well do these services meet the needs of residents and what are the gaps?
- What opportunities exist for system improvements in order to prevent residents living with serious mental illness from becoming stuck in institutional environments?

The Board of Commissioners sought an understanding of viable options for development of community-based mental health services to help more residents living with serious mental illness maintain community living, reduce their experiences of hospitalization, detention and civil commitment, and ultimately support their recovery.

Methodology

This report is based on a review of available county and state data as well as relevant local, state and national best practice frameworks and empirical publications. Findings and recommendations are drawn from a number of county and state reports as well as utilization data and documented stakeholder perspectives. DHS is working on a more robust tool for measuring the adequacy of various mental health services in different regions of Minnesota, but there is no known timeline for this nor its methodology. This review takes a pragmatic approach to describing our current system based on the data available. Key documents and links are included in the bibliography.

Findings

Hennepin County has many positive outcomes from its adult mental health system. Compared to most places in the country and our state, Hennepin County has a broader range of adult mental health services available. In Minnesota, many needed mental health services and supports are payable under Medicaid that are not in other states. Outcomes by program, including those from several county-operated adult mental health programs, are excellent. Many of the service models available in Hennepin County are supported by national evidence and local findings for what works to effectively treat people living with serious mental illness and co-occurring conditions.

At the same time, Hennepin County's expenses for people who receive treatment through the state operated hospital system have doubled since 2013 and now make up 30% of the county's Human Service budget for adult mental health support. This is due to a number of factors including per diem rate increases, changes to cost allocation formulas that shift responsibility from the state to the county, and criminal justice system impacts of the 48-hour rule. Underlying this is the inability of our community-based services to sufficiently meet the complex needs of residents living with serious mental illness without policy reform, financial investment in early detection and treatment, and the development of enhanced services that address persons with co-occurring conditions and the root causes driving crisis-oriented and deep-end residential services.

Empirical evidence points to specific areas to target system reform that can address these drivers and lead to sustainable outcomes and a cost-effective use of resources. The challenges that need to be overcome to move from today's environment to one in which residents receive optimal care regardless of geography, socio-economic and cultural background demand that all stakeholders -- policy makers, funders, communities, providers -- contribute to alternative solutions. It is critical to consider larger system implications that span the range of community, governmental and provider agencies. Reform work, therefore, requires close collaboration and partnership with stakeholders that make up the diverse entities both in and outside of mental health disciplines.

Empirical evidence points to specific areas to target system reform that can address these drivers and lead to sustainable outcomes and a cost- effective use of resources.

Key challenges within the current adult mental health system include:

- Hennepin County's mental health services are fragmented and are weighted toward crisis and deep-end responses rather than upstream interventions.
- Mental health and substance use disorder services are poorly integrated.
- Residents with serious mental illness who become involved in the justice system are very likely to end up in institutional care.
- Disparities lead to poor outcomes for residents with serious mental illness.

Recommendations

Hennepin County Human Services will develop a comprehensive strategic plan for behavioral health that uses a range of cross-sector data, addresses root causes driving poor outcomes and high costs, promotes evidence-based strategies, and informs policy. This plan will contain three interdependent and actionable approaches that can be pursued both short-term and long-term:

1: Invest in early interventions across the continuum:

Create an integrated continuum of children's, transition-age and adult mental health services that focuses on early intervention when symptoms first appear, reduces barriers to access, and eliminates system bottlenecks.

2: Innovate for complex-need populations:

Invest in new approaches for residents whom traditional health and human service systems fail to support because of co -occurring conditions and cross-sector involvement.

3: Promote strong policy to advance system reform:

Advance strong policy to improve access to evidenced-based interventions and address disparities that disproportionately impact persons with mental illness and substance use disorders.

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How is mental illness defined?

Mental illness occurs at many levels of severity. For purposes of this report, it is chiefly defined by the degree of impact on a person's functioning:

- Mental illness (MI) is defined by the National Institutes of Mental Health (NIMH) as a mental, behavioral, or emotional disorder. It can vary in impact, ranging from no impairment to mild, moderate, or severe impairment. Mental illnesses are very common, with one in five adults diagnosed every year.

- Serious mental illness (SMI) is defined by the National Institutes of Mental Health (NIMH) as a *mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities*. It often refers to four serious diagnostic conditions: schizophrenia, bipolar disorder, major depression, and schizoaffective disorder. It is a much smaller group of approximately 5.0% of our adult population.

- Serious and persistent mental illness (SPMI) is a further subset of serious mental illness. People in this category must have experienced hospitalization within the past year and have persistent difficulty functioning in community settings without significant support. Persons with SPMI make up about 2.5% of the adult population.

- Co-occurring disorders (COD) refers to people who have both mental illness and substance use disorder (SUD). It is estimated that between half and two-thirds of people with serious mental illness also have substance use disorder. "Behavioral health treatment" is a term that encompasses both mental health and substance use disorder treatment.

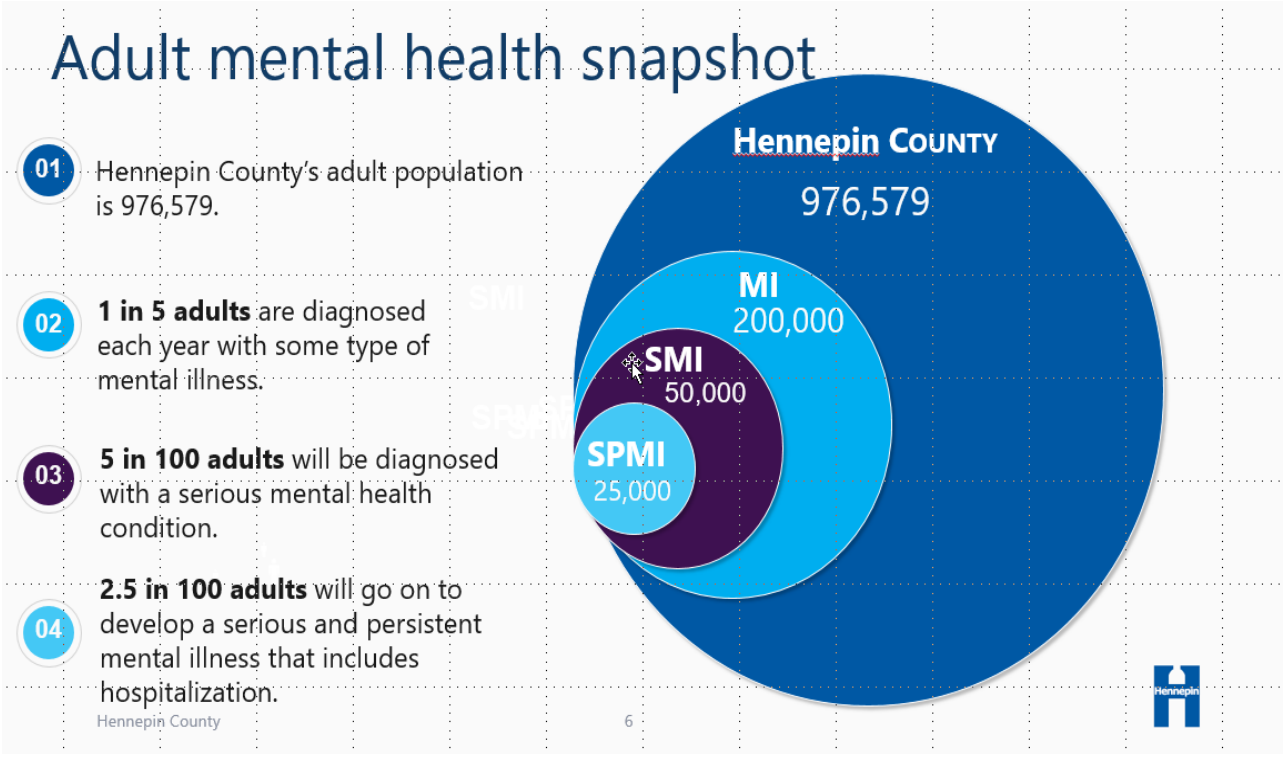
- Complex conditions are additional challenges to both community living and participation in SMI/COD treatment. These can include aggressive behaviors, sex offense behaviors, physical health challenges, brain injury, and cognitive impairments.

For purposes of this report, our focus is people with SMI, including those with SMPI, COD, and complex conditions. An effective mental health system must address all these levels of need. In general, the farther down the list above, the greater the gaps in access to responsive community-based services. People with SMI/COD and especially those with complex conditions are the most likely to end up in institutional environments.

What is the prevalence of mental illness among Hennepin County adults?

Hennepin County does not maintain a registry of people with mental illness. We can, however, roughly estimate the number of people in need of mental health services based on national data. According to the National Institute of Mental Health (NIMH), in 2017, approximately 20% of U.S. adults lived with mental illness, 5% lived with serious mental illness, and 2.5% lived with serious and persistent mental illness.[1]

Applying these prevalence rates to Hennepin County's census of 976,579 adults:



1 National Institute of Mental Illness. "Mental Illness." Accessed April 20, 2019. https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

Disparities in prevalence of serious mental illness

Some demographic groups are somewhat more likely to have a diagnosis of serious mental illness:

- People living with serious mental illness are more likely to be women (5.7% vs. 3.3% for men).
- Rates are elevated for young adults aged 18-25 (7.5%) compared to mature and older adults.
- More than 20% of children have or have had a serious mental health disorder, including a mood, anxiety, or behavior disorder.
- While many studies show that members of minority groups have either lower or equivalent rates of mental disorders as compared with whites,[2] their outcomes are worse. People of color who become mentally ill tend to have more persistent disorders, are over-represented in deep-end services, and more often experience cross-sector involvement with justice and social service systems.[3]

[2] Source: "Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/
[3] Source: "Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/

Stages of serious mental illness

Serious mental illnesses such as schizophrenia, bipolar disorder, major depression, or schizoaffective disorder usually progress through sequential stages of severity.[4]

In stage 1, the person might begin experiencing symptoms such as hallucinations, but they are still able to function at work, home or school. Many people at this stage often conceal their symptoms.

In stage 2, symptoms begin to multiply and become more pronounced. These symptoms are uncomfortable and impact the person's ability to function. It is common for people in stage two to begin self-medicating with alcohol or marijuana.

Serious mental illness is often not diagnosed until stage 3, when the person is no longer able to maintain control of their life. People may drop out of school and work. Close relationships are strained and people with SMI often become very isolated if they do not successfully access treatment.

At stage 4, the condition has become extreme and prolonged and is often marked by crisis and hospitalization. This is the most common stage for people to come into contact with police. Experiences of eviction, unstable relationships, and criminal charges driven by the mental illness make stable housing and employment difficult.

Serious mental illness is a lifelong condition that requires early detection and intervention and must be managed throughout the person's life. Mental health treatment and supports reduce harm to the person from the illness and help the person achieve recovery goals for stability, independent living, and quality of life.

Growth in the demand for mental health services — and the associated growth in costs — has increased more than those of heart disease, cancer or any of the other top five costly physical conditions.

Growth in the demand for mental health services—and the associated growth in costs – has increased more than those of heart disease, cancer or any of the other top five costly physical conditions.[5] Even with this growth, studies show that only 48% of people with mental illness receive treatment.[6] As with other disorders such as cancer, delays in treatment (or lack of treatment) create a predictable progression to advanced stages of disease. Earlier intervention is associated with better outcomes.

[4] Mental Health America. "B4Stage4: Changing the Way We Think about Mental Health." Accessed April 30, 2019. http://www.mentalhealthamerica.net/b4stage4-changing-way-we-think-about-mental-health.
[5] Minnesota Hospital Association. "Mental & Behavioral Health Options & Opportunities in Minnesota." Minnesota Hospital Association, December, 2015, p. 8.
[6] Ibid., p. 8.

What is the county role in providing mental health services?

Providing a continuum of care to meet the needs of residents with mental health disorders is a legal responsibility of the county that is governed through the state Department of Human Services (DHS). Per MN Statute 245.466, *the county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services*.

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>
> *Department of Human Services (DHS)*
> *Per MN Statute 245.466*

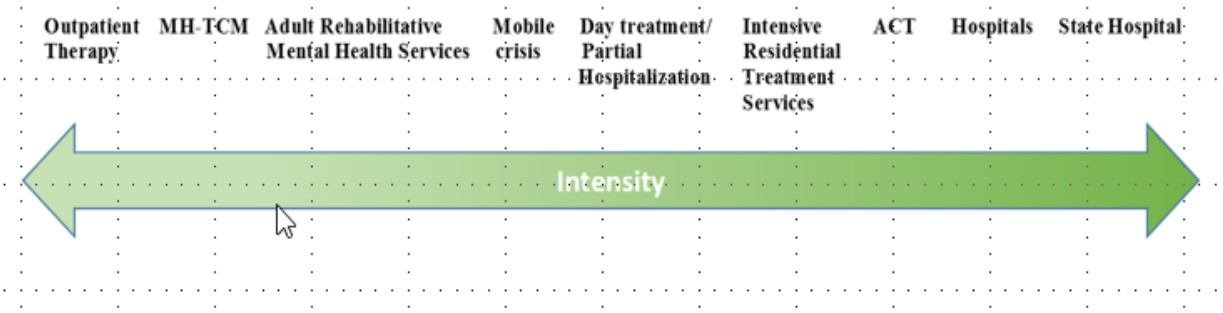
By statute, the adult mental health service system developed by each county board must include *education and prevention services, emergency services, outpatient services, community support program services, residential treatment services, acute care hospital inpatient treatment services, regional treatment center inpatient services, screening, and case management*. Counties may provide the services directly or through contracts. Hennepin County Health and Human Services has executive responsibility for the local mental health continuum of care.

In practice, people with mental illness access services from a variety of providers based on their needs. In Hennepin County, about 75% of people with SMI are served by community providers, 25% directly by county staff, and a small subset (less than .5%) directly by state-operated services. The greater the needs of the person, the more likely they are to receive direct county or state mental health services. Traditionally, treatment for people with serious mental illness who have complex and challenging needs (for example, aggressive behavior or need for competency restoration to face felony charges) has been directly provided by the state. However, over time, the state has reduced its capacity to provide inpatient psychiatric stabilization and hospitalization *only* to people who are committed through the civil probate court. Details of these changes and their impacts on Hennepin County are detailed in the Findings section.

More broadly, the role of the county with regards to mental health aligns with the larger responsibilities of our public health and human service departments to administer and oversee effective programs that safeguard communities and individuals whom others fail to adequately attend. Because of this, Hennepin County pays close attention to meeting the unmet needs of persons who are the most vulnerable, disenfranchised and underserved in the county.

What mental health services and supports are currently available?

Many people think of mental health services in limited terms of medication, therapy and hospitalization. In reality, the continuum of adult mental health services is much broader and more complex. Services offer a continuum that range in intensity.



People with serious mental illness need rehabilitative services that help them function in the community, stay engaged in treatment, and pursue their recovery goals. They need 24/7 crisis services to keep them safe when their symptoms flare.

People with complex conditions need specialty services that are responsive to their unique needs. In an ideal system, people can easily access ongoing community-based services, reducing the need for deeper-end services.

Mental health services may be roughly classified into:

- Ongoing treatment services to treat the condition,
- Rehabilitative and supportive services to maintain community living,
- Crisis services to address acute symptoms, and
- Deep-end residential services such as hospitalization.

Some interventions, for example, Assertive Community Treatment (ACT), combine different types of services. Innovative solutions to connect residents with SMI to ongoing care are also very important, especially for people of color, people who are involved in the justice system or homeless, and others who are underserved by the standard continuum of care.

Services that address the complex needs of people with SMI/COD who have justice system involvement are an area of innovation and a growing edge for Hennepin County. Adult mental health services available in Hennepin County include:

Ongoing treatment services to treat the condition

- **Outpatient Clinical Services**. People with SMI may access ongoing outpatient mental health treatment with providers of their choice. Two common providers for people with public insurance or no insurance are the county-operated Mental Health Center (MHC) and the NorthPoint Behavioral Health Clinic. Each site offers a range of outpatient services, including diagnostic assessments, psychiatric evaluations, psychological evaluations, individual and group therapy using several different evidence-based methodologies, medication management, and pharmacy services as well as primary medical care. These two clinics also feature additional services such as dental care, optometry, housing and employment services, domestic violence and gang violence prevention, financial counseling, HIV education and prevention, care coordination, and co-parenting services.

  In 2018, MHC served 3,767 unduplicated patients during 22,459 visits. Eighty-eight of MHC patients had incomes at or below the federal poverty level. Insurance status for the MHC population was 58% Medicaid, 23% Medicare, 14% self-pay, and 5% private commercial.

  In 2018, NorthPoint Mental Health Clinic served 3,746 patients during 24,306 visits. Ninety-four percent identified with communities of color and 87% were on public insurance or uninsured.

  An unknown number of people with SMI accessed their outpatient treatment through community providers.

  Hennepin Healthcare also provides Outpatient Clinical Services available to Hennepin County residents. They provide outpatient treatment for most of our residents who are assigned to county-operated case management and under civil commitment. Residents with SMI typically need ongoing medical monitoring and support of their treatment and symptoms.

Rehabilitative services to maintain community living

- **Adult Rehabilitative Mental Health Services (ARMHS).** ARMHS are services which are rehabilitative and enable people with SMI to achieve and maintain psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills. The services also enable people to retain stability and functioning if the recipient is at risk of losing significant functionality or being admitted to a more restrictive service setting without these services. Up to 300 hours of ARMHS services annually may be provided. Services are delivered by mental health practitioners in home and community settings. ARMHS providers are certified by MN DHS and services are paid through insurance. According to DHS data, 56 agencies in Hennepin County provided 5,766 individuals with AHRMS services in 2018. This represents 20.5% of the individuals who received ARMHS services throughout Minnesota in 2018. This is up from 5,022 served by agencies in Hennepin in 2017 for an additional 744 individuals served in 2018. ARMHS capacity shifts based on the number of providers and their outreach.

- **Community Support Programs (CSPs).** Community support programs offer neighborhood-based multi-service drop-in centers with a wide range of wellness-oriented services and housing and employment supports for people with SMI. Residents with SMI can enroll with a free "membership" to the CSP in their neighborhood. CSP members can walk in for one-on-one support with issues that arise due to financial, housing, employment, or mental health concerns. They can also access on-site and community-based social, recreational, nutritional and therapeutic opportunities that provide a supportive community. Seven contracted agencies provided approximately 2,500 Hennepin County residents with Community Support Program (CSP) services in 2018.

- **Permanent Supportive Housing.** Hennepin County has many housing options that are specialized to the needs of people with SMI and combine base rates to cover housing costs (various federal, state or county vouchers and subsidies) plus services to help the person retain housing. Examples include Individualized Home Supports to help people with SMI maintain tenancy (caseload approximately 75:1) and a variety of permanent supportive housing models with an approximately 20:1 case management ratio, delivered in site-based and scattered-site settings. Adult Foster Care and Customized Living options serve individuals with higher need for on-site staff support. The overall movement is toward independent living in individual apartments for as many people as possible. Housing First models provide housing without preconditions to prevent homelessness and support recovery. High rents, the tight rental market, and landlord reluctance to rent to people with SMI are barriers to achieving community living.

- **Supportive Employment.** Supportive employment is a best practice approach proven to help people with SMI maintain community stability and better quality of life.[7] Hennepin County currently contracts with three supportive employment providers that served a total of 300 people with SMI in 2018. Of those, 123 obtained permanent supported employment. Supportive employment services were also provided directly by county staff to 200 people in 2018 and about half of those served also obtained supported employment at average wages of $13.00/hour. Employment specialists are also integrated into many other mental health service teams (e.g., ACT).

- **Adult Mental Health Targeted Case Management (TCM).** Case management services help adults with SPMI in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. TCM services include developing a functional assessment and individual community support plan, assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services. They serve both people under commitment and individuals who access TCM services voluntarily. Hennepin County directly operates nine teams with 50 Case Managers with an optimal total capacity of approximately 1,000 cases. They currently operate at 88% of their capacity. These teams offer multi-disciplinary support including licensed social workers and alcohol and drug counselors, registered nurses, case management assistants, vocational specialists and peer recovery specialists. Hennepin County also contracts with eight provider agencies who serve an additional 4,000 cases.

- **Assertive Community Treatment (ACT)** is an intensive service model provided by community-based, mobile mental health treatment teams and sometimes referred to as "hospitalization without walls." The ACT team approach is designed to provide comprehensive psychiatric treatment, rehabilitation, and support to persons with SPMI to live independently in the community. A team of specialists addresses mental health, housing, employment, and other needs. Persons served by ACT usually have complex issues such as homelessness, substance abuse, frequent hospitalization, and/or involvement with the justice system. It is an intensive service that combines 24-hour availability of mental health treatment and symptom monitoring along with rehabilitative supports in order to prevent future episodes of crisis, hospitalization, homelessness and justice system involvement. Hennepin County currently has seven operated and contracted ACT teams, each serving about 70 people for a total capacity of 540. Three of these ACT teams are specialized. One targets homeless individuals, one is specialized for youth, and one works with criminal-justice-involved populations (Forensic ACT Team).

[7] IPS Employment Center. Last modified 2019. https://ipsworks.org/index.php/evidence-for-ips/

Crisis services to stabilize acute symptoms

- **Emergency Mental Health Services** are operated by Hennepin County Public Health. The purpose of the program is to intervene during a mental health crisis. Services are available to people of any age. Services include a 24/7 crisis line answered by mental health professionals. Responses vary dependent on the needs of the person and vary in intensity, from phone counseling or resource referral all the way to being offered a face-to-face visit in the community. A mobile crisis team (COPE) visits people in the community when this is needed. Emergency Mental Health Services responded to about 4,500 people and made almost 30,000 mobile crisis visits in 2018. Data on the number of crisis calls shows a 61% increase from 2017 to 2018.

- **First Episode Psychosis Services** are operated through Hennepin Healthcare and are designed to provide early intervention and support to residents and families who are at the early stages of serious mental illness, often teens or young adults. This evidence-based model is a comprehensive clinical strategy to prevent rapid progression of serious mental illness. Hennepin is the only county in Minnesota that currently offers this service. Hennepin County's First Episode Psychosis HOPE Program enrolled 55 adults and 7 adolescents in 2018.

- **Mental Health Crisis Stabilization Services** are an alternative to hospitalization for residents experiencing acute mental health crisis who can be safely stabilized in the community with a short stay, generally less than 10 days. In 2016 there were a total of 16 beds to serve all of Hennepin County through one contracted agency (People Incorporated). HCMC opened an additional 16-bed program in 2017 and the new Behavioral Health Care Center (1800 Chicago) added a 16-bed program in 2018. The total current bed capacity currently is 48.

- **Day and Partial Hospital Programs.** Day programs are limited-duration intensive mental health programs that typically provide several hours of structured treatment daily. The person returns home to sleep. Hennepin Healthcare's Partial Hospital Program provides short-term (approximately 3 weeks) intensive mental health treatment as an alternative to inpatient hospitalization or as an option following inpatient psychiatric hospitalization. It offers a structured program of psychiatric services, group psychotherapy, and other therapeutic services specifically designed to meet the mental health needs of individuals experiencing an acute crisis. The goal of the Partial Hospital Program is to reduce the need for inpatient psychiatric hospitalization whenever possible while supporting mental health recovery. The program's philosophy is based on the belief that individuals can learn to cope effectively with symptoms and stressors.

Deep-end residential services

- **Intensive Residential Treatment Services (IRTS)** are time-limited mental health services provided in a residential setting. Recipients of IRTS are in need of structure and assistance from 24-hour mental health staff and are at risk of significant functional deterioration if they do not receive these services. IRTS is often an alternative to hospitalization or a "step-down" facility after hospitalization. In 2015 Hennepin County expanded IRTS capacity by two additional 16-bed programs, bringing the total to 140 IRTS beds. County staff monitor the wait list and saturation points for this level of service. Hennepin County is developing two more IRTS programs in 2019 to bring the total to 164 beds.

- **Inpatient Psychiatric Beds** are intended to provide short-term mental health services to help stabilize people in crisis. Hennepin County has a total of 331 available psychiatric inpatient beds available at four hospitals (HCMC, Fairview, Abbott and North Memorial) at a rate of 3.39 per 10,000 adult residents (this does not include beds at state facilities located outside Hennepin County).

- **Direct Care and Treatment.** Direct Care and Treatment services are provided by the state. DHS provided Direct Care and Treatment for 285 Hennepin County residents with serious mental illness in 2018. Direct Care and Treatment beds are located at the Anoka Regional Treatment Center (AMRTC), the Minnesota Security Hospital in St. Peter which offers an array of forensic services including a Competency Restoration Program and the Forensic Nursing Home, and six regional Community Mental Health Hospitals (CBHHs). Hennepin County utilization of state hospital beds is driven by civil commitments with many individuals transferring directly from detention to state hospitals under the 48-hour rule. AMRTC is currently staffed for 95 inpatient psychiatric beds; the 2019 governor's budget includes increased funding to staff for up to 114 beds. The average length of stay is several months. The Minnesota Security Hospital has inpatient psychiatric beds that exclusively serve about 100 people committed as mentally ill and dangerous (MI and D) and a 25-bed Competency Restoration Program (CRP). The average stay for patients committed as MI and D is six years and for patients placed in the CRP program averages three and a half months. A "community" Competency Restoration Program operates just outside the secure perimeter and serves an additional 30 people for a stay of approximately 2 months. The future of state-operated CRP programs is unclear, but recent state communications suggest these supports are time-limited. The state Forensic Nursing Home (FNH) serves 20 elderly residents annually with SMI who have been civilly committed with aggressive or sexually dangerous behaviors. The six state Community Behavioral Health Hospitals have an average length of stay of 75 days. They are located in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, and Rochester. A 7th location (St. Peter) closed in 2016. Each CBHH is licensed to operate 16 beds and had 60-80% utilization last year. Hennepin County residents are more likely to go to AMRTC than to these regional sites. The most recent annual utilization data for Hennepin County residents of these state facilities is as follows: AMRTC= 88; MSH=94; MN FNH=18; CBHH=37; and CRP=48.

Services for justice-involved residents

Partnerships with the criminal justice system lie outside the classic continuum of care, but are crucial to Hennepin County's strategy to divert people with SMI/COD into community-based, upstream interventions. The Hennepin County Criminal Justice Mental Health Initiative (CJBHI), launched in 2014 at the directive of the County Board, has made Hennepin County a national innovator in targeting specific touchpoints to bring tailored services to people with SMI/COD and divert them from justice responses where possible. Hennepin County is not alone in facing the disproportionate numbers of people with SMI/COD involved with the criminal justice system and as such, has been awarded several competitive federal and state grants to advance this work and inform the national dialogue that is shaping policy and practice.

Since justice-involved residents with SMI/COD are the primary population driving county utilization of state hospitals, addressing their needs through community-based services is paramount.

Since justice-involved residents with SMI/COD are the primary population driving county utilization of state hospitals, addressing their needs through community-based services is paramount. This work is ongoing and treated in more detail in subsequent sections of this report. Accomplishments to date include:

- **Improved police response capacity.** The Minneapolis Police Department provides escalation Crisis Intervention Training (CIT) to all its officers and offers co-responder teams of police officers and psychiatric social workers in five precincts.

- **Embedded social workers.** Hennepin County has embedded social workers in six suburban police departments, the public defender's office, the county jail and detention center, and the county attorney's office. These embedded social workers identify clinical needs of people and help link people to treatment services and community-based supports.

- **Access to mental health treatment.** Hennepin County has improved access to evidence-based treatment for SMI/COD at its detention and correctional facilities, including continuation of needed medications and mental health assessments.

- **Forensic Assertive Community Therapy (FACT) teams.** New specialty FACT teams deliver the "hospitalization without walls" community-based ACT model specifically for residents with SMI/COD who also have criminal justice involvement. This model is currently under a federal review to establish best practice fidelity standards.

- **Specialty Courts.** The Fourth Judicial District has a number of different specialty courts that have developed expertise in working with residents with SMI/COD, combining treatment and accountability to promote recovery and personal and community safety.

- **Behavioral Health Care Center.** Hennepin County is about halfway through a major project to establish an innovative Behavioral Health Care Center (BHCC) at 1800 Chicago Ave. that offers holistic care including residential and non-residential services for both SMI and COD. The model includes triage and assessment, opioid-responsive withdrawal management services, short-term residential mental health crisis stabilization services, primary care services, and interim case management to help residents with SMI/COD access the ongoing treatment and supports they need to stay out of detention, homeless shelters, and hospitalization and pursue their recovery goals. Law enforcement officers can divert residents with known or suspected SMI/COD to the BHCC at their discretion as an alternative to detention or emergency department care. Residents can also walk in for services or visit by referral from community partners. The goal is to provide highly accessible immediate care and to connect residents with SMI/COD who are underserved to ongoing mental health supports, closing the detention-to-hospitalization pipeline and increasing access to quality mental health care for underserved communities.

Capacity vs. need

Determining the appropriate level of capacity for each adult mental health service is more an art than a science. There are several reasons why this is true:

- **It is difficult to quantify what capacity exists.** It is challenging to determine the number of "slots" available for many services because case management ratios vary from provider to provider, and because every provider maintains separate databases. No government agency publishes a comprehensive capacity count that includes all categories of available mental health services: child/adolescent, adult, forensic, public and private, crisis and rehabilitation, mental health and substance use, and all the others that serve patients with behavioral health conditions. State data is not regularly published, and the state is often unable to meet requests for summary data.

- **There are few to no quality standards guiding the number of slots there should be per capita.** Most mental health services do not have evidence-based per capita standards, either in the United States or elsewhere.[8]

- **It is difficult to quantify the number of people who need specific services.** While we can estimate the number of individuals in Hennepin County living with serious mental illness based on national prevalence rates provided by NIMH, we do not have a true count of people with this diagnosis, let alone the intensity of services they require.

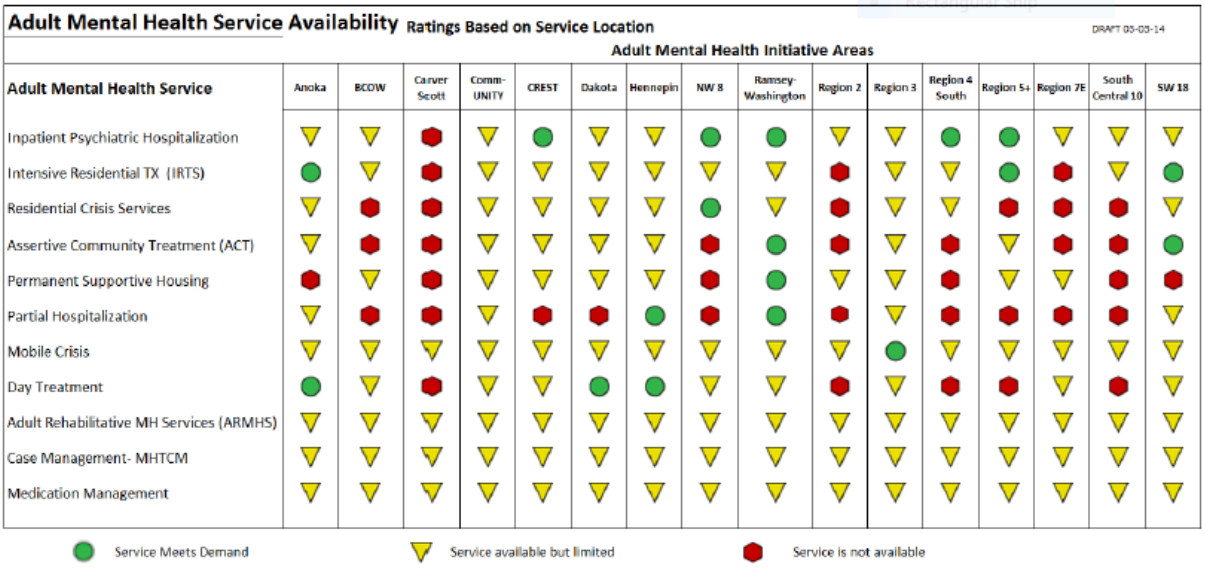
- **Wait lists are not a reliable indicator**. Wait lists are not a reliable indicator of pent-up demand because residents sign up for numerous wait lists simultaneously in order to secure an opening. In addition, we know that almost half of people with mental illness who need services don't receive them. It is almost certainly true that many people who need and qualify for a given mental health service don't know how to sign up for a wait list, or even that the service exists.

Assessing capacity more accurately would require state leadership and sophisticated analysis beyond the abilities of local government. DHS has completed periodic assessments and those results are below.

[8] Pinals, Debra A and Fuller, Doris A. Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. The National Association of State Mental Health Program Directors and Treatment Advocacy Center, October, 2017, p. 3.

What we do know about capacity needs

In 2014, DHS conducted a statewide analysis of mental health service gaps by region. It is important to note that the results are not based on objective analysis, but rather capture clinical and provider perspectives on the adequacy of capacity in their region. DHS concluded that the community-based adult mental health infrastructure across the state is not meeting demand. The following chart from the report indicates that Hennepin County's service system offers limited availability across the categories of service that DHS examined (as indicated by yellow triangles):[9]



Adult Mental Health Service Availability Ratings Based on Service Location

DRAFT 05-03-14

Adult Mental Health Initiative Areas

Adult Mental Health Service	Anoka	BCOW	Carver Scott	Comm-UNITY	CREST	Dakota	Hennepin	NW 8	Ramsey-Washington	Region 2	Region 3	Region 4 South	Region 5+	Region 7E	South Central 10	SW 18
Inpatient Psychiatric Hospitalization	▼	▼	●	▼	○	▼	▼	○	○	▼	▼	○	○	▼	▼	▼
Intensive Residential TX (IRTS)	○	▼	●	▼	▼	▼	▼	▼	▼	●	▼	▼	○	●	▼	○
Residential Crisis Services	▼	●	●	▼	▼	▼	▼	○	▼	●	▼	▼	●	●	●	▼
Assertive Community Treatment (ACT)	▼	●	●	▼	▼	▼	▼	●	○	●	▼	●	▼	●	●	○
Permanent Supportive Housing	●	▼	●	▼	▼	▼	▼	●	○	▼	▼	●	▼	▼	●	●
Partial Hospitalization	▼	●	●	▼	●	●	○	●	○	●	▼	●	●	●	●	▼
Mobile Crisis	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	○	▼	▼	▼	▼	▼
Day Treatment	○	▼	●	▼	▼	○	○	▼	▼	●	▼	●	●	▼	●	▼
Adult Rehabilitative MH Services (ARMHS)	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Case Management- MHTCM	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Medication Management	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼

○ Service Meets Demand ▼ Service available but limited ● Service is not available

While this is a subjective study design based on structured interviews, the data are helpful to get a broad sense of where in the state services are absent (red) and where providers feel they are adequate (green). The overall message is that more adult mental health capacity is needed to support Minnesota residents.

[9] Minnesota Department of Human Services, "Minnesota's Mental Health System Gaps," 2015, p. 2.

Another perspective on capacity comes from an analysis of metro-area mental health "slots" or beds per 10,000 residents for four metro-area counties, completed by county Adult Behavioral Health staff as part of capacity planning in 2018:

Adult Mental Health Services – Per 10,000 Residents in Metro Counties (2018)				
SERVICE	**Hennepin**	**Ramsey**	**Anoka**	**Dakota**
Assertive Community Treatment (slots)	5.02	14.47	3.74	4.24
Adult Rehabilitative Mental Health Services (annual served)	59.04	77.37	49.36	34.51
Crisis Mobile Services (agencies)	0.01	0.02	0.04	0.03
Crisis Residential Services (beds)	0.49	0.38	0.30	0.00
Community Support Programs (agencies)	0.07	0.10	0.00	0.06
First Mental Health Episode (slots)	1.08	0.00	0.00	0.00
Intensive Residential Treatment Services (beds)	1.43	3.47	0.94	0.79
Psychiatric Inpatient (beds)	3.39	3.57	3.56	0.00
Targeted Case Management (total slots)	43.78	47.59	7.38	37.69

This information will quickly be out of date as Hennepin County added 16 Mental Health Crisis Residential beds in late 2018 and is adding 24 additional IRTS beds in 2019.

Comparing slots per 10,000 people vs. other counties indicates possible directions for growth but does not necessarily mean that immediately adding slots is the right priority. For example, although Hennepin County has fewer ACT slots than Ramsey County, our ACT capacity is only 88% utilized.

Providers contemplating expansion need a certain level of confidence that new slots will fill and that the program will be able to bill enough to cover its costs. At the same time, the system needs enough capacity to serve people with SMI/COD without excessive wait lists. A well-managed adult mental health system builds sustainable capacity in response to needs and opportunities.

Hennepin County takes comparison data, utilization data, saturation, sustainability, and provider and consumer feedback all into account when designing service expansions.

How is the system funded?

Many different payers contribute to mental health services needed by Hennepin County residents with SMI/COD:

- **Medicaid, Medicare, and other insurance.** Many mental health services, including community-based supports, are billable to Medicaid, Medicare, or private insurance. Compared to other states, Minnesota has many more community mental health supports that are directly billable to Medicaid. We continually advocate with DHS to add mental health services to the benefit set. Medicaid Expansion enrollment also greatly benefitted our residents, enrolling over 46,000 residents with mental health and/or substance use orders. County social workers at multiple sites enroll people in insurance so that much of their care is billable, and county policies require providers to maximize medical billing. Medicaid, Medicare and private insurance fund millions of dollars in mental health services and supports for our residents.

- **Competitive grants.** Hennepin County regularly secures limited-term state and federal grants that help develop new capacity or introduce additional evidence-based practices into the system. The goal of grant projects is to cover startup costs, improve quality, and assess the effectiveness and sustainability of new models. Grants are not a viable source of funding for ongoing services.

- **State payments.** The state pays a portion of the cost for the Direct Care and Treatment services it operates. It also issues grants and contracts to counties and community providers to fill systems gaps, using legislative appropriations funded by state taxes.

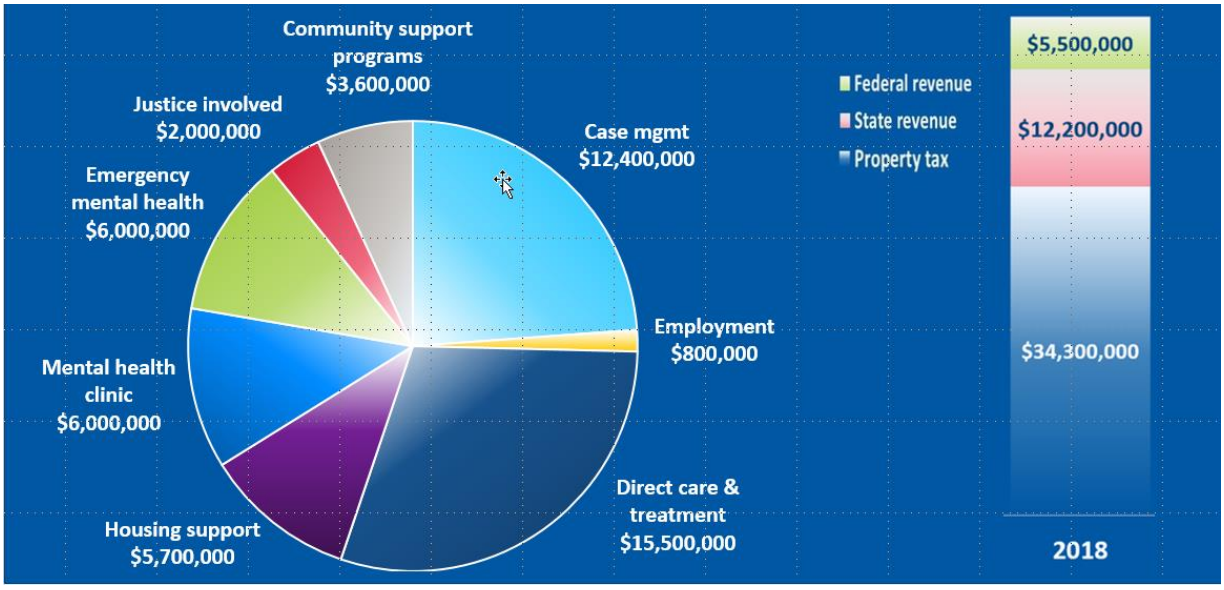
- **County payments.** Hennepin County directly pays certain mental health costs from county taxes and appropriations. Where people are uninsured and ineligible for Medicaid enrollment (current state rate of 6.7%), Hennepin County is the payor of last resort. We pay for essential mental health services that are not eligible for Medicaid or Medicare reimbursement under federal law, including mental health competency restoration services associated with criminal charges, mental health services provided in detention and correctional facilities, and room and board (hospital bed) costs for standalone mental health hospitals with more than 16 beds.[10] State or local governments must bear the entirety of these federally excluded costs and they make up a significant and expanding portion of Hennepin County's mental health expenditures. Adult Behavioral Health also directly operates or contracts for non-billable or partially billable services for people with SMI/COD, such as case management, emergency mental health services, ancillary clinic services, housing supports, community support programs, services for justice-involved populations, and employment services.

[10] This rule is called the Institutes for Mental Disease (IMD) Exclusion and was enacted in together with Medicaid in 1965 as part of mental health reform, with the intent to promote community-based services.

Hennepin County Adult Mental Health Expenditures

Below is a cost breakdown for Adult Mental Health expenditures in the Human Services and Public Health Department.

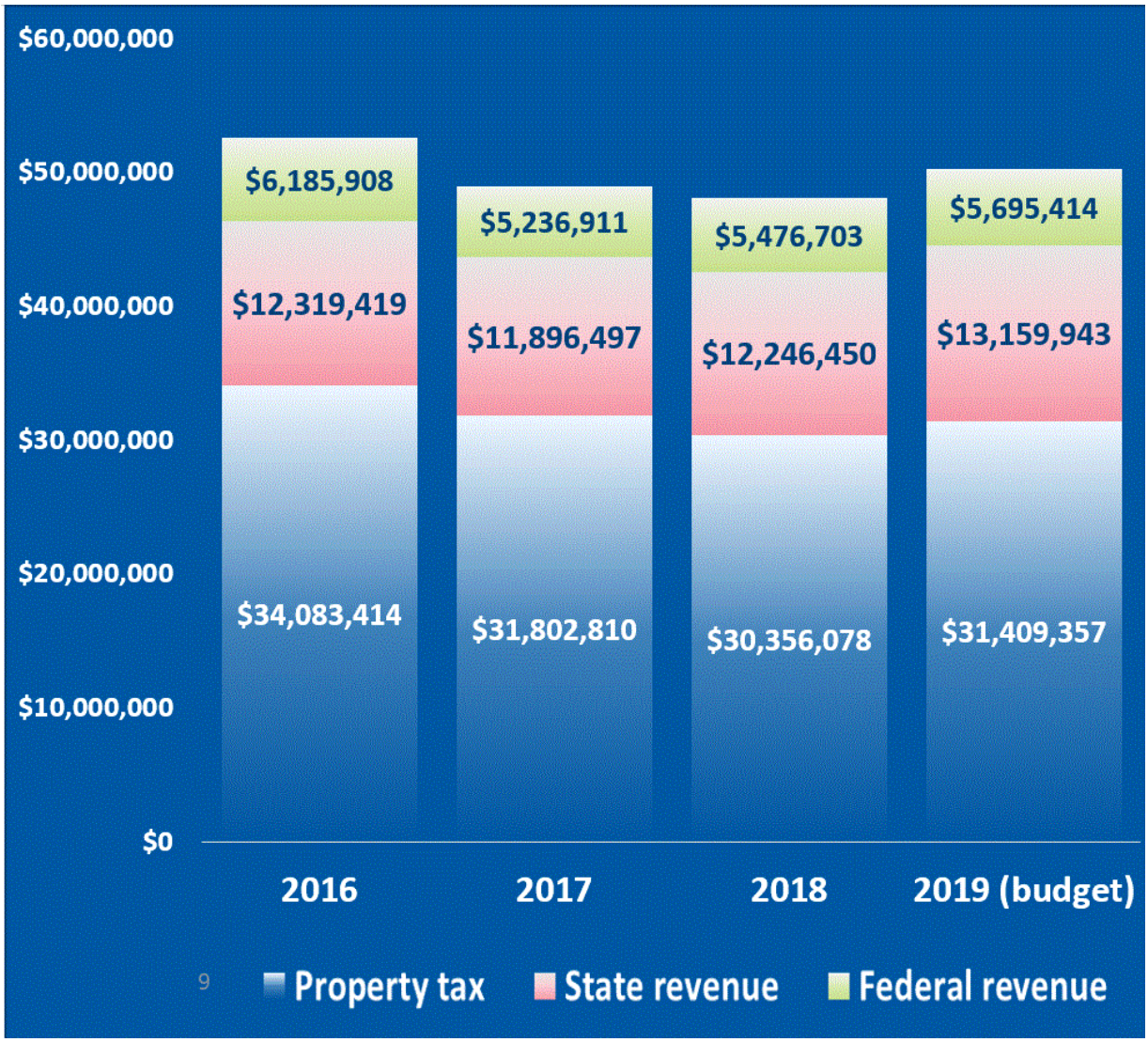
Cost breakdown for Human Services and Public Health Adult Mental Health, 2018



Funding considerations and trends

Hennepin County's investment in the Adult Mental Health system is significant and has remained reasonably flat over the past four years at about $50M per year. Income sources toward this budget have similarly remained stable:

Hennepin County Adult Mental Health Budget Comparison

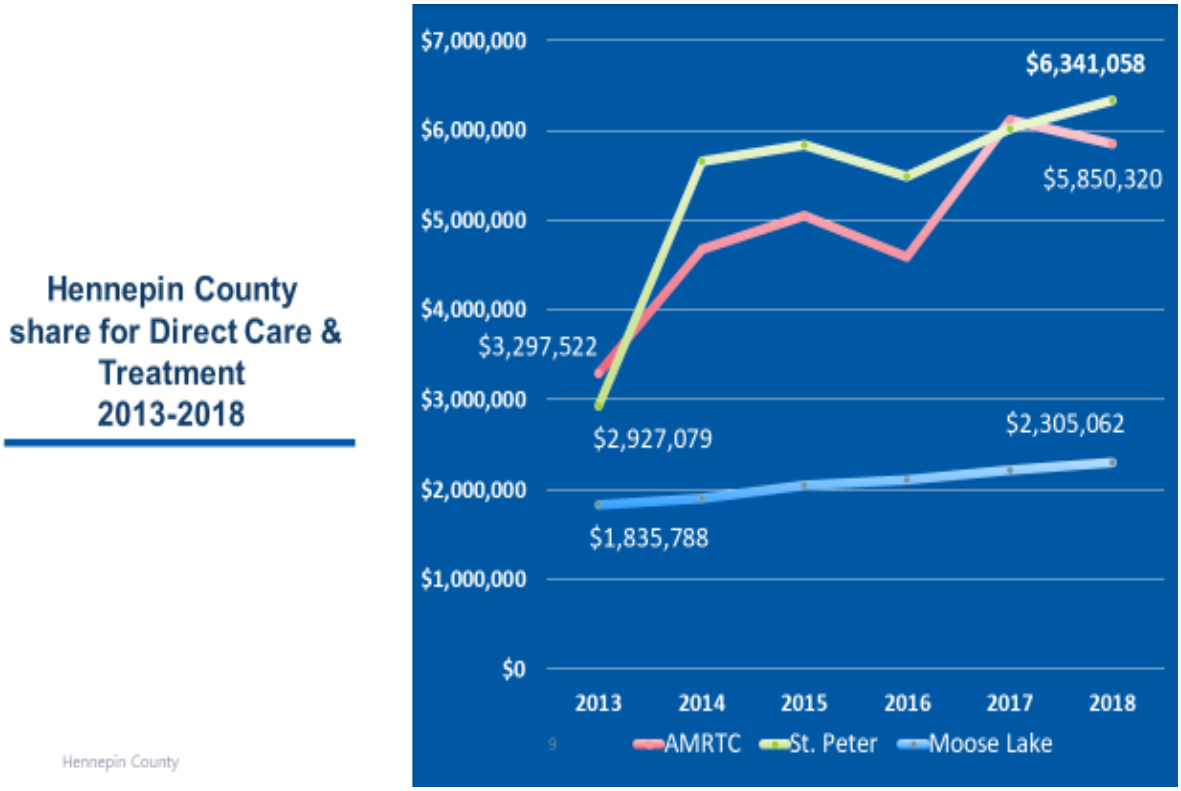


Rising county share of Direct Care & Treatment costs

However, cost allocations within the county Adult Behavioral Health budget are changing significantly. County expenditures for Direct Care & Treatment services provided at the state's two psychiatric hospitals have nearly doubled since 2013, and due to recent developments at DHS may accelerate even further.

Total county expenditures for care at these two state hospitals increased from $6.2M in 2013 to $12.3M in 2018, an increase of $6.1M, and are budgeted at $15.5M for 2019. Direct Care and Treatment expenses for less than 300 residents now account for almost half of the total Human Service Adult Mental Health budget. In addition to these costs, the county also pays approximately $2 million per year to the Minnesota Sex Offender Program (MSOP) Moose Lake facility house for Hennepin County residents who have been petitioned for civil commitment but not yet committed.

Hennepin County share for Direct Care & Treatment, 2013-2018



Why are county DCT costs increasing?

Hennepin County DCT expenditures are increasing even though the number of our residents using these facilities is not. Although the number of county residents served at the Minnesota Security Hospital at St. Peter has remained stable for the last five years, costs have increased by $3M.

At AMRTC, the number of Hennepin County residents served has actually decreased by 40% vs. 2013, yet costs are up by $3M at AMRTC as well.

Several compounding factors affect county Direct Care and Treatment expense:

- **IMD Exclusion.** Enacted in 1965 along with Medicaid, the IMD exclusion is a federal regulation that prohibits Medicaid reimbursement for bed costs for adult patients receiving mental health or substance abuse care in a psychiatric or substance abuse treatment facility with more than 16 beds. It was intended to de-institutionalize people with SMI in favor of community-based treatment and support. The IMD exclusion means that 100% of hospital bed costs at AMRTC and the MSH must be paid by state or local governments. While significant steps are being made at the federal level to reform the IMD exclusion by granting demonstration waivers to states, it still has a profound impact on our local costs for residents at the highest level of mental health needs.

- **Costs of care / per diem rates.** Health care costs are going up and the cost of care at state hospitals is no exception. Per diem costs at AMRTC have more than doubled from $670 per day in 2008 to $1,396 in 2019. Cost of care across every other state-operated program has also increased. We noted 12% increases since 2014 in St. Peter's Security Hospital. Hospital stays are expensive and residents with SMI/COD placed in state hospitals require extended stays.

- **Cost shifts from state to local government.** Changes in state legislation and policy have steadily shifted the cost burden for Direct Care and Treatment from the state to counties. In 2013, the county share of DCT costs changed from 10% to 50% of the per diem rate. The state/county cost share formula changed again at AMRTC on July 1, 2016 to incentivize discharge of people designated Does Not Meet Criteria (DNMC) for psychiatric hospitalization. Prior to 2016, the county paid for DNMC residents using a tiered formula (0-3 days DNMC at $0/day, 30-60 days DNMC at $220/day, 60+ days DNMC at $825/day). In July 2016, the county cost share jumped to 100% of cost ($1,385 per diem) for even a single day of DNMC. While our average monthly census remained between 140 and 160 from 2013 to 2018, we saw an increase in cost of over $3M in those five years.

- **Rule 20 and the 48-hour rule.** State criminal justice policies profoundly impact which Hennepin County residents go into state hospitals and the likelihood that they will extend their stay on DNMC status with the county paying 100% of their costs. One impact is from "Rule 20." Pursuant to the Minnesota Rules of Criminal Procedure (20.01 and 20.02), Rule 20 evaluations occur in criminal cases when there is a belief that a defendant may not be competent to proceed with the case or was not responsible at the time of the alleged offense because of mental illness or a developmental disability. Most of the competency restoration capacity statewide in concentrated in state hospitals. In 2016, the Minnesota state legislature passed the "48-Hour Rule," which only allows people with serious mental illness to be held in custody for 48 hours after they are deemed not competent to stand trial.

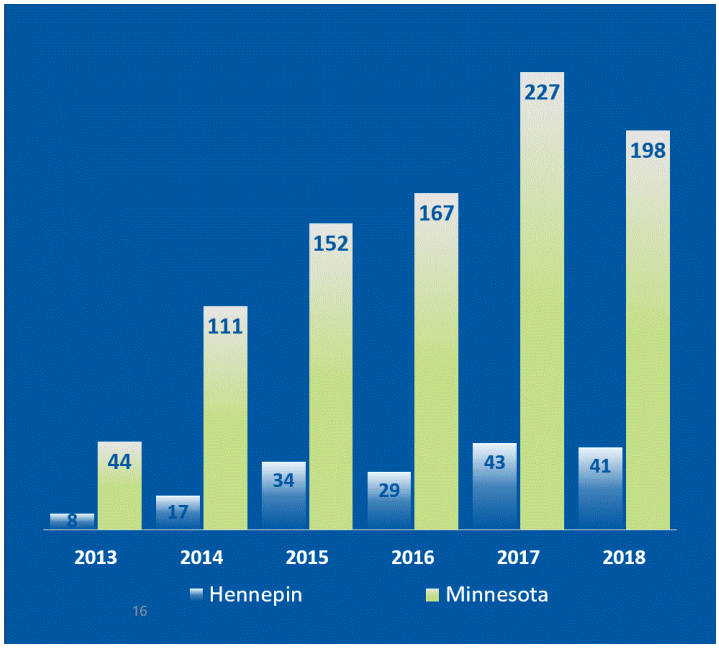
Impact of the 48-hour rule

The 48-hour Rule in effect fast-tracks people with SMI/COD who are in custody to state hospitals. In 2018, approximately 62% (54 people) of Hennepin residents admitted to AMRTC were Rule 20 patients. Many Rule 20 patients initially meet criteria for psychiatric hospitalization, but are assessed as DNMC for hospitalization earlier than they can be considered restored to competency and face trial. Therefore, almost everyone released back to custody after competency restoration will have experienced a DNMC extension of their hospital stay.

Hennepin County currently has one IRTS program and will develop a second IRTS to which residents can be discharged to complete the competency restoration process; however, neither is a secure locked facility. This system gap has led to a difficult legal, financial, clinical and public safety situation where individuals can neither be legally held in custody nor appropriately released to community settings.

The chart on the next page shows how admissions are shifting under the 48-Hour Rule.

Priority "48 hour rule" admissions to AMRTC 2013-2018



Admissions under the 48-hour Rule now make up 47% of total Hennepin County admissions to a state-operated facility.

Statewide, the number of 48-Hour Rule admissions has increased 450% since 2013; in Hennepin County the increase is 513%. Admissions under the 48-hour Rule now make up almost half of total Hennepin County admissions. More admissions from detention under Rule 20 and the 48-Hour Rule means more days of DNMC and increased county Direct Care and Treatment costs at state hospitals. Together with increased per diem costs and the 2013 changes to the cost-sharing formula, this change in criminal justice policy has doubled county expenditures for Direct Care and Treatment in state hospital even though the total number of residents entering state hospitals is decreasing.

Recent changes at the state level are again leaving counties to question the reliance on state-operated placements. New per diem rates that combine programming of forensic services not only raise county costs for people sent to a state program but also leave new gaps in community options. In a recently released bulletin, DHS noted that it will no longer refer to its activities as "Competency Restoration Program" and the "Community Competency Restoration Program". This renaming of programs to "Forensic Mental Health" describes the movement of the state to provide psychiatric treatment to persons civilly committed after being found incompetent on felony and gross misdemeanor level offenses and may provide competency restoration education services secondary to mental health treatment. The change is raising serious concerns among policy makers, criminal and civil courts and local governments, including Hennepin County, as to how to fill a newly created gap in the system. As mentioned above, there are currently limited options for local competency restoration programs and alternative considerations are mired in legal and fiscal challenges. Toward this end, the Governor will convene a task force in 2019 to make recommendations to state policy makers.

Issues and opportunities

The fact that significant investment is expended on a small number of residents admitted to state hospitals has caused policy makers to ask what is needed to keep individuals stable in the community as a means to use resources more effectively and achieve healthier client outcomes overall.

Right now, emergency rooms in Hennepin County regularly report boarding psychiatric patients in emergency departments, and local inpatient hospitals tell us that they have all but given up on state hospital placements because of extended bed waits. Bed shortages are often correlated with homelessness, mass incarceration, mass violence, and a host of other social system failures.[11]

Timely and appropriate supports are the first line of mental health care. When fully realized, they reduce the demand for inpatient beds which provide essential backup when psychiatric needs cannot be met in the community.

The number of state hospital beds, in particular, is often looked upon as the only viable solution to meet the needs of people with serious mental illness. The new state budget does include staffing to increase the number of beds operating at AMRTC from 95 to 114. Longer-term hospitalization is a necessary service to stabilize many people with SMI/COD, saving lives and promoting recovery.

The reality, however, is that residential care represents only a single component of a well-functioning continuum of care for any life-threatening health condition. The National Association of State Mental Health Program Directors puts this well in *Beyond Beds*, a 2017 analysis:

> *We acknowledge that people living with other medical conditions may require hospitalization at some point, but we do not expect hospitals to provide all the care required for those patients to survive and recover.*

Furthermore, while community-based treatment such as medication and therapy is essential, it is not sufficient to support the mental health and functioning of people with complex needs. Keeping a person stable in the community is an entirely different problem that requires a range of supports which fall outside the narrow range of traditional health care services. A strong and vital continuum of care reduces episodes of hospitalization and helps more people with SMI/COD receive treatment and support in community settings and pursue their recovery goals.

[11] Pinals, Debra A, and Fuller, Doris A. Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. The National Association of State Mental Health Program Directors and Treatment Advocacy Center, October 2017, p. 3.

Community-based services have excellent outcomes

Both local and national data indicate that community-based services have strong impacts in helping people with SMI/COD maintain community living, reduce episodes of institutionalization, and improve their ability to pursue recovery goals.

County-operated programs demonstrate excellent outcomes, despite serving some of the most complex and vulnerable residents in Hennepin County.

As mentioned earlier, county-operated community mental health programs demonstrate excellent outcomes, despite serving some of the most complex and vulnerable residents in Hennepin County. Community stability can be measured by comparing experiences of crisis and hospitalization during a set period (for example, six months or a year) before and after a resident begins a service). For example:

- County-operated mental health targeted case management teams provide ongoing monitoring and support of residents' needs to connect them to needed treatments and supports. It has reduced emergency room visits by 56% and inpatient hospitalizations by 36% for residents under civil commitment.

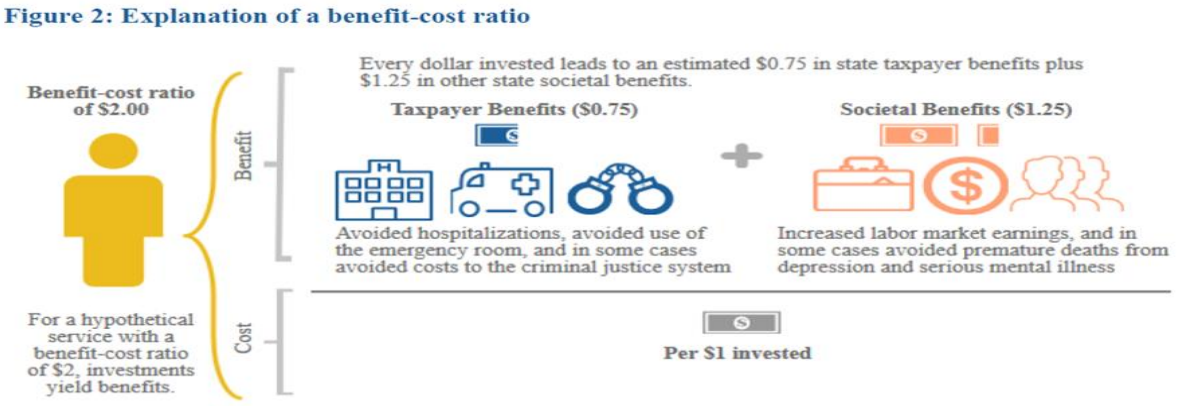
- The county-operated Supported Employment Program helps people with SMI/COD pursue and maintain employment by using an evidence-based model proven effective in eight randomized controlled trials and promoted by SAMHSA, the federal agency supporting people with mental illness and substance use disorders. Despite living with serious mental illness, 75% of residents who participate maintain employment for at least one year and make on average $13.00/hour salary. National data show that people with SMI/COD who achieve employment also improve self-esteem and symptom control.[12]

- The Integrated Access Team at the county jail in Minneapolis identifies detainees with SMI/COD (about 20% of the population on any given day) and provides them with transitional mental health services that actively connect them to community-based treatment and supports. Participants in the program have shown a 48% reduction in rebooking into the jail.

These are remarkable positive outcomes for individuals with SMI/COD who are most likely to be at risk or involved in multiple county systems.

[12] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services. *Evidence-based practices kit for Supported Employment: The Evidence*. February 2020, Publication ID SMA08-4365. https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4365

Community-based services are cost-effective



Graphic from Minnesota Office of Management and Budget[13]

Enhancements to cost-effective services at the earlier stages of our continuum of care could lessen the demand for inpatient facilities. Individuals who do not access treatment early show more serious disability and utilization of services in the later stages of the continuum. People with the most complex needs often resort to inpatient and residential services. These services are expensive, and as noted in the Results First Inventory, there is limited evidence of their effectiveness. SAMHSA (2014) also notes "current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning."

A 2016 report by Wilder Research studied 20 community hospitals and found that 1 in 5 inpatient psychiatric bed days were avoidable if other community based supports were available.

The current lack of community support services has led to overreliance on inpatient psychiatric beds and stays that exceed the needed length. Both issues exacerbate patient conditions and waste scarce resources that could be better spent on appropriate care and prevention programs.

While they are certainly not free, community-based mental health services are less costly than hospitalization and other deep-end responses. Cost-effectiveness is of course only one factor to consider when evaluating mental health investments. Equity, innovation, effectiveness, and the well-being of residents with SMI/COD are other key factors.

[13] Merrick, Weston, Kristina Shuey, and Pete Bernardy. Adult Mental Health Benefit-Cost Analysis. Minnesota Management and Budget, December, 2016. Accessed April 30, 2019. https://mn.gov/mmb-stat/results-first/adult-mental-health-report.pdf.

A December 2016 analysis by the Minnesota Office of Management and Budget Results First team found that six of seven community-based mental health services studied delivered benefits that exceeded their costs. Among these were certified peer specialists, mobile crisis response, and individual placement and supports.[14]

Given that state-operated Anoka-Regional Treatment Center costs $1,396 a day, which annualizes to around a half a million dollars per person per year in direct county expenditures, investment in community-based care for people with complex conditions offers a more cost-effective option. Many community-based mental health supports cost closer to $500 a month than $1,385 per day. Flexible thinking about expenditures can yield excellent results.

Individuals living with mental illness have the same aspirations as the rest of the population including living in decent housing, meaningful work, friendships, and a high quality of life. Over the last two decades, the psychiatric rehabilitative community has made significant advancement in the development of service interventions that help people with SMI/COD pursue meaningful personal goals in recovery.

Growing evidence points to employment as an essential part of recovery for many. Being productive is a basic human need and can be both a way out of poverty and a means to prevent long-term dependence on the disability system. Competitive employment also has a positive impact on self-esteem, life satisfaction, and reducing symptoms.[15] Two-thirds of people with serious mental illness want to work but only 15% are employed; only 2% of people with SMI who could benefit from effective employment services have access to them. Individual Placement and Support (IPS) is a model of supported employment for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment.

Permanent Supportive Housing is another area in the literature that warrants mention. SAMHSA reports substantial literature demonstrating that components of permanent supportive housing are shown to decrease emergency room visits and hospitalization. The level of evidence indicates that permanent supportive housing is promising, but notes additional research is needed to clarify the model and determine the most effective elements for various subpopulations. Policy makers should consider including permanent supportive housing as an important service for individuals with mental and substance use disorders.

[14]Merrick, Weston, Kristina Shuey, and Pete Bernardy. Adult Mental Health Benefit-Cost Analysis. Minnesota Management and Budget, December, 2016. Accessed April 30, 2019. https://mn.gov/mmb-stat/results-first/adult-mental-health-report.pdf.

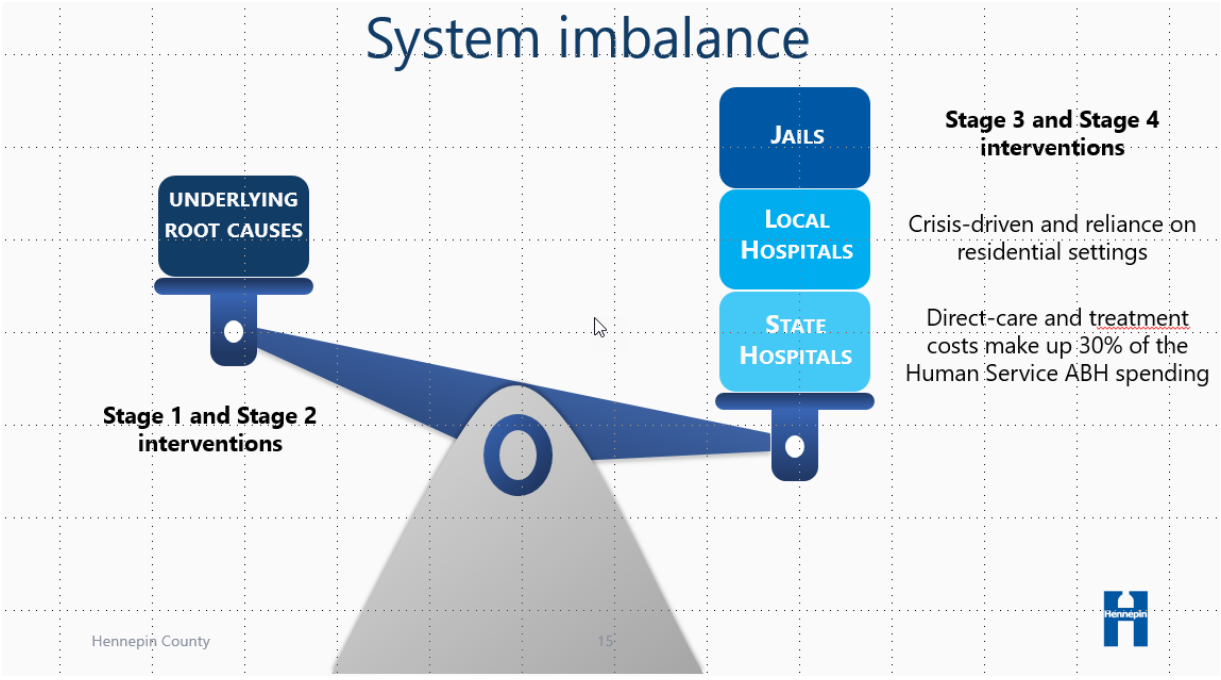
[15] Luciano, Bond, & Drake, 2014. Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research. Schizophrenia Research, 2014 Nov;159 (2-3):312-21.

Opportunities for improvement

The review of national literature and local data tells us that Hennepin County has many essential services in place to bring about health and sustain wellbeing for persons with SMI. Individual program outcomes are particularly strong and effective for county-operated services that serve people with complex needs. However, the review also points to clear opportunities to make improvements to the larger system as a whole. Hennepin County has already committed significant resources to reform its adult mental health system within the justice system. Innovations and learning from those reform efforts will have limited impact overall unless additional reforms are accomplished. The system still has three high-level and inter-related challenges:

1. System Imbalance

Hennepin County's continuum of care is weighted toward deep-end interventions that serve people at stages 3 & 4 of serious mental illness. We need to shift the balance "upstream" to the earlier stages of serious mental illness to address underlying root causes and deliver treatment and supports that can slow, halt or reverse progression of mental illness.



2. System Inequity

Disparities impact outcomes for residents with serious mental illness. Our review found a long list of systemic inequity that promotes deep end care and limits community stability among this population.

- People with mental illness die on average 25 years younger than people without mental illness.[16]
- People living with mental illness are 4 times more likely to be arrested for minor crimes.[17]
- People of color who become mentally ill tend to have more persistent disorders, are over-represented in deep-end services, and more often experience cross-sector involvement with justice and social service systems.[18]
- American Indian/Alaska Native people had the highest rates of suicide of any racial/ethnic group in the United States in 2017 and are the most likely to die from suicide as adolescents or young adults.[19]
- One in four African American residents in Hennepin reports frequent mental distress and two in five Hispanic residents experience Health Care insecurity.[20]

There are undoubtedly many more statistics pointing to a systemic lack of service equity and compounding implications of system involvement. These experiences can worsen symptoms, making health disparities even more pronounced.

Increasing access to culturally responsive treatment and improving social determinants of health (such as housing, employment and social connection) are both promising strategies to improve outcomes for American Indian and African American residents with serious mental illness. "Cross-sector" populations need targeted interventions to reduce episodes of both detention and hospitalization and maintain community living.

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[16] National Alliance on Mental Illness. "Mental Health by the Numbers." Accessed April 30, 2019. https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers.
[17] Valdiserri, E.V., Carroll, K.R., & Hartt, A.J. (1986). A study of offenses committed by psychotic inmates in a county jail. Hospital Community Psychiatry, 37: 163-166.
[18] Source: "Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/
[19] Suicide Prevention Resource Center, "Suicide Rate by Age for American Indians/Alaska Natives vs. U.S. Average." Accessed June 27, 2019. https://www.sprc.org/racial-ethnic-disparities
[20] Hennepin County Public Health. SHAPE 2018: Preliminary results for CHNAs. Hennepin County Public Health Department. April 25, 2019.

3. System is fragmented and difficult to access.

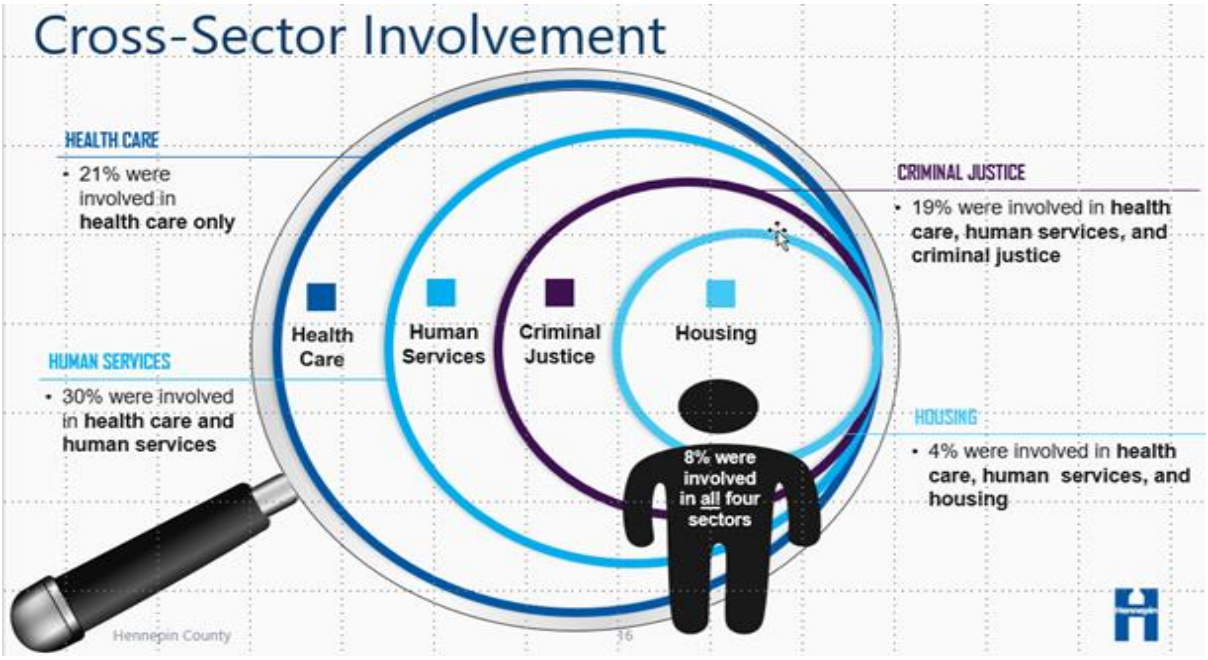
Hennepin County has a large and complex mental health system. Some barriers and bottlenecks are driven by legislative and insurance requirements; others are due to local policies. Policy work is needed to change what can be changed to eliminate bottlenecks and barriers.

To address remaining complexity in the system, wrap-around services can help residents with serious mental illness navigate systems more effectively and pull together the specific supports they need from various mental health, housing, employment, and social service sectors.

Care providers and case examples indicate that people also experience disruptions in care in the transition from child to adult services. Hennepin County children's and adult mental health services have historically operated as separate systems. Many young adults disengage from care when they turn 18 or have difficulty navigating systems. Even if they remain engaged, they often experience a drop in level of support and see a deeper progression of their mental illness during these years. Special services for transition-age year (age 16-24) can help avoid these risks. Consolidation of administrative responsibility for adult and children's mental health services may prove an effective strategy to improve coordination and lead to improved outcomes.

While this review focused on the mental health service delivery system, data demonstrating the significant overlap in mental illness and substance abuse disorders is clearly established both in literature and practice. Mental health and substance use disorder services operate in separate silos even though an estimated 50% of people with serious mental illness have co-occurring substance use disorder. The two issues are inseparably intertwined. These overlap is seen in cost of care. The county's Center for Innovation and Excellence recently conducted a study on the Medicaid expansion population. [21]

[21] Bodurtha, Peter et al. "Cross-Sector Service Use and Costs among Medicaid Expansion Enrollees in Minnesota's Hennepin County." Center for Health Care Strategies, Inc, October, 2017. Accessed April 30, 2019. https://www.chcs.org/media/Hennepin-Research-Brief_103017.pdf.



This study found that a very small population with mental illness and substance use disorder is consuming resources at significantly higher proportion than other individuals. While Individuals with SMI/COD accounted for 21% of the Medicaid expansion population in Hennepin County, this group was consuming 53% of public costs. This translated into a difference of $15,843 per person per year for enrollees with SMI/COD, compared to $2,252 per person per year for enrollees without any diagnosed SMI or SUD. Substance use disorder is also a major predictor of criminal justice involvement, even more so than serious mental illness. Providers working with people who have serious mental illness must be able to address substance use disorder to assist the person in overall recovery. Policy, funding, and licensing as well as our system infrastructure (e.g. separate divisions within state and local government) all need to evolve to accommodate the range of needs of this population. Flexible approaches that respond to each individual's unique set of circumstances should be evaluated against empirically sound fidelity models of care.

Recommendations and Next Steps

Hennepin County needs to work within the current realities of the system while also examining opportunities to serve residents with SMI/COD earlier in the progression of their mental illness and divert them from hospitalization, criminal justice systems, and residential care whenever possible. The following high level recommendations are based on analysis of the current system and informed by national best practice and input from multiple stakeholders including advocates, the local mental health advisory committee, state agencies and service providers.

It is clear that outpatient supports effectively reduce the number of patients in need of inpatient care. However, because these often are unevenly distributed and operate in silos rather than in collaboration, system inefficiencies occur that create barriers to recovery as individuals are left to themselves to navigate a complex array of interventions despite their significant mental health and other challenges.

Policymakers must recognize that justice, human service and health systems are interconnected and implement policies that close gaps between them. Practices should be flexible and allow fluid service delivery such as "warm hand-offs" and other necessary supports to help individuals access care between the systems in which they are engaged.

Hennepin County Human Services will develop a comprehensive strategic plan for behavioral health that uses a range of cross sector data; addresses root causes driving poor outcomes and costs, promotes evidence-based strategies, and informs policy. This plan will contain three interdependent approaches that delineate short- and long-term actionable items:

1: Invest in early detection and intervention

Create an integrated continuum of children's, transition-age and adult mental health services that focuses on early intervention when symptoms first appear, reduces barriers to access, and eliminates system bottlenecks.

2: Innovate for complex-need populations

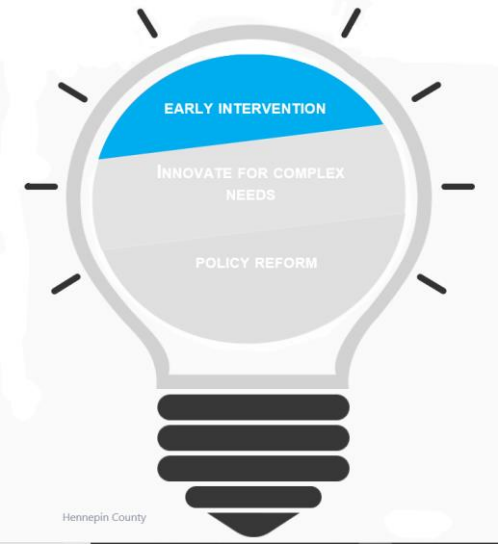
Invest in new approaches for individuals who traditional health and human service systems fail to support because of complexity of needs and cross sector involvement.

3: Promote strong policy for system reform

Advance strong policy to improve access to evidence-based interventions and address disparities that disproportionately impact persons with mental illness and substance use disorders.

Actionable Items

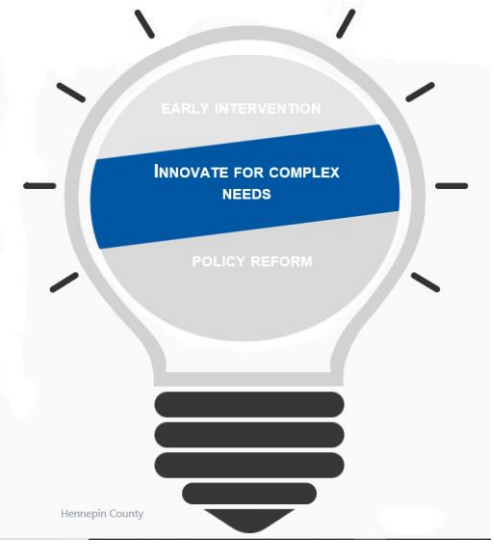
1: Invest in early detection and intervention



Goal	Activities	Why?
Create an integrated continuum of children's, transition-age and adult mental health services that focuses on early intervention when symptoms first appear, reduces barriers to access, and eliminates system bottlenecks.	Expand First Episode Psychosis Treatment Services.	First Episode Psychosis Treatment is an evidence-based practice proven Effective by SAMHSA. It catches SMI at Stage 1, with positive impacts on lifelong outcomes. Hennepin has this service, it is functioning well, and we should expand it.
	Develop transition-age youth diversion program.	SMI often manifests or worsens during the transition years, age 14-24 though the service systems operate in silos. Continuity of Care is needed to prevent inpatient care, including hospitalizations.
	Invest in Supported Employment and Housing.	Supportive Employment is an evidence-based practice that Hennepin county is already delivering with fidelity and can expand. Supportive Housing has a demonstrated track record of helping people with SMI/COD manage their symptoms and maintain community living.

Actionable Items

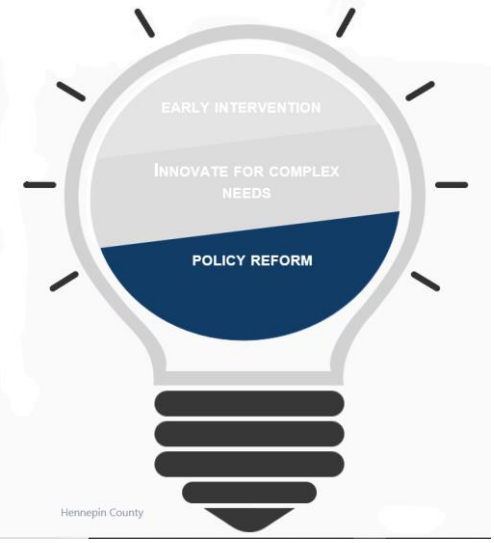
2: Innovate for complex-need populations



Goal	Activities	Why?
Invest in new approaches for individuals whom traditional health and human service systems fail to support because of complex needs, co-occurring conditions and cross sector involvement.	Continue investment in work of the Criminal Justice Behavioral Health Initiative such as the Behavioral Health Center (BHC) at 1800 Chicago.	The BHC is nationally recognized as an innovative model to divert people who have low-level offenses from detention facilities and emergency rooms into immediate services and ongoing community-based mental health, housing and social services. It helps rebalance the system to maintain or return people to earlier, less severe stages of mental illness and prevents use of more restrictive service settings.
	Add capacity that provides alternatives to avoid or shorten hospitalization in state facilities.	Crisis Residential Programs, IRTS facilities and ACT services provide less restrictive or step-down options to hospitalizations. They offer access to Medicaid reimbursement as they do not fall under the IMD exclusion and are good options when mental health and security needs can be met outside of hospitalization.
	Develop plan to handle Competency Restoration / Rule 20 needs.	The need for Competency Restoration and the 48-hour rule are key drivers for state hospital utilization. Key state holders across public safety and human services must work together to determine the best structure for Competency Restoration with appropriate levels of mental health services and public safety.

Actionable Items

3: Promote strong policy for system reform



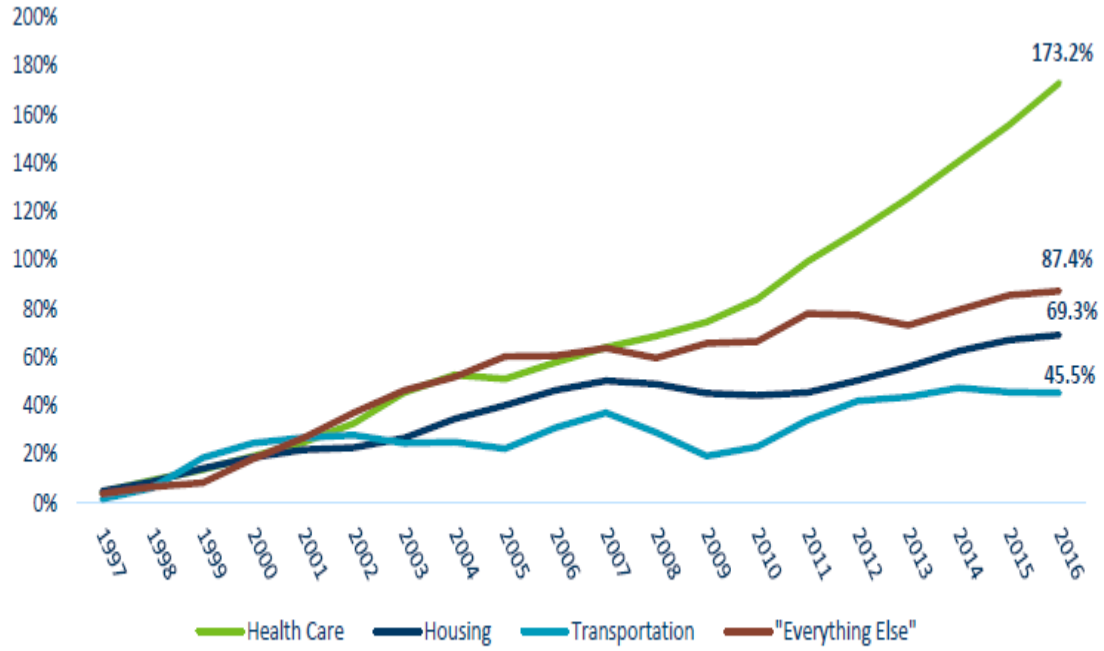
Goal	Activities	Why?
Advance strong policy to improve access to evidence-based interventions and address disparities that disproportionately impact persons with mental illness and substance use disorders.	Support culturally specific treatment through contracts and advocacy for improved medical reimbursement.	African American and American Indian communities have poor outcomes from the current system compared to white populations. Traditional and culturally specific healing and support practices are often desired by people with SMI/COD and may help close this gap. Certified Peer Specialists (people with lived experience of mental illness) have demonstrated strong return on investment and can also provide culturally responsive care.
	Integrate mental health and substance use disorder services in operated services and through contract requirements.	Even though somewhere between half and two-thirds of people with serious mental illness have co-occurring substance use disorder (SUD), these two systems operate in near-total silos. There are very few outpatient options to address SMI/COD. This is a very high-need population that needs a fully integrated response.
	Expand access to services through policy change.	Regulation around eligibility, licensing and reimbursement promotes inequitable access and distribution of services, and reinforces more restrictive, deep-end care.

Risks to Consider

All strategies involve risk and the adult mental health system is strongly shaped by shifting policies and trends. As we implement changes and improvements, we must be mindful of changing environments. Some of the key complicating factors include:

Rising Health Care Costs: Minnesota's health care spending is projected to grow 7.4 percent on average each year from 2017 to 2026. At this rate, both aggregate spending and spending growth will double from what occurred over the past decade ($47.1 billion; 3.6 percent growth on average), resulting in Minnesota health care spending reaching approximately $94.2 billion by 2026. Individual household expense is remaining consistent in every category except health care. Plans need to account for these rising costs to both the system and individual households.

Figure E1: Cumulative Growth in Household Spending, Select Categories (1997-2016)



Source: MDH, Health Economics Program analysis of the U.S. Bureau of Labor Statistics, Consumer Expenditure Surveys for the Midwest; survey years 1996-1997 through 2016-2017. More information at https://www.bls.gov/cex/tables.htm. Pre-tax annual income growth of the same period was 80.0 percent; "Everything Else" is the remaining percent of income not spent, and includes food, clothing, education, and entertainment.

Increasing complexity and diversity of residents: Demographic information tells us that by mid-to-late century, the Twin Cities metro will not have a racial majority. Hennepin County is expected to enlarge its lead in diversity over all other counties in Minnesota moving to 2045. We will see the largest population growth among Asian, Black, and Latino groups by 2030. When accounting for the need for culturally appropriate mental health services, our current system doesn't reflect current make up of our population. This is seen both at the provider level and the workforce level. Currently, Hennepin County has very few contracted providers who offer culturally recognized forms of treatment such as traditional healers in the Native American community. As state struggles with an overall shortage of mental health professionals, mental health practitioners and direct service workers, the current mental health care workforce does not reflect even current levels of diversity, let alone future projections. Changing this reality requires workforce development efforts at the state level.

Cost shifts at the state or federal level: As noted in the financial section of this report, the MN Department of Human Services has shifted and continues to shift costs to local government for the cost of care for services not billable to Medicaid. Additional shifts (for example, requiring counties to pay 100% of cost for all state hospital placements, or discontinuing state-operated Competency Restoration programs) could have dramatic impacts on Hennepin County's system of care and budget. Similarly, IMD demonstration waivers or legislative changes to the IMD exclusion at the federal level that allow Medicaid reimbursement at state hospitals would radically change cost allocations. Several policies that would have transformative financial impacts are in a time of flux, bringing a certain degree of chaos into planning efforts.

Build Wisely: Timely and appropriate supports are the first line of mental health care. These supports require services that address not only the specific mental health condition but also the underlying root causes that lead to psychiatric instability. When fully realized, these supports will reduce the demand for the inpatient beds which provide essential backup when psychiatric needs cannot be met in the community. Policy makers must resist the temptation to overbuild residential solutions at the expense of developing a robust array of community based options, yet build wisely when necessary. We must also build sustainable capacity that reimburses providers fairly and encourages growth where most needed.

Conclusion

Hennepin County offers a wide array of serves and supports for people living with SMI. These services reflect many best practice models and demonstrate positive results. While it is difficult to determine exactly how much capacity is needed to effectively keep people stable in the community, it is clear that county investment is heavily weighted toward institutional settings. The review of the system revealed opportunities to improve the mental health system. Our research suggests that investment in early interventions, innovative models of care for the most people living with the most complex needs and strong policies that drive larger system reform are guideposts for improving the system.

Hennepin County residents living with mental illness enter services through a variety of community doors. Law enforcement, county social services, education, and tribal entities are common entry points for people and as such offer important considerations for larger system reform. Each stakeholder brings with it a unique capacity to deliver interventions, leverage resources, and offer valuable insight into the complexity of intersection points for improved service delivery. No one agency can bring about an effective solution. Creating a vital continuum of adult mental health services requires collaboration and sophisticated orchestration of system reform: efforts that extend beyond only one agency or discipline. Through joint action, we can set policies that promote the best possible outcomes for our residents with serious mental illness and co-occurring disorders. Hennepin County Human Services will need the support of many other stakeholders at the local, state and tribal levels to bring about successful reform. A clear strategic plan that is supported by the County Board and County Administration will help ensure successful application of the recommendations detailed in this report.

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