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Boarding Mental Health Patients in Minnesota Emergency Departments--The Unintended Consequence of an Inadequate Mental Health System

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**BOARDING MENTAL HEALTH PATIENTS IN MINNESOTA
EMERGENCY DEPARTMENTS—THE UNINTENDED
CONSEQUENCE OF AN INADEQUATE MENTAL HEALTH
SYSTEM**

Jordan Engler[‡]

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I. INTRODUCTION

Mental illness has become increasingly prevalent throughout our society.¹ It is estimated that one in five adults already suffer from a mental

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¹ See Governor’s Task Force, *Reforming Mental Health in Minnesota*, MINN. DEP’T HUM. SERVS. (July 2016), https://mn.gov/dhs/assets/Overview-Mental-Health-Presentation-ppt_tcm1053-250266.pdf [<https://perma.cc/5VQ8-BF4L>] (“Approximately 1 in 5 adults will experience a diagnosable mental health condition within a given year. About 5.4% experience a serious mental illness (SMI). The underlying cause can be any mental illness, distinguished by a severity that impacts that person’s function in major life areas . . . About half of that population, or 2.6% of the general population, experience serious and persistent mental illness (SPMI). This is defined in Minnesota by a person’s frequent or long-term use of high intensity services, such as inpatient hospitalization or a crisis team.”).

health condition each year.² The situation has undoubtedly worsened with twice as many adults now reportedly struggling with their mental health due to the novel coronavirus pandemic.³ Mental health issues are soaring at an all-time high for adults and children alike.⁴ Unfortunately, Minnesota lacks the magnitude of mental health services necessary to appropriately care for all these patients in need, resulting in numerous heartbreaking stories across the state. People in mental health crises frequently go to local emergency departments, desperately seeking help, only to find themselves languishing in emergency rooms for days, even weeks, waiting for an inpatient psychiatric bed to open. This devastating practice is known as “boarding.”⁵

Boarding is a glaring problem, but it is really just the unintended consequence of a much larger issue.⁶ According to the Department of Health and Human Services (“HHS”), boarding “is a systems issue that manifests itself in the [emergency departments], which is a common pathway for the problem; but the real problem is about capacity in other parts of the system, adequate funding, and being able to move patients to the level of care they need.”⁷ Minnesota’s mental health system has a long history of inadequacy; though, this has not been without effort to change and improve upon the system over the last century and a half.⁸ Unfortunately, such effort has not been enough to successfully rectify the

² *Id.*

³ Mark É. Czeisler, Rashon I. Lane, Emiko Petrosky, Joshua F. Wiley, Aleta Christensen, Rashid Njai, Matthew D. Weaver, Rebecca Robbins, Elise R. Facer-Childs, Laura K. Barger, Charles A. Czeisler, Mark E. Howard & Shantha M.W. Rajaratnam, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020*, CTRES. DISEASE CONTROL & PREVENTION (Aug. 14, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm> [<https://perma.cc/E47A-8SND>] (finding 40.9% of adults reporting “considerably elevated adverse mental health conditions” related to the coronavirus pandemic).

⁴ *See generally* Maddy Reinert, Theresa Nguyen & Danielle Fritze, *The State of Mental Health in America 2022*, MENTAL HEALTH AM. (Oct. 2021), <https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf?eType=ActivityDefinitionInstance&eId=a7a571c8-7fac-4660-b06d-ff88af5c2bec> [<https://perma.cc/YT3Z-P6JN>]. “The estimated number of adults with serious suicidal thoughts is over 11.4 million—an increase of 664,000 people from last year’s data set.” *Id.* at 22. “The number of youths experiencing [at least one major depressive episode] increased by 306,000 . . . from last year’s dataset.” *Id.* at 25.

⁵ *Definition of Boarded Patient*, AM. COLL. EMERGENCY PHYSICIANS (Sept. 2018), <https://www.acep.org/globalassets/new-pdfs/policy-statements/definition-of-boarded-patient.pdf> [<https://perma.cc/E27A-EH55>] (defining “boarding” as “the practice of holding patients in the emergency department after they have been admitted to the hospital, because no inpatient or observation beds are available”).

⁶ *See infra* Part II.

⁷ DAVID BENDER, NALINI PANDE & MICHAEL LUDWIG, PSYCHIATRIC BOARDING INTERVIEW SUMMARY, U.S. DEP’T HEALTH & HUM. SERVS. 2 (2009), <https://aspe.hhs.gov/sites/default/files/private/pdf/75756/PsyBdInt.pdf> [<https://perma.cc/PZJ7-RTSS>].

⁸ *See infra* Part III.

state's futile mental health system. The system continues to fail Minnesotans every day. The state's mental health system must be reformed to maximize its impact and positively improve psychiatric care for a greater number of patients across the spectrum.⁹

This Article begins by describing the overall problem of boarding mental health patients in Minnesota emergency departments and the underlying problem of a statewide inpatient psychiatric bed shortage.¹⁰ Next, it proceeds by drawing attention to another contributing factor, which is delayed discharges from inpatient psychiatric units due to a shortage of "step-down" mental health programs.¹¹ Then, this Article addresses the impact of emergency room boarding on patients, providers, and health care systems as a whole.¹²

This Article continues by delving into the historical background of Minnesota's mental health system.¹³ First, it discusses the history of the state psychiatric hospitals and what led to their mass closing.¹⁴ Next, it describes the aftermath of the state hospitals closing, including the new age of Community Behavioral Health Hospitals,¹⁵ the unanticipated effect of the "48-Hour Rule" on hospitals,¹⁶ and the misplaced blame on the state's hospital-bed moratorium for the inadequacy of Minnesota's mental health system.¹⁷

Finally, this Article identifies a multifaceted solution to this exceedingly complex problem.¹⁸ It begins by addressing one state's apparent solution to the problem of boarding psychiatric patients in emergency departments.¹⁹ Although this apparent solution is noteworthy, there is a critical systems issue at the forefront that must be resolved first. Therefore, this Article concludes by addressing further solutions to reform Minnesota's mental health system at various levels of service,²⁰ incentivize psychiatric bed development,²¹ and expand the mental health workforce across the state.²²

⁹ See *infra* Part IV.

¹⁰ See *infra* Part II, Section A.

¹¹ See *infra* Part II, Section B.

¹² See *infra* Part II, Section C.

¹³ See *infra* Part III.

¹⁴ See *infra* Part III, Section A.

¹⁵ See *infra* Part III, Section B.

¹⁶ See *infra* Part III, Section C.

¹⁷ See *infra* Part III, Section D.

¹⁸ See *infra* Part IV.

¹⁹ See *infra* Part IV, Section A.

²⁰ See *infra* Part IV, Section B.

²¹ See *infra* Part IV, Section C.

²² See *infra* Part IV, Section D.

II. THE PROBLEM

A. *Boarding Mental Health Patients in Minnesota Emergency Departments*

Grace was only seventeen years old when she learned “how broken the mental health system is.”²³ She was an honor student with a 4.0 GPA, involved in extracurricular activities, with a loving family and a bright future.²⁴ No one would have guessed she struggled with mental illness since she was in first grade, including “anxiety, depression and intrusive thoughts.”²⁵ Eventually, Grace suffered a severe panic attack that led to “pretty significant self-harm.”²⁶ Grace was taken by ambulance to her local emergency department where she endured her first hospital stay of the month.²⁷ The hospital desperately “searched the entire state” for any open bed at an inpatient psychiatric unit that could properly care for Grace.²⁸ “All of the beds in the state were full,” and even when a bed did open, it was decided that Grace was “too acute” or “not acute enough” for the particular facility.²⁹ This futile attempt to find an available bed lasted four days before Grace ultimately returned home without appropriate treatment.³⁰ Unsurprisingly, Grace landed back in the hospital just a few weeks later, “waiting for help again.”³¹

Grace’s story is incredibly unsettling, but unfortunately, it is not a rarity. These disturbing occurrences have become commonplace in local emergency departments across the state of Minnesota. Sue Abderholden, Minnesota Executive Director of the National Alliance on Mental Illness (“NAMI”), reports hearing from “struggling families all the time.”³² One mother described her seventeen-year-old son, George, deteriorating in a hospital emergency room for ten days “to the point that he threatened to

²³ Jennifer Brooks, *Grace Note: A Teen Shares the Story of Her Long Wait for Help*, STAR TRIB. (Minneapolis) (Mar. 17, 2021, 8:01 PM), <https://www.startribune.com/grace-note-a-teen-shares-the-story-of-her-long-wait-for-help/600035581/> [https://perma.cc/84KG-Q4DD].

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.* (describing recent instances of “parents in southern Minnesota who had to drive their child to Fargo, [North Dakota], to find a bed” and “the mother . . . who found her adult daughter, delusional but newly released from the emergency room, standing alone in the snow”).

kill himself” while awaiting an open inpatient psychiatric bed.³³ George was suffering from “suicidal depression and anxiety” and was forced to spend ten days in a windowless room on a metal gurney before finally being admitted to the hospital’s inpatient psychiatric unit.³⁴ This is far from a therapeutic atmosphere, especially as George also witnessed the chaotic environment of an emergency department.³⁵ This included other patients screaming in neighboring rooms and even panicked patients being chased by security guards as they endured their own mental health crises.³⁶ These experiences certainly do not aid in recovery and may even traumatize adolescents, resulting in a failure to seek additional help in the future.³⁷

This detrimental problem has certainly been exacerbated by the coronavirus pandemic due to statewide hospital bed shortages and increased mental health crises among both adults and children.³⁸ However, boarding mental health patients in emergency departments is not a new issue. Over the years, the number of emergency department visits by mental health patients has significantly increased, whereas the total number of inpatient psychiatric beds throughout Minnesota has decreased.³⁹

Emergency department visits for mental health concerns increased by twenty-four percent from 1995 to 2005.⁴⁰ These mental health visits further increased by forty-four percent between 2006 and 2014.⁴¹ Conversely, the

³³ Chris Serres, *‘No Place for a Child’: Minnesotans Languish in ERs While Awaiting Mental Health Services*, STAR TRIB. (Minneapolis) (May 15, 2021, 6:01 PM), <https://www.startribune.com/no-place-for-a-child-minnesota-children-languish-in-hospital-ers-while-awaiting-mental-health-servic/600057742/> [https://perma.cc/5S2F-49AV].

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*

³⁸ See generally Sarah Fielding, *Emergency Rooms See Significant Rise in Mental Health Visits During Pandemic*, VERY WELL MIND (Feb. 11, 2021), <https://www.verywellmind.com/mental-health-er-visits-during-covid-5105124> [https://perma.cc/RV7S-CZK5]; Rui Pina, *The Truth About the Twin Cities’ Health Care Bed Shortage*, NAT’L NURSES UNITED (Sept. 2021), <https://www.nationalnursesunited.org/article/the-truth-about-twin-cities-health-care-bed-shortage> [https://perma.cc/H8EP-5KD8].

³⁹ Amy M. O’Neil, Christopher S. Russi, Annie T. Sadosty & Romma L. Campbell, *Behavioral Health Boarding in Community Emergency Departments*, MINN. MED. 37, 37 (2016), <https://www.mnmed.org/MMA/media/Minnesota-Medicine-Magazine/Clinical-ONEIL-160708.pdf> [https://perma.cc/M56J-GYV7].

⁴⁰ *Id.* (citing Jason M. Nolan, Christopher Fee, Bruce A. Cooper, Sally H. Rankin & Mary A. Blegen, *Psychiatric Boarding Incidence, Duration, and Associated Factors in United States Emergency Departments*, 41 J. EMERGENCY NURSING 57, 57 (July 14, 2014), [https://www.jenonline.org/article/S0099-1767\(14\)00205-0/fulltext](https://www.jenonline.org/article/S0099-1767(14)00205-0/fulltext) [https://perma.cc/J5LB-C2MJ]).

⁴¹ Jeremy R. Simon, Chadd K. Kraus, Jesse B. Basford, Elizabeth P. Clayborne, Nicholas Kluesner & Kelly Bookman, *The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact and Proposed Solutions*, AM. COLL. EMERGENCY PHYSICIANS

total number of inpatient psychiatric beds throughout Minnesota decreased by fifty-six percent from 2005 to 2010⁴² and further decreased by six percent between 2010 and 2016.⁴³ This significant decrease resulted in only 3.5 psychiatric inpatient beds per 100,000 people in Minnesota.⁴⁴ According to the Treatment Advocacy Center, a minimum of forty to sixty psychiatric inpatient beds per 100,000 people is recommended by health policy experts to adequately provide treatment for mental health patients.⁴⁵ Minnesota fails to meet this minimum standard at only seven percent of the “target beds per capita.”⁴⁶ Consequently, Minnesota is ranked fiftieth in the country for this exceptionally low number of inpatient psychiatric beds per population.⁴⁷

In 2008, HHS conducted a survey of hospitals across the United States in which “the majority indicated that the boarding of psychiatric patients is a problem in their hospital.”⁴⁸ Additionally, in 2008, the American College of Emergency Physicians (“ACEP”) conducted a survey of 328 emergency department physicians in which seventy-nine percent reported “routine psychiatric patient boarding.”⁴⁹ Thirty-five percent of the physicians indicated boarding more than one psychiatric patient per day in their

(Oct. 2019), <https://www.acep.org/globalassets/new-pdfs/information-and-resource-papers/the-impact-of-psychiatric-boarders-on-the-emergency-department.pdf> [https://perma.cc/UZD2-26SQ] (citing Brian J. Moore, Carol Stocks & Pamela L. Owens, *Trends in Emergency Department Visits, 2006-2014*, AGENCY HEALTHCARE RSCH. & QUALITY (Sept. 2017), <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf> [https://perma.cc/ANN2-LAG6]).

⁴² O’Neil et al., *supra* note 39 (citing E. Fuller Torrey, Doris A. Fuller, Jeffrey Geller, Carla Jacobs & Kristina Ragosta, *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals, 2005-2010*, TREATMENT ADVOC. CTR. 1 (July 19, 2012), https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf [https://perma.cc/UJX2-LLED]).

⁴³ See Doris A. Fuller, Elizabeth Sinclair, Jeffrey Geller, Cameron Quanbeck & John Snook, *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, TREATMENT ADVOC. CTR. 1, 8 (June 2016), <https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf> [https://perma.cc/PP8X-JVEA].

⁴⁴ *Id.* These 2016 data specifically refer to state-operated psychiatric hospital beds. *Id.* at 6-7. It does not include county, general, community, or private psychiatric beds. *Id.* However, these alternative mental health beds “continued to decline in tandem with state hospitals.” *Id.* at 7.

⁴⁵ *Id.* at 3.

⁴⁶ *Id.* at 8.

⁴⁷ *Id.* at 14. Minnesota is ranked fiftieth out of fifty-one, only ahead of Iowa, because the District of Columbia was ranked as its own “state” in the 2016 data set. *Id.*

⁴⁸ Simon et al., *supra* note 41 (citing BENDER ET AL., *supra* note 7, at 2).

⁴⁹ B.A. Nicks & D.M. Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments*, EMERGENCY MED. INT’L (July 22, 2012), <https://www.hindawi.com/journals/emi/2012/360308/> [https://perma.cc/67SV-QPAQ] (citing ACEP *Psychiatric and Substance Abuse Survey 2008*, AM. COLL. EMERGENCY PHYSICIANS 1, 1 (2008), <https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/federal-issues/psychiatricboardingsummary.pdf> [https://perma.cc/6U79-8PEW] [hereinafter *ACEP Survey 2008*]).

emergency department.⁵⁰ Additionally, over ninety percent of the physicians reported boarding mental health patients “every week,” while fifty-five percent reported boarding psychiatric patients “daily or multiple times per week.”⁵¹ Further data from 2008 showed that while eleven percent of all emergency department patients were boarded, the rate was nearly double for psychiatric emergency department patients.⁵² Psychiatric patients were found to be 4.78 times more likely to board in emergency departments than non-psychiatric patients.⁵³

Psychiatric patients not only board more frequently in emergency departments, but they also tend to remain boarding in emergency departments longer than their non-psychiatric counterparts.⁵⁴ A 2008 national survey indicated that psychiatric patients boarded an average of 2.78 hours longer than non-psychiatric patients.⁵⁵ Furthermore, the 2008 ACEP survey found that more than sixty percent of psychiatric patients boarded in emergency departments for greater than four hours, thirty-three percent boarded for greater than eight hours, and six percent for greater than twenty-four hours.⁵⁶ In 2012, a study showed psychiatric patients boarded 3.2 times longer than non-psychiatric patients.⁵⁷ Additionally, in 2012, the National Association of State Mental Health Program Directors conducted a “survey of more than 6,000 emergency departments nationwide” in which seventy percent reported boarding mental health patients for “hours or days.”⁵⁸ Meanwhile, ten percent of those same emergency departments reported boarding “individuals in psychiatric crisis for several *weeks*.”⁵⁹

More recently, in 2016, the ACEP conducted another survey of emergency department physicians in which forty-eight percent reported psychiatric patients boarding in their emergency department on a daily

⁵⁰ Nicks & Manthey, *supra* note 49 (citing *ACEP Survey 2008*, *supra* note 49, at 1).

⁵¹ *ACEP Survey 2008*, *supra* note 49, at 1.

⁵² Nolan et al., *supra* note 40 (finding 21.5% of all psychiatric emergency department patients were boarded).

⁵³ *Id.*

⁵⁴ Simon et al., *supra* note 41.

⁵⁵ Nolan et al., *supra* note 40. This survey classified boarding as all emergency department stays of greater than six hours. *Id.* at 61. The baseline boarding time for all boarded patients was determined to be an additional 3.3 hours, with psychiatric patients boarding an average of 2.78 hours longer than their non-psychiatric counterparts. *Id.* at 62.

⁵⁶ *ACEP Survey 2008*, *supra* note 49, at 1.

⁵⁷ Nicks & Manthey, *supra* note 49.

⁵⁸ Torrey et al., *supra* note 42, at 11 (citing Robert W. Glover, Joel E. Miller & Stephanie R. Sadowski, *Proceedings on the State Budget Crisis and the Behavioral Health Treatment Gap: The Impact on Public Substance Abuse and Mental Health Treatment Systems*, NAT'L ASS'N STATE MENTAL HEALTH PROGRAM DIRS. (Mar. 22, 2012), https://www.kff.org/wp-content/uploads/sites/2/2012/12/summary-congressional-briefing_march_22_website.pdf [<https://perma.cc/YKH4-WCCK>]).

⁵⁹ Torrey et al., *supra* note 42, at 11 (citing Glover et al., *supra* note 58).

basis.⁶⁰ Furthermore, twenty-one percent of the emergency department physicians reported mental health patients waiting between two and five days for an inpatient psychiatric bed.⁶¹ According to Rebecca Parker, the president of the ACEP, “[p]sychiatric patients wait in the emergency department for hours and even days for a bed, which delays the psychiatric care they so desperately need.”⁶² Parker further emphasized that boarding “also leads to delays in care and diminished resources for other emergency patients. The emergency department has become the dumping ground for these vulnerable patients who have been abandoned by every other part of the health care system.”⁶³

B. Delayed Discharges from Inpatient Psychiatric Units

An additional contributing factor to this glaring problem of boarding mental health patients in emergency departments and the overall deficit of inpatient psychiatric beds is the lack of appropriate “step-down” services. “Step-down” mental health services could accept patients who are ready to leave hospital-level care, but not yet ready to return home.⁶⁴ The absence of such essential treatment programs creates a vicious cycle because it delays patient discharges from inpatient psychiatric units. In turn, these delays result in fewer inpatient beds available for new patients in mental health crises, thus, further contributing to the problem of bed shortages and boarding in emergency departments. “Each person who is ‘stuck’ in the wrong level of care creates a further cascade of individuals who cannot transition to the next stage of their treatment and recovery.”⁶⁵

A man in his early twenties, diagnosed with schizoaffective disorder, was “stuck in inpatient care for seven months because there [were] no vacancies in long-term state facilities.”⁶⁶ The young man went to his local hospital following a suicide attempt and “exhausted most short-term treatment options at the hospital.”⁶⁷ He sat “at the top of the waiting list” for two months hoping to transfer to Anoka-Metro Regional Treatment Center

⁶⁰ Mary Caffrey, *Emergency Physicians See More Mental Health Patients Waiting for Beds*, AM. J. MANAGED CARE (Oct. 18, 2016), <https://www.ajmc.com/view/emergency-physicians-see-more-mental-health-patients-waiting-for-beds> [<https://perma.cc/G3TU-HS5E>].

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Jeremy Olson, *Shortage of State Psychiatric Beds Leaves Local Hospitals Jammed*, STAR TRIB. (Minneapolis) (Nov. 2, 2015, 12:16 AM), <https://www.startribune.com/shortage-of-state-psychiatric-beds-jams-twin-cities-hospitals/339185701/> [<https://perma.cc/8NCK-4SW4>]. “People [hospitalized with severe mental illnesses] have no place to go, but they can’t just be put on the street,” said Roberta Opheim, Minnesota’s state mental health ombudsman. *Id.*

⁶⁵ Governor’s Task Force, *supra* note 1.

⁶⁶ *Id.*

⁶⁷ *Id.*

(“AMRTC”).⁶⁸ Other Minnesota hospitals have reported similar instances where mental health patients “have exhausted short-term treatment services and linger nonetheless.”⁶⁹ One Minnesota hospital reportedly “held a patient for nearly 300 days.”⁷⁰ Health care staff at these hospitals are frustrated by the suboptimal treatment being provided for these patients who are unable to receive timely transfers to more appropriate facilities such as AMRTC.⁷¹

Here, the problem continues because there “is an absence of ‘step-down’ community programs that could accept patients ready to leave [AMRTC].”⁷² AMRTC reported fifty-two patients at one time who were “ready for release” when beds became available in local treatment programs within their home counties.⁷³ In an attempt to expedite this process, “the state . . . made counties fully responsible for the cost of care at [AMRTC] when it becomes medically unnecessary to keep them there.”⁷⁴

In 2016, the Wilder Foundation in St. Paul, Minnesota, conducted a

⁶⁸ *Id.* “The [AMRTC] is the state’s largest psychiatric hospital. Overseen by the Minnesota [DHS], the hospital operates 110 beds on a secure campus in Anoka, Minnesota. AMRTC provides inpatient psychiatric care to adults who require treatment in a hospital setting.” *Anoka-Metro Regional Treatment Center*, MINN. DEP’T HUM. SERVS. (June 30, 2020), <https://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/programs-services/anoka-metro-regional-treatment-center/> [https://perma.cc/XV43-PJNY]. “Patients have highly complex medical conditions and can exhibit volatile behaviors. Many are facing criminal proceedings. Lacking the necessary clinical expertise, secure facilities and support staff, community hospitals cannot or will not treat these patients. AMRTC is a secure facility, which means the building and treatment units are locked.” *Id.*

⁶⁹ Olson, *supra* note 64.

⁷⁰ *Id.*

⁷¹ *Id.* (“The extremely acute patients may be held in restraints or in seclusion on and off for days, getting injected with high doses of antipsychotic medication to quell immediate mental health symptoms, while staff scramble to meet their basic needs As a nurse in this department, I am troubled when I have to tell patient families that their loved one might not get optimal treatment for several days.”)

⁷² *Id.*

⁷³ *Id.* “Minnesota’s publicly provided mental health system, as reflected in the Minnesota Comprehensive Mental Health Acts, is supervised by DHS and administered by counties. Counties act as the local mental health authority.” *Mental Health Services: Overview*, MINN. DEP’T HUM. SERVS. (Mar. 3, 2021), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058037 [https://perma.cc/487N-SF7R]. The Minnesota Comprehensive Mental Health Acts states “[t]he 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.” MINN. STAT. § 245.466, subdiv. 1 (2017).

⁷⁴ Olson, *supra* note 64. “A county’s payment of the cost of care provided at [AMRTC] shall be . . . 100 percent for each day during the stay . . . when the facility determines that it is clinically appropriate for the client to be discharged.” MINN. STAT. § 246.54, subdiv. 1a (2021).

statewide analysis of delayed discharges from inpatient psychiatric units.⁷⁵ Twenty Minnesota hospitals participated, finding nineteen percent of patient bed days potentially avoidable because the patient was “stabilized and ready to be discharged.”⁷⁶ This amounts to approximately 48,000 potentially avoidable days per year among these twenty hospitals.⁷⁷ A “lack of bed space at a state psychiatric hospital” accounted for twenty-two percent of the potentially avoidable days, making it the most commonly cited reason for delay.⁷⁸ The Wilder study highlighted important implications, including that mental health patients continuing to occupy inpatient psychiatric beds, despite being eligible for discharge, result in fewer beds available for new patients in need of hospital-level care.⁷⁹ Consequently, “while the patients described in this study may not be accessing most appropriate level of care when they are eligible to be discharged, they are also likely preventing other patients from accessing appropriate care within inpatient psychiatric units.”⁸⁰

C. The Impact of Boarding on Patients, Providers, and Systems of Care

Boarding mental health patients in emergency departments can have a negative impact on patients, providers, and the health care system as a whole.⁸¹ Patients “awaiting inpatient psychiatric care are unlikely to be receiving optimal treatment for their mental health conditions while in the [emergency department].”⁸² Emergency departments simply “do not have the physical and staffing resources and specialty expertise to provide definitive psychiatric care.”⁸³ Furthermore, even if patients are able to receive some psychiatric care while boarding in the emergency department, these mental health patients “frequently decompensate” because the chaotic environment “worsens their underlying disease process.”⁸⁴ Emergency departments rarely provide pleasant experiences for patients, and long-term exposure to such a tumultuous atmosphere is hardly conducive to positive health outcomes for anyone, but especially those suffering from mental health crises.

⁷⁵ KRISTIN DILLON & DARCI THOMSEN, REASONS FOR DELAYS IN HOSPITAL DISCHARGES OF BEHAVIORAL HEALTH PATIENTS: RESULTS FROM THE MINNESOTA HOSPITAL ASSOCIATION MENTAL AND BEHAVIORAL HEALTH DATA COLLECTION PILOT, WILDER RSCH. 1 (2016), https://www.wilder.org/sites/default/files/imports/MHA_Report_7-16.pdf [<https://perma.cc/E7MY-HHRR>].

⁷⁶ *Id.* at 3.

⁷⁷ *Id.*

⁷⁸ *Id.* (including bed space at AMRTC (seven percent), Community Behavioral Health Hospitals (fourteen percent), or St. Peter Regional Treatment Center (one percent)).

⁷⁹ *Id.* at 8.

⁸⁰ *Id.*

⁸¹ Simon et al., *supra* note 41.

⁸² *Id.* (citing Vidhya Alakeson, Nalini Pande & Michael Ludwig, *A Plan to Reduce Emergency Room ‘Boarding’ of Psychiatric Patients*, 29 HEALTH AFFS. 1637, 1637 (Sept. 2010)).

⁸³ *Id.*

⁸⁴ *Id.* (citing BENDER ET AL., *supra* note 7).

Mental health patients who “spend prolonged time” in the emergency department are also at a “greater risk for requiring chemical and physical restraints.”⁸⁵ Additionally, a 2014 observational study found that psychiatric patients boarding in emergency departments are at a greater risk for medication errors.⁸⁶ This study showed that sixty-five percent of boarded psychiatric patients suffered “one or more medication errors that required intervention.”⁸⁷ Each of these factors, including prolonged stays, use of restraints, and medication errors, contributes to “measurable negative outcomes” for mental health patients boarding in emergency departments.⁸⁸ According to the ACEP, such prolonged stays are “inefficient at best and harmful at worst.”⁸⁹

Emergency department providers, including physicians and other health care staff, face multiple challenges when boarding mental health patients.⁹⁰ One significant challenge is “increasing violence against emergency department staff.”⁹¹ In general, health care providers have a greater risk of workplace violence, “including both physical and verbal attacks,” compared to other professions.⁹² However, emergency departments and psychiatric facilities have an even greater risk, and they are among the “highest risk environments for workplace violence.”⁹³

In 2018, the ACEP conducted a polling survey of 3,539 emergency physicians regarding emergency department violence.⁹⁴ The survey found forty-seven percent of emergency physicians have personally been physically assaulted, while seventy-one percent have witnessed an assault while working in the emergency department.⁹⁵ Among those who have been physically assaulted, twenty-seven percent have been injured as a result.⁹⁶ Furthermore,

⁸⁵ *Id.* (citing Chun-Chi Hsu & Hung-Yu Chan, *Factors Associated with Prolonged Length of Stay in the Psychiatric Emergency Service*, PLOS ONE (Aug. 20, 2018)).

⁸⁶ *Id.* (citing Hussain T. Bakhsh, Stephen J. Perona, Whitney A. Shields, Sara Salek, Arthur B. Sanders & Asad E. Patanwala, *Medication Errors in Psychiatric Patients Boarded in the Emergency Department*, 26 INT’L J. RISK & SAFETY MED. 191, 191 (2014)).

⁸⁷ Bakhsh et al., *supra* note 86, at 191.

⁸⁸ Simon et al., *supra* note 41.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.* (citing James P. Phillips, *Workplace Violence Against Health Care Workers in the United States*, 374 NEW ENG. J. MED. 1661 (2016)).

⁹³ *Id.* (citing OCCUPATIONAL SAFETY & HEALTH ADMIN., 3148-06R, GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTHCARE AND SOC. SERV. WORKERS (2016), <https://www.osha.gov/sites/default/files/publications/osha3148.pdf> [<https://perma.cc/B9FV:JK53>]).

⁹⁴ ACEP EMERGENCY DEPARTMENT VIOLENCE POLL RESEARCH RESULTS, AM. COLL. EMERGENCY PHYSICIANS 2 (2018), <https://www.emergencyphysicians.org/globalassets/files/pdfs/2018acep-emergency-department-violence-pollresults-2.pdf> [<https://perma.cc/RS3F-UC3W>].

⁹⁵ *Id.* at 6.

⁹⁶ *Id.* at 11.

seventy-seven percent of “emergency physicians believe that violence in the emergency department has harmed patient care.”⁹⁷ Additionally, this polling survey found forty-one percent of emergency physicians believed more than half of the assaults committed in emergency departments were by mental health patients,⁹⁸ while thirty-two percent of emergency physicians believed psychiatric patients are a “main contributing factor to violence in the emergency department.”⁹⁹ Therefore, as mental health visits to emergency departments continue to rise, “the risk of violence is also likely to grow.”¹⁰⁰

Another significant challenge for emergency department providers is the additional stress created by boarding mental health patients.¹⁰¹ Boarding patients, in general, increases the stress level for providers,¹⁰² but, as highlighted above, these mental health patients also “provide a less safe environment for [providers] to work in.”¹⁰³ Each of these challenges “add[s] stress to the already stressful job of caring for [emergency department] patients.”¹⁰⁴ Providers “are aware of the needs of these patients, but unable to adequately provide for those needs with available resources. This moral distress can lead to a multitude of adverse outcomes for [providers].”¹⁰⁵ This heightened stress and moral conflict can lead to long-term problems for emergency department providers, including increased levels of frustration, compassion fatigue, and burnout.¹⁰⁶

Burnout is a considerable problem among health care providers, even so far as being described as an “epidemic” by the American Medical Association.¹⁰⁷ Provider burnout is “defined as a long-term stress reaction

⁹⁷ *Id.* at 18. Emergency physicians reported “patients have been adversely affected by emergency department violence” due to loss of productivity (eighty-three percent), emotional trauma (eighty-one percent), increased wait times (eighty percent), less focused staff (seventy-six percent), physical harm to the patient (fifty-one percent), and patients leaving without being seen or treated (forty-seven percent). *Id.* at 19.

⁹⁸ *Id.* at 16.

⁹⁹ *Id.* at 25.

¹⁰⁰ Simon et al., *supra* note 41 (citing *Violence in Emergency Departments Is Increasing, Harming Patients, New Research Finds*, AM. COLL. EMERGENCY PHYSICIANS (Oct. 2, 2018), <https://www.emergencyphysicians.org/press-releases/2018/10-2-2018-violence-in-emergency-departments-is-increasing-harming-patients-new-research-finds> [<https://perma.cc/HMW3-4948>]).

¹⁰¹ Simon et al., *supra* note 41.

¹⁰² *Id.* (citing Claire Morley, Maria Unwin, Gregory M. Peterson, Jim Stankovich & Leigh Kinsman, *Emergency Department Crowding: A Systematic Review of Causes, Consequences and Solutions*, PLOS ONE (Aug. 30, 2018)).

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* (citing Robin Fernandez-Parsons, Lori Rodriguez & Deepika Goyal, *Moral Distress in Emergency Nurses*, 39 J. EMERGENCY NURSING 547 (2013)).

¹⁰⁶ *Id.*

¹⁰⁷ *What Should Be Done About the Physician Burnout Epidemic*, AMA, <https://www.ama-assn.org/practice-management/physician-health/what-should-be-done-about-physician-burnout-epidemic> [<https://perma.cc/2T3Y-YWUJ>].

characterized by depersonalization.”¹⁰⁸ Burnout has negative effects on the providers themselves, their patients, and the organizations for which they work.¹⁰⁹ Providers experiencing burnout often develop “[c]ynical or negative attitudes toward patients, [e]motional exhaustion, [a] feeling of decreased personal achievement, [and l]ack of empathy for patients.”¹¹⁰ Of course, each of these has a negative impact on the providers’ own mental health and well-being.¹¹¹ However, these can also further contribute to decreased quality of care for their patients as well.¹¹² Furthermore, provider burnout also has a significant impact on the health care organizations for which they work because burnout decreases overall productivity, morale, and retention rates among providers.¹¹³ Each of these factors plays a significant role in the quality and cost of care provided within health care organizations.¹¹⁴

The considerable burden of boarding mental health patients in emergency departments can also have a negative impact on the health care system as a whole.¹¹⁵ First, because psychiatric patients remain in emergency departments longer than non-psychiatric patients, they decrease the overall bed availability for other patients requiring emergency care. One study found that these prolonged stays prevent 2.2 “bed turnovers,” meaning a loss of 2.2 additional patients seen in the emergency department per boarded mental health patient.¹¹⁶ As such, this prevention of bed turnover decreases financial revenue for the hospital.¹¹⁷ “Factoring the loss of bed turnover for waiting patients and opportunity cost due to loss of those patients, psychiatric patient boarding cost the department \$2,264 per patient.”¹¹⁸ Given the rates of reported mental health boarding in emergency departments, “the financial impact of this problem is massive with individual hospital systems and government payers bearing the brunt of the financial burden.”¹¹⁹

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Simon et al., *supra* note 41.

¹¹⁶ Nicks & Manthey, *supra* note 49.

¹¹⁷ *Id.*

¹¹⁸ *Id.* (“The hourly payment for an [emergency department] bed was calculated to be \$99.50. When applied to the total [length of stay] for the psychiatric patients less the facility average payment per admitted patient, the facility payment loss for each admitted or transferred psychiatric patient was \$1,198. This was then applied to the potential missed patients being seen assuming patients are awaiting an unavailable bed in the [emergency department] due to psychiatric patient boarding. Factoring the financial factors associated with the loss of bed turnover for waiting patients, psychiatric patient boarding awaiting inpatient placement cost the department \$2,264 per patient.”).

¹¹⁹ Simon et al., *supra* note 41 (citing BENDER ET AL., *supra* note 7).

Due to the negative impact on providers, as described previously, boarding psychiatric patients “has also been linked to increased staff turnover.”¹²⁰ This results in an additional financial burden on health care systems because the cost of staff turnover is generally higher than the cost of retention.¹²¹ Furthermore, boarding mental health patients in emergency departments uses a substantial amount of emergency department space, staff, time, and resources.¹²² Eighty-five percent of emergency department directors believe that wait times would be lower in emergency departments if “better inpatient psychiatric services were available.”¹²³ Boarded mental health patients “not only receive suboptimal care themselves, but also prevent other patients . . . from accessing the limited resources” of emergency departments.¹²⁴

In 2016, a study found the “amount and type of resources available” for treatment of mental health patients boarding within Minnesota emergency departments “varied across the system,” but they were frequently inadequate.¹²⁵ It further showed that both the mental health patients themselves and the health care staff caring for them are at an increased risk of being harmed during the course of their stay due to this overall lack of resources.¹²⁶ The study identified that half of the emergency departments “did not have rooms ideally equipped to ensure safety.”¹²⁷ Furthermore, seventy-three percent of the emergency departments also did not have twenty-four-hour security available.¹²⁸ This study addressed another level of concern that some community hospitals lacked adequate “staff to provide ongoing monitoring and care” of those mental health patients boarding in their emergency departments.¹²⁹ Inadequate staffing puts these patients at “risk for poor outcomes” because they may not receive the medications they need or may not be properly reassessed.¹³⁰

A final concern this study reported was the “distance to inpatient psychiatric care” because many times when a bed was finally identified, “the

¹²⁰ *Id.*

¹²¹ See, e.g., Cheryl Bland Jones & Michael Gates, *The Costs and Benefits of Nurse Turnover: A Business Case for Nurse Retention*, 12 ONLINE J. ISSUES NURSING (Sept. 30, 2007), <https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No3Sept07/NurseRetention.html> [https://perma.cc/QKZ8-VMFM] (finding nurse turnover costs ranging from about \$22,000 to over \$64,000 per nurse turnover).

¹²² Simon et al., *supra* note 41 (citing BENDER ET AL., *supra* note 7).

¹²³ *Id.* (citing *ACEP Survey 2008*, *supra* note 49).

¹²⁴ *Id.*

¹²⁵ O’Neil et al., *supra* note 39, at 39.

¹²⁶ *Id.*

¹²⁷ *Id.* (including “limited medical equipment, tempered glass and video monitoring”).

¹²⁸ *Id.* (“In those facilities without 24-hour security, staff in other areas of the hospital, including maintenance staff, were sometimes asked to provide security if a patient was violent. Alternatively, law enforcement personnel were sometimes called on to provide security.”).

¹²⁹ *Id.*

¹³⁰ *Id.*

patient often had to be transferred a great distance.”¹³¹ This certainly causes logistical concerns across the system in providing such transportation, however, it can also lead to worse patient outcomes. Keeping care close to home is always a goal for patients because it is human nature to thrive better with local support systems intact.

Each of these factors negatively impacts patients, providers, and the health care system as a whole. Unfortunately, boarding mental health patients in emergency departments is nothing more than an unintended consequence of an inadequate mental health system. According to Abderholden, “[t]he mental health care system in this country isn’t broken . . . ‘it was never built.’”¹³² Thus, in order to address the problem of boarding mental health patients in Minnesota emergency departments, we must first address the underlying issue: the inadequacy of the state’s mental health system.

III. HISTORICAL BACKGROUND

A. *Closing the State Hospitals in Minnesota*

Minnesota’s mental health system has a long history, dating back over a century and a half ago with the opening of its very first state psychiatric hospital.¹³³ In 1866, Minnesota established its first institution for the treatment of the mentally ill, the St. Peter Asylum for the Insane.¹³⁴ Minnesota opened a total of eleven state psychiatric facilities over the next century.¹³⁵ Most notably, the Anoka Asylum for the Insane opened in

¹³¹ *Id.* at 40.

¹³² Brooks, *supra* note 23.

¹³³ MINN. DEP’T OF HUM. SERVS., DHS-5228-ENG, THE EVOLUTION OF STATE OPERATED SERVICES 1 (2008), <https://www.lrl.mn.gov/docs/2008/other/080246.pdf> [<https://perma.cc/B7VR-M62V>] [hereinafter THE EVOLUTION OF STATE OPERATED SERVICES].

¹³⁴ *Id.* On March 2, 1866, the Minnesota legislature passed “An Act for the establishment and location of a Hospital for the Insane in the State of Minnesota.” Act of Mar. 2, 1866, ch. 6, 1866 Minn. Laws 10,

<https://www.revisor.mn.gov/laws/1866/0/General+Laws/Chapter/6/pdf/>

[<https://perma.cc/62LV-8EJ7>]. In July of 1866, the St. Peter site was selected as the designated location for Minnesota’s first Insane Asylum, and the hospital officially began accepting patients in December of 1866. THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133.

¹³⁵ THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 4–19. In 1879, the State Inebriate Asylum opened in Rochester, and an Experimental School for Imbeciles opened in Faribault. *Id.* at 4–5. In 1890, Fergus Falls opened the state’s third Asylum for the Insane. *Id.* at 7. In 1900, the Anoka Asylum for the Insane and Hastings Asylum for the Insane opened. *Id.* at 9–11. In 1912, the Willmar Hospital Farm for Inebriates was established, changing its name to Willmar State Asylum in 1919. *Id.* at 13. In 1925, the Minnesota Colony for Epileptics opened in Cambridge. *Id.* at 15. In 1937, the Anoka,

1900.¹³⁶ Additionally, an institution for the “dangerously and criminally insane” was established in 1910 to operate in conjunction with the St. Peter Asylum for the Insane.¹³⁷ In 1957, the St. Peter Asylum for the Dangerously Insane changed its name to the Minnesota Security Hospital.¹³⁸ By 1967, the ten remaining Minnesota psychiatric facilities had all changed their respective names to State Hospitals.¹³⁹

In 1972, it was the beginning of the end for the Minnesota State Hospitals when a class action suit was filed against Brainerd, Cambridge, Faribault, Fergus Falls, Hastings, and Moose Lake State Hospitals.¹⁴⁰ This lawsuit was brought by the parents of six “mentally retarded residents” of the respective Minnesota State Hospitals.¹⁴¹ By stipulation, the parties confined the case to the “purported subclass of residents at the Cambridge State Hospital” with the understanding that the determination of certain issues would help “facilitate consideration of the issues at the five other challenged institutions.”¹⁴²

The plaintiffs asserted that the treatment, care, conditions, education, and training for the residents of the State Hospitals necessarily violate the due process clause of the Fourteenth Amendment of the Constitution by

Hastings, Willmar, Fergus Falls, Rochester, and St. Peter Asylums changed their respective names to State Hospitals. Act of Mar. 25, 1937, ch. 107, 1937 Minn. Laws 171, <https://www.revisor.mn.gov/laws/1937/0/Session+Law/Chapter/107/pdf/> [<https://perma.cc/SMH6-KRVY>]. In 1938, Moose Lake State Hospital opened. THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 16. In 1949, Faribault was designated as the Minnesota School and Colony, while the Colony for Epileptics in Cambridge changed its name to Cambridge State School and Hospital. Act of Mar. 18, 1949, ch. 142, 1949 Minn. Laws 223, <https://www.revisor.mn.gov/laws/1949/0/Session+Law/Chapter/142/pdf/> [<https://perma.cc/G9DY-5JD6>]. In 1950, the Sandstone State Hospital opened, closing only nine years later in 1959. THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 17. In 1958, Brainerd State School and Hospital opened. *Id.* at 19. In 1967, the Faribault, Cambridge, and Brainerd facilities changed their respective names to State Hospitals. Act of Feb. 15, 1967, ch. 6, 1967 Minn. Laws 43, <https://www.revisor.mn.gov/laws/1967/0/Session+Law/Chapter/6/pdf/> [<https://perma.cc/MZS3-UV69>].

¹³⁶ THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 9.

¹³⁷ *Id.* at 14.

¹³⁸ *Id.*; Act of Mar. 25, 1957, ch. 196, 1957 Minn. Laws 240, <https://www.revisor.mn.gov/laws/1957/0/Session+Law/Chapter/196/pdf/> [<https://perma.cc/4M7H-UN7P>].

¹³⁹ See THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133.

¹⁴⁰ *Welsch v. Likins*, 373 F. Supp. 487, 489 (D. Minn. 1974), *aff'd*, 525 F.2d 987 (8th Cir. 1975).

¹⁴¹ *Id.* (“They seek to represent a class composed of themselves and all other mentally retarded persons currently and hereafter involuntarily committed to the Minnesota State Hospitals.”).

¹⁴² *Id.* at 490.

failing to provide an adequate program of “habilitation.”¹⁴³ District Judge Larson eloquently stated:

The evidence in the instant case is overwhelming and convincing that a program of “habilitation” can work to improve the lives of Cambridge’s residents. Testimony of experts and documentary evidence indicate that everyone, no matter the degree or severity of retardation, is capable of growth and development if given adequate and suitable treatment.¹⁴⁴

The court held the Due Process Clause requires that civil commitment by reason of mental retardation must be accompanied by minimally adequate care and treatment designed to provide “a realistic opportunity to be cured or to improve his or her mental condition.”¹⁴⁵ The court determined there was also a statutory right to treatment, existing separately from the constitutional rights asserted, requiring all “mentally deficient” individuals who are involuntarily committed to “receive adequate care and treatment.”¹⁴⁶ Furthermore, the Due Process Clause requires “good faith attempts” to place civilly committed persons in “settings that will be suitable and appropriate to their mental and physical conditions while least restrictive of their liberties.”¹⁴⁷

Additionally, the court addressed constitutionality under the cruel and unusual punishment clause of the Eighth Amendment of the Constitution¹⁴⁸ as it pertained to specific practices and conditions which existed at Cambridge.¹⁴⁹ The Eighth Amendment “applies to mere confinement to an institution which is ‘characterized by conditions and practices so bad as to

¹⁴³ *Id.* “No state shall . . . deprive any person of life, liberty, or property, without due process of law.” U.S. Const. amend. XIV, § 1.

¹⁴⁴ *Welsch*, 373 F. Supp. at 495.

¹⁴⁵ *Id.* at 499 (quoting *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971)).

¹⁴⁶ *Id.* at 501. This statutory right to treatment was prescribed by the Minnesota Legislature under a 1973 amendment to the Minnesota Hospitalization and Commitment Act, providing in pertinent part: “Every person hospitalized or otherwise receiving services under this section shall be entitled to receive proper care and treatment, best adapted, according to contemporary professional standards, to rendering further custody, institutionalization or other services unnecessary.” *Id.* at 500 (quoting Act of May 23, 1973, ch. 552, 1973 Minn. Laws 1240, <https://www.revisor.mn.gov/laws/1973/0/Session+Law/Chapter/552/pdf/> [<https://perma.cc/RCY8-XBQE>]).

¹⁴⁷ *Id.* at 502 (citing *Covington v. Harris*, 419 F.2d, 617, 623 (D.C. Cir. 1969); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1096 (E.D. Wis. 1972); *Wyatt v. Stickney*, 344 F. Supp. 373, 386 (M.D. Ala. 1972)).

¹⁴⁸ *Id.* “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. Const. amend. VIII.

¹⁴⁹ *Welsch*, 373 F. Supp. at 503. Cambridge allegedly took part in several questionable practices including seclusion, physical restraints, and excessive use of tranquilizing medications. *Id.*

be shocking to the conscience of reasonably civilized people.”¹⁵⁰ The court finally asserted that, “whether grounded on due process or the Eighth Amendment,” residents have a right to a “humane and safe living environment while confined under State authority.”¹⁵¹

Welsch v. Likins resulted in nearly fifteen years of litigation involving several prominent outcomes for Minnesota’s mental health system.¹⁵² First, the 1977 Minnesota Legislature ordered the closing of Hastings State Hospital in response to the ongoing litigation.¹⁵³ Hastings officially closed in 1978.¹⁵⁴ Next, a system-wide consent decree was approved following settlement negotiations in 1980.¹⁵⁵ The 1980 Consent Decree increased direct care staffing requirements, establishing “qualified staff personnel in sufficient numbers” throughout the system as a whole.¹⁵⁶ The settlement reached in 1980 also called for an overall “reduction in state hospital population of mentally retarded persons.”¹⁵⁷ The Consent Decree further required persons discharged from state hospitals to be “placed in community programs which appropriately meet their individual needs.”¹⁵⁸ In the early stages of litigation there was substantial focus on physical changes to the hospital for safety and comfort; however, in 1980, there was limited attention given to these because “[t]here is simply no need to spend money on institutions which will not be needed.”¹⁵⁹ Rather, the goal was depopulation and closing Minnesota institutions altogether, in favor of community-based services.¹⁶⁰

Throughout the next decade, Minnesota worked to downsize its state hospitals, placing as many higher-functioning residents into community-based programs as possible.¹⁶¹ In 1985, the names of all remaining state

¹⁵⁰ *Id.* (quoting *Martarella v. Kelley*, 349 F. Supp. 575, 597 (S.D.N.Y. 1972)).

¹⁵¹ *Id.* at 502–03 (citing *N.Y. State Assoc. for Retarded Child., Inc. v. Rockefeller*, 357 F. Supp. 752, 764–65 (E.D.N.Y. 1973); *Gates v. Collier*, 349 F. Supp. 881, 894 (N.D. Miss. 1972); *Holt v. Sarver*, 309 F. Supp. 362, 384 (E.D. Ark. 1970), *aff’d* 442 F.2d 304 (8th Cir. 1971)) (including “protection from assaults or other harms from fellow residents, reasonable access to exercise and outdoor activities, and basic hygienic needs”).

¹⁵² Luther A. Granquist, *A Brief History of the Welsch Case 1* (1982), <https://mn.gov/mnddc/past/pdf/80s/82/82-granquist-history-welsch.pdf> [<https://perma.cc/V5EU-5BEF>].

¹⁵³ *Id.* at 6.

¹⁵⁴ THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 11.

¹⁵⁵ Granquist, *supra* note 152, at 7 (“The Consent Decree was expanded to include all eight of the institutions then serving mentally retarded persons.”).

¹⁵⁶ *Id.* at 8–11.

¹⁵⁷ *Id.* at 12.

¹⁵⁸ *Id.* (quoting Consent Decree at 24, *Welsch v. Noot*, No. 4-72 Civ. 451 (D. Minn. Sept. 15, 1980), <https://mn.gov/mnddc/past/pdf/80s/80/80-WELSCH-15.pdf> [<https://perma.cc/4EB9-RRJF>]).

¹⁵⁹ *Id.* at 14.

¹⁶⁰ *Id.*

¹⁶¹ THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 15. Rochester State Hospital closed in 1982. *Id.* at 4.

hospitals were changed to “regional treatment centers,” by executive order of Governor Perpich, to “reflect the broad spectrum of professional treatment services provided” by the facilities.¹⁶² The regional treatment centers gradually closed over the next twenty years as they continued to move towards a community-based model.¹⁶³ Willmar Regional Treatment Center was the last to close in 2006.¹⁶⁴ AMRTC and the Minnesota Security Hospital still remain open to this day serving the mentally ill population in Minnesota.

B. The Age of Community Behavioral Health Hospitals

In 2003, the Minnesota Legislature adopted a plan to further develop community-based services for mentally ill persons.¹⁶⁵ Both public and private partnerships were formed and collaborated to expand the state’s capacity for adult mental health treatment.¹⁶⁶ The goal of these community-based alternatives was “smaller settings, closer to individuals’ communities, homes, and natural supports of family and friends.”¹⁶⁷ In 2005, Community Behavioral Health Hospitals (“CBHHs”) were designed to “[p]rovide acute psychiatric hospitalization for assessment, stabilization and treatment.”¹⁶⁸ CBHHs have a sixteen-bed maximum capacity.¹⁶⁹ In 2006, the first six “CBHHs opened in Alexandria, St. Peter, Rochester, Amundale, Wadena, and Fergus Falls.”¹⁷⁰ In 2007, three more “CBHHs opened in Baxter, Cold Spring, and Bemidji.”¹⁷¹ In 2008, the tenth CBHH opened in Willmar.¹⁷²

These sixteen-bed psychiatric facilities have several benefits, including being smaller and providing a less institutionalized feel.¹⁷³ CBHHs are also sized to qualify for federal money under Medicaid, which is generally

¹⁶² *Id.* at 7; Exec. Order No. 85-17 (Minn. 1985),

<https://www.leg.mn.gov/archive/execorders/85-17.pdf> [<https://perma.cc/TV7J-T9PK>].

¹⁶³ THE EVOLUTION OF STATE OPERATED SERVICES, *supra* note 133, at 5-19. Moose Lake Regional Treatment Center closed in 1995. *Id.* at 16. Faribault Regional Treatment Center closed in 1998. *Id.* at 5. Cambridge Regional Treatment Center closed in 1999. *Id.* at 15. Fergus Falls Regional Treatment Center and Brainerd Regional Treatment Center closed in 2003. *Id.* at 7-19.

¹⁶⁴ *Id.* at 13.

¹⁶⁵ *Id.* at 22.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ Tony Leys, *Minnesota Has Closed 10 of 11 State Mental Hospitals*, DES MOINES REG. (Feb. 14, 2015), <https://www.desmoinesregister.com/story/news/2015/02/14/minnesota-iowa-mental-hospitals/23430427/> [<https://perma.cc/H4HU-5EHN>].

unavailable for larger mental institutions.¹⁷⁴ Additionally, these smaller facilities were designed to save money while also serving the mentally ill population closer to home.¹⁷⁵

Unfortunately, CBHHs have shown to be problematic in their own way.¹⁷⁶ For example, these facilities lack their own security forces and, therefore, must rely on local police departments “when aggressive patients become violent.”¹⁷⁷ The system is ill-equipped to handle the most severely mentally ill patients, especially those who are aggressive, violent, and unstable.¹⁷⁸ These severely mentally ill patients pose a danger to themselves and their communities.¹⁷⁹ Consequently, this often results in psychiatric patients boarding in hospital emergency departments or ending up in local jails.¹⁸⁰

Furthermore, many communities have been slow to develop essential housing and therapeutic services to appropriately supplement the CBHHs.¹⁸¹ According to Abderholden, this is likely due to a lack of appropriate funding and “discriminatory attitudes in communities” that simply “do not want programs in their neighborhoods.”¹⁸² These are significant challenges because, as Abderholden aptly stated, it is “hard to build a mental-health system without funding and without a place to locate it.”¹⁸³ Unfortunately, three CBHHs have already closed.¹⁸⁴ In 2009, Cold Spring closed, and just two years later, Willmar and Wadena closed their facilities.¹⁸⁵

Despite the numerous hurdles, Minnesota has made substantial progress in its mental health system since the closing of the state hospitals,

¹⁷⁴ *Id.* “Currently, the law prohibits states from using Medicaid to pay for care provided in ‘institutions for mental disease’ (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds.” *Medicaid IMD Exclusion: NAMI Public Policy Position*, NAT’L ALL. MENTAL ILLNESS (2021), <https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Medicaid-IMD-Exclusion-for-web-3-2021.pdf> [https://perma.cc/S9FJ-HAX8].

¹⁷⁵ Brad Schrade & Glenn Howatt, *Breakdown: In Rural Minnesota, Mental Health Safety Net Is in Limbo*, STAR TRIB. (Minneapolis) (Dec. 27, 2013, 9:27 AM), <https://www.startribune.com/in-rural-minnesota-mental-health-safety-net-is-in-limbo/229340841/> [https://perma.cc/7FFL-HYZZ].

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² Sue Abderholden, *Counterpoint: Minnesota Hasn’t Truly Built a Mental-Health System*, STAR TRIB. (Minneapolis) (July 13, 2018, 6:07 PM), <https://www.startribune.com/counterpoint-minnesota-hasn-t-truly-built-a-mental-health-system/488152741/> [https://perma.cc/4RWW-MR4K].

¹⁸³ *Id.*

¹⁸⁴ Schrade & Howatt, *supra* note 175.

¹⁸⁵ *Id.*

which President John F. Kennedy vividly described as “shamefully understaffed, overcrowded, unpleasant institutions from which death too often provided the only firm hope of release.”¹⁸⁶ According to Abderholden, “[i]nstitutions weren’t great places back then, and there was a good reason they closed. It was the next step that faced hurdles and was never completed—building a mental health system.”¹⁸⁷ Minnesota has developed more community-based services than ever before; however, it is still not enough to serve the enormous mental health population looming throughout the state.¹⁸⁸

C. The Unanticipated Effect of the “48-Hour Rule”

In 2013, the Minnesota Legislature enacted a “48-hour rule” requiring all jail inmates to be transferred from the jail to a state-operated mental health treatment program, such as AMRTC or the Minnesota Security Hospital, within forty-eight hours of being civilly committed by a judge for inpatient psychiatric care.¹⁸⁹ This was in response to increasing numbers of mentally ill people being locked up in county jails for extended periods of time without proper psychiatric treatment.¹⁹⁰ Unfortunately, this has had an unanticipated effect on Minnesota hospitals.¹⁹¹ Jail inmates are being admitted to state psychiatric facilities before hospital patients, “regardless of clinical need or cost.”¹⁹² This is having an unintended consequence of longer wait times for hospital patients to receive a bed at these state-operated mental health treatment programs.¹⁹³ This further results in safety concerns for these affected hospitals because “more mentally ill and violent patients are being kept longer in hospitals where staff are less prepared to deal with possible flare-ups.”¹⁹⁴

In 2012, prior to the enactment of the 48-hour rule, hospitals transferred 253 psychiatric patients to AMRTC.¹⁹⁵ Whereas, in 2015, following passage of the 48-hour rule, hospitals had only transferred sixty-

¹⁸⁶ Abderholden, *supra* note 182 (quoting President John F. Kennedy as he urged the closing of state institutions in the 1960s).

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ Chris Serres, *New Minnesota Law Pushes Mental Health System to a Crisis Point*, STAR TRIB. (Minneapolis) (Dec. 8, 2014, 10:13 PM), <https://www.startribune.com/sept-14-minnesota-law-pushes-mental-health-system-to-a-crisis-point/275076241/#:~:text=The%20law%2C%20known%20as%20the,raised%20safety%20concerns%20in%20hospitals> [<https://perma.cc/Y9JD-XAW6>]; See MINN. STAT. § 253B.10 (2021).

¹⁹⁰ Serres, *supra* note 189.

¹⁹¹ *Id.*

¹⁹² *Id.* (stating this is so “even if a hospital patient with more severe mental health needs has been waiting months”).

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ Olson, *supra* note 64.

one psychiatric patients to AMRTC.¹⁹⁶ Meanwhile, the number of jail inmates transferring to AMRTC had increased from 64 to 103 over this same time period.¹⁹⁷ Today, most of the patients in state-operated treatment programs “are from the jails, greatly delaying treatment for anyone coming from a community hospital.”¹⁹⁸ This is a devastating outcome of a well-intentioned law, and it should not need to be a competition between the jails and the hospitals to find appropriate placement for mental health patients to receive proper treatment.¹⁹⁹

In fact, the criticism of the 48-hour rule is likely misplaced because, although the law did cause this unintended competition between jails and hospitals, there is a critical underlying systems issue to blame instead.²⁰⁰ The long wait times at the state-operated psychiatric facilities is a “symptom of broader failings that began with the deinstitutionalization of mental health treatment decades ago.”²⁰¹ The real problem is not the 48-hour rule, but rather the statewide bed shortages and lack of adequate community health options.²⁰² “There has been a ripple effect throughout the whole system” that cannot be solved by only addressing the impact on jails because they are just one small part of the mental health system.²⁰³ Instead, we must work together and reform the system as a whole because each part “has an impact on the rest.”²⁰⁴

D. Misplaced Blame on Minnesota’s Hospital-Bed Moratorium

Bed expansion has failed to keep up with the rising demand for inpatient psychiatric beds throughout Minnesota for many years now.²⁰⁵ In 2009, one Minnesota hospital recalled opening with twenty psychiatric beds and immediately reaching full capacity.²⁰⁶ The same hospital later expanded to fifty psychiatric beds, then again to seventy-one psychiatric beds, and each time it immediately reached full capacity.²⁰⁷ “Despite rising demand, the number of available inpatient [psychiatric] beds for . . . Minnesotans has remained stagnant for years”²⁰⁸

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

¹⁹⁸ Abderholden, *supra* note 182.

¹⁹⁹ Olson, *supra* note 64.

²⁰⁰ Serres, *supra* note 189.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ Andy Steiner, *With Legislative OK, Local Mental Health Providers Plan Significant Inpatient Expansions*, MINNPOST (July 26, 2021), <https://www.minnpost.com/mental-health-addiction/2021/07/with-legislative-ok-local-mental-health-providers-plan-significant-inpatient-expansions/> [https://perma.cc/8LCW-X6LW].

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

Many people tend to blame the statewide bed shortages on Minnesota's hospital-bed moratorium, which places limitations on the construction and expansion of all hospital beds throughout the state, including inpatient mental health beds.²⁰⁹ These limitations have been in place since 1984 when the Minnesota Legislature first established the Hospital Moratorium Law, which prohibits the “[e]stablishment of new hospital licenses” and the “expansion of existing hospital licensed beds.”²¹⁰ The moratorium applies to all hospital beds in the state and requires a public review process in order to gain an exception to construct any additional beds.²¹¹ Thus, without an approved exception, mental health providers are essentially “stuck at current capacity levels.”²¹² Hospitals at full capacity must undergo the public review process each time they want to create additional beds.²¹³ With the extensive need for statewide psychiatric bed expansion, undoubtedly, we should be making it easier for hospitals to add mental health beds.²¹⁴

However, this criticism is likely misplaced because as Abderholden states, “The moratorium . . . is just one hurdle in adding more beds.”²¹⁵ The statewide moratorium is not “necessarily a barrier to building more beds.”²¹⁶ When the moratorium was first put in place, hospitals were allowed to keep their existing licensed beds, even if they were unused.²¹⁷ As such, many hospitals still have “licensed beds that are not being used.”²¹⁸ As of January 25, 2021, Minnesota had 16,382 licensed beds throughout the state, while only 11,587 were designated as available for use.²¹⁹ Therefore, even with the statewide moratorium in place, existing hospitals with these “banked” beds could legally convert them to inpatient psychiatric beds if they so choose.²²⁰ Nearly 5,000 beds are currently licensed, but unused, in Minnesota and could be legally converted to inpatient psychiatric beds without requiring any review process or exception under the moratorium.²²¹ Rather, those

²⁰⁹ *Id.*

²¹⁰ Stefan Gildemeister, *Regulating Hospital Bed Capacity in Minnesota*, MINN. DEP'T HEALTH 1, 6-7 (Jan. 27, 2021), https://www.house.leg.state.mn.us/comm/docs/radytZw7G0eLVa6Qe_SiGA.pdf [<https://perma.cc/W9U8-WSMU>]; MINN. STAT. § 144.551 (2021).

²¹¹ Steiner, *supra* note 205. In 2004, the Minnesota Hospital Moratorium Law established the Public Interest Review Process for reviewing proposals for additional beds and granting exceptions to the moratorium. Gildemeister, *supra* note 210; MINN. STAT. § 144.552 (2021).

²¹² Steiner, *supra* note 205.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ Gildemeister, *supra* note 210, at 16.

²²⁰ Steiner, *supra* note 205.

²²¹ *See* Gildemeister, *supra* note 210, at 16.

same hospitals are choosing to board psychiatric patients “for days or even weeks” in their emergency departments, waiting for beds to open in other psychiatric facilities.²²² “Abderholden believes that hospitals with banked beds that consistently board psychiatric patients are not fulfilling their responsibility to the communities they serve.”²²³

There are several factors that may be contributing to why hospitals that have “banked” beds are continually choosing not to expand psychiatric care in their facilities when there is such a clearly prominent need.²²⁴ First, according to Kyle Cedermark, a child and adolescent psychiatrist and chief psychotherapy officer of a Minnesota psychiatric facility, it is a matter of economics and profitability.²²⁵ Cedermark further stated, “[C]ardiology, orthopedic surgery, [and] labor and delivery . . . are all considered better beds to have in your hospital,” regarding the relative profitability in comparison to mental health programs.²²⁶ Cedermark believes another factor may be public relations; mental health care is “not sexy. It speaks to the vulnerability of the population.”²²⁷ Even mental health care advocates, such as Cedermark, are cautious about how they market their mental health services to the community.²²⁸

Lastly, even if hospitals with unused licensed beds decide they would like to add inpatient psychiatric beds to their facilities, “[b]anked beds are just a piece of paper.”²²⁹ Hospitals would still require funding and square footage for the construction of such beds.²³⁰ Furthermore, “finding and hiring staff to work in these units” is another significant obstacle to adding mental health beds.²³¹ Abderholden hopes “there is a more robust discussion about the funding and workforce needed” to address such barriers for existing hospitals to expand inpatient psychiatric beds.²³²

IV. THE SOLUTION

A. One State’s Apparent Solution to Emergency Department Boarding

“In 2014, the Washington State Supreme Court ruled that the boarding of psychiatric patients was illegal.”²³³ The court’s ruling was an

²²² Steiner, *supra* note 205.

²²³ *Id.*

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ Simon et al., *supra* note 41 (citing *Det. of D.W. v. Dep’t of Soc. & Health Servs.*, 332 P.3d 423 (Wash. 2014)).

undoubtedly momentous decision and did, at least theoretically, put an end to the practice of boarding psychiatric patients in Washington.²³⁴ However, we must be cautious about other states “drawing substantial lessons from this case” for several reasons.²³⁵ First, this ruling was made on the particular way in which Washington hospitals executed their boarding, specifically in relation to compliance with their state’s civil commitment statutes.²³⁶ In order to comply with Washington State’s civil commitment statutes, “hospitals had to have the nonpsychiatric beds their boarding patients were occupying temporarily certified as mental health beds. It was this temporary certification that the court ruled was illegal.”²³⁷ Therefore, this decision is not widely applicable to other states.²³⁸

Second, the Washington State Supreme Court’s ruling “only applied to involuntary patients.”²³⁹ Thus, mentally ill patients voluntarily seeking care are still at risk for boarding,²⁴⁰ likely resulting in a greater negative impact on voluntary patients by increasing the prevalence of psychiatric boarding for them. Similar to the unanticipated effect of the “48-hour rule” on hospitals, this decision simply shifts the burden and prioritizes involuntary patients for open beds throughout the state. Consequently, this limits the number of beds available for voluntary patients who are mentally ill and require appropriate treatment.

“Third, although the Washington State legislature indeed responded to the court decision by creating more mental health beds, it is not entirely clear where the resources came from.”²⁴¹ It is likely that “other priorities were downgraded to provide these funds and beds.”²⁴² Of course, states can be ordered to act on such rulings; however, the “the value of this path requires assessing not just the benefits, but also the cost.”²⁴³ It would certainly be preferable if the legislature simply chose to “designate funds to alleviate the [emergency department] psychiatry boarding crisis.”²⁴⁴ This would allow

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ *Id.* (citing Joseph D. Bloom, *Psychiatric Boarding in Washington State and the Inadequacy of Mental Health Resources*, 43 J. AM. ACAD. PSYCHIATRY & L. 218 (2015), <http://jaapl.org/content/jaapl/43/2/218.full.pdf> [<https://perma.cc/BY5D-XSZC>]).

²³⁸ *Id.*

²³⁹ *Id.* (citing Bloom, *supra* note 237).

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.* (citing Ethan DeWitt, *Sununu Signs Bipartisan Mental Health Bill to Address ER Boarding Crisis*, CONCORD MONITOR (May 21, 2019), <https://www.concordmonitor.com/Sununu-signs-bipartisan-mental-health-bill-to-address-New-Hampshire-ER-boarding-crisis-25712048> [<https://perma.cc/5WDX-RSRC>]) (comparing a recent New Hampshire bill, which allocated \$10.6 million to help open pathways for care and address the state’s emergency department boarding crisis).

the allocation of funds to “balance against other competing priorities, rather than being forced by a [court] that is considering the problem in isolation.”²⁴⁵

Finally, Washington’s apparent solution is only temporary because “the number of beds is not infinitely expandable.”²⁴⁶ Although the increased number of beds helped to resolve the issue at the time, there will come a time when the number of patients in need outweighs the number of available beds again.²⁴⁷ “At that point, no court ruling will create beds immediately, and providers will be caught between their legal and ethical obligation to care for these patients and the court decision that their only means for doing so is illegal.”²⁴⁸ As such, the burden on providers unduly increases while the system continues to fail its patients.²⁴⁹ The momentous decision was a brave attempt by the Washington State Supreme Court to solve the vexing problem of emergency department boarding; however, it is likely not a feasible solution for Minnesota. Rather, we must rectify the state’s inadequate mental health system which, in turn, will work to alleviate psychiatric boarding in Minnesota emergency departments.

B. Reform Minnesota’s Mental Health System at Various Levels of Service

At first glance, the solution may seem obvious: increase the number of inpatient psychiatric beds throughout the state. However, this is a superficial solution to an exceedingly complex problem. Such a complex problem requires a multifaceted solution. That is, we must reform Minnesota’s mental health system at all levels of service to appropriately meet the needs of the entire mental health community.²⁵⁰ Abderholden emphasizes that “[b]uilding a system that focuses only on hospital-level care will not solve the vexing problems in our system, because people spend a majority of their

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ See generally Minnesota Comprehensive Adult Mental Health Act, MINN. STAT. § 245.461 (2013) (“The commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that: (1) recognizes the right of adults with mental illness to control their own lives as fully as possible; (2) promotes the independence and safety of adults with mental illness; (3) reduces chronicity of mental illness; (4) eliminates abuse of adults with mental illness; (5) provides services designed to: (i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning; (ii) stabilize adults with mental illness; (iii) prevent the development and deepening of mental illness; (iv) support and assist adults in resolving mental health problems that impede their functioning; (v) promote higher and more satisfying levels of emotional functioning; and (vi) promote sound mental health; and (6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.”).

lives in the community—not in the hospital.”²⁵¹

Of course, we must increase inpatient psychiatric beds for those medically necessary cases, but some patients could likely avoid inpatient care altogether if they were treated at an earlier stage.²⁵² “Hospitalization should be accessible but reserved for individuals who truly require acute care.”²⁵³ Furthermore, numerous inpatient psychiatric beds are being unnecessarily occupied because of delayed discharges to state-operated psychiatric facilities which are overwhelmed by their own bed shortages.²⁵⁴ Unfortunately, “[h]aving more state-operated hospital beds is fraught with concerns, since their size precludes them from receiving Medicaid,²⁵⁵ and, frankly, both [AMRTC] and the Minnesota Security Hospital in St. Peter have struggled to meet basic licensing and programmatic standards.”²⁵⁶ These state-operated facilities are also having their own delayed discharges due to the statewide shortage of “step-down” community programs for those patients who are ready to leave hospital-level care, but not yet return home.²⁵⁷ Therefore, although increasing the number of inpatient psychiatric beds is certainly important, it is equally, if not more, important to expand less intensive mental health programs throughout the state as well.

“Increasing community mental health services, especially urgent care [and] walk-in services could avert the need for admission in patients with severe mental health concerns.”²⁵⁸ Many of these admissions may be preventable with earlier intervention. The expansion of less intensive services, such as partial hospitalization and day treatment programs, could also help to reduce mental health crises across the state.²⁵⁹ “Additionally, developing crisis response, stabilization, and observation services for patients with severe mental health complaints could be a satisfactory

²⁵¹ Abderholden, *supra* note 182.

²⁵² Steiner, *supra* note 205.

²⁵³ MENTAL & BEHAVIORAL HEALTH: OPTIONS & OPPORTUNITIES FOR MINNESOTA, MINN. HOSP. ASS’N 1, 5 (2015), <https://www.mnhospitals.org/Portals/0/Documents/policy-advocacy/mental-health/Public%20mental%20health%20white%20paper.pdf> [<https://perma.cc/AU5B-FU7L>].

²⁵⁴ See *supra* Part II, Section B.

²⁵⁵ Abderholden, *supra* note 182; see also NAT’L ALL. MENTAL ILLNESS, *supra* note 174.

²⁵⁶ Abderholden, *supra* note 182. “From time to time, State-Operated programs at St. Peter and the AMRTC have faced scrutiny from Federal and state regulators about patient safety and quality of care.” *NAMI Minnesota 2021 Legislative Goals*, NAT’L ALL. MENTAL ILLNESS (Nov. 21, 2020), <https://2a392k31wksy2wkej1y03dp-wpengine.netdna-ssl.com/wp-content/uploads/sites/188/2020/12/NAMI-Minnesotas-2021-Legislative-Goals.pdf> [<https://perma.cc/2UUH-VNV5>].

²⁵⁷ See *supra* Part II, Section B.

²⁵⁸ Simon et al., *supra* note 41.

²⁵⁹ Steiner, *supra* note 205. Partial hospitalization and day treatment programs are intensive outpatient services. Governor’s Task Force, *supra* note 1. Partial hospitalization is “[t]eam led treatment, with a physician as head of the team, [and] includes group therapy and other services.” *Id.* Whereas day treatment programs are “[s]hort term group services . . . led by [a] Mental Health Professional, with a mix of therapy and rehab services.” *Id.*

alternative to inpatient hospitalization and prolonged [emergency department] boarding.”²⁶⁰

Crisis response services can be provided through either mobile or residential crisis services.²⁶¹ Mobile crisis services are provided by “teams of mental health professionals and practitioners” who travel to individuals within their own homes or other community locations.²⁶² Mobile crisis teams provide “face-to-face, short-term, intensive mental health services . . . during a mental health crisis or emergency.”²⁶³ Mobile crisis services are available twenty-four hours a day, seven days a week, across every county in the state of Minnesota.²⁶⁴ Mobile crisis services are “effective at diverting people in crisis from psychiatric hospitalization.”²⁶⁵ Mobile crisis interventions necessarily reduce inpatient hospitalizations by an estimated eighty-five percent.²⁶⁶

Residential crisis services provide a “short-term safe place” for voluntary patients to stay and receive counseling and education to help manage their mental health symptoms in order to safely return living at home.²⁶⁷ Residential crisis services effectively decrease the demand for inpatient hospitalizations by approximately ninety percent.²⁶⁸ Residential crisis stays are typically between three and ten days and may be offered in a dedicated crisis stabilization unit, or in a few reserved beds at Intensive Residential Rehabilitative Treatment Services (“IRTS”).²⁶⁹ Minnesota has 609 IRTS beds total, and about 150 of those can be used for residential crisis services.²⁷⁰ IRTS can also be used as a step-down program from the hospital setting, with stays that are intended to be between thirty and ninety days.²⁷¹

Another potentially favorable solution, according to Abderholden, could be the development of “[s]upportive-housing programs in which there are multiple apartments or all of the apartments in a building dedicated to

²⁶⁰ Simon et al., *supra* note 41.

²⁶¹ Governor’s Task Force, *supra* note 1.

²⁶² *Mobile Crisis Mental Health Services*, MINN. DEP’T HUM. SERVS. (Apr. 23, 2021), <https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/programs-services/mobile-crisis.jsp> [<https://perma.cc/3Z27-G4V8>] (“Mobile crisis services provide for a rapid response and will work to assess the individual, resolve crisis situations, and link people to needed services.”).

²⁶³ *Id.*

²⁶⁴ Governor’s Task Force, *supra* note 1.

²⁶⁵ *Mobile Crisis Mental Health Services*, *supra* note 262.

²⁶⁶ Governor’s Task Force, *supra* note 1.

²⁶⁷ *Crisis Residential*, CENT. MINN. MENTAL HEALTH CTR., <https://cmmhc.org/services/crisis-residential/> [<https://perma.cc/ETN6-BVXW>].

²⁶⁸ Governor’s Task Force, *supra* note 1.

²⁶⁹ *Id.*

²⁷⁰ *Id.*

²⁷¹ *Id.*

people with mental illnesses.”²⁷² Such programs have proven to help stabilize people within their communities.²⁷³ Unfortunately, these same programs have been looked upon negatively and labeled as being “too institutional.”²⁷⁴ However, “[t]wenty apartments in a building with ample access to mental health professionals who can provide a higher level of care is certainly better than a jail, being homeless, boarding in an [emergency department] or sitting in a state hospital.”²⁷⁵

There is likely no perfect mental health system that will work for every psychiatric patient because each individual has unique treatment requirements. However, reforming the system at various levels of service will undoubtedly cast a wider net, allowing us to improve mental health care for a greater number of patients across the state of Minnesota.

C. Incentivize Psychiatric Bed Development Across Minnesota

Unfortunately, simply knowing we must reform the system is not enough. Expanding bed capacity and treatment programs requires adequate funding. “You cannot build the mental health system without paying for it.”²⁷⁶ We must “[i]dentify and reform public policies that incentivize” psychiatric bed development.²⁷⁷ The ACEP recommends “increas[ing] payment for admitted behavioral health patients and [creating] higher acuity inpatient psychiatric reimbursement codes for patients with worse problems, similar to medical ICU codes.”²⁷⁸ Low reimbursement rates for

²⁷² Abderholden, *supra* note 182. *See generally* Minnesota Comprehensive Adult Mental Health Act, MINN. STAT. § 245.461 (2013) (“The commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system: (1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance; (2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and (3) provide necessary support regardless of where persons with mental illness choose to live.”).

²⁷³ Abderholden, *supra* note 182.

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ NAT’L ALL. MENTAL ILLNESS, *supra* note 256.

²⁷⁷ Fuller et al., *supra* note 43, at 3.

²⁷⁸ Simon et al., *supra* note 41. “Reimbursement for procedures and services performed by providers is made by commercial payers . . . based on claims and documentation filed by providers using medical diagnosis and procedure codes.” *What Is Medical Reimbursement?*, AM. ACAD. OF PRO. CODERS, <https://www.aapc.com/resources/medical-coding/reimbursement.aspx> [<https://perma.cc/6B9E-JFT6>]. “Commercial payers must use standards defined by the U.S. [HHS] but are largely regulated state-by-state. . . . [C]ommercial payers determine their own rules of medical necessity or payment and reimbursement fee schedules.” *Id.* “Current Procedural Terminology [“CPT”] refers to a set of medical codes used by physicians . . . to report procedures and services to federal and private payers for reimbursement of rendered healthcare.” *What is CPT?*, AM. ACAD. OF PRO. CODERS, <https://www.aapc.com/resources/medical-coding/cpt.aspx>

mental health care is a well-known problem across the spectrum from both public and private payers of insurance.²⁷⁹

Currently, the federal law prohibits the use of Medicaid as a means for states to finance care provided to patients within “institutions for mental disease” (“IMDs”).²⁸⁰ IMDs are defined as “a hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”²⁸¹ The IMD exclusion is a “discriminatory exclusion” because it is “the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated.”²⁸² The IMD exclusion has been in place since 1965 when Medicaid was first enacted.²⁸³ It was “intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.”²⁸⁴ Unfortunately, this exclusion “has resulted in unequal coverage of mental health care,” compared to general medical care.²⁸⁵

Eliminating the discriminatory nature of the IMD exclusion would require an act of Congress because it is included within the federal Medicaid statute.²⁸⁶ There are several legislative options which Congress could consider in addressing this issue.²⁸⁷ First, “Congress could fully repeal the IMD exclusion.”²⁸⁸ Some may find this to be an extreme approach, albeit productive. However, it certainly does present risks, such as “encourag[ing] inpatient treatment when outpatient treatment is preferable” and, of course,

[<https://perma.cc/X3C8-F9R7>]. “[T]he [AMA] created CPT codes to standardize reporting of medical, surgical, and diagnostic services and procedures performed in inpatient and outpatient settings. Each CPT code represents a written description of a procedure or service, eliminating the subjective interpretation of precisely what was provided to the patient.” *Id.*

²⁷⁹ NAT’L ALL. MENTAL ILLNESS, *supra* note 256.

²⁸⁰ NAT’L ALL. MENTAL ILLNESS, *supra* note 174; *The Medicaid IMD Exclusion: An Overview and Opportunities for Reform*, LEGAL ACTION CTR. 1, 1,

https://www.lac.org/assets/files/IMD_exclusion_fact_sheet.pdf [<https://perma.cc/R4QP-N3GL>]. The IMD exclusion prohibits “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.” Social Security Act § 1905, 42 U.S.C. § 1396d (2022).

²⁸¹ 42 U.S.C. § 1396d (2022); NAT’L ALL. MENTAL ILLNESS, *supra* note 174; LEGAL ACTION CTR., *supra* note 280.

²⁸² NAT’L ALL. MENTAL ILLNESS, *supra* note 174; *see also* LEGAL ACTION CTR., *supra* note 280.

²⁸³ NAT’L ALL. MENTAL ILLNESS, *supra* note 174; LEGAL ACTION CTR., *supra* note 280.

²⁸⁴ LEGAL ACTION CTR., *supra* note 280, at 1.

²⁸⁵ NAT’L ALL. MENTAL ILLNESS, *supra* note 174.

²⁸⁶ LEGAL ACTION CTR., *supra* note 280, at 2.

²⁸⁷ *Id.* at 2-3.

²⁸⁸ *Id.* at 3.

being “quite expensive for the federal government.”²⁸⁹ An alternative, and maybe less controversial, approach would be that “Congress could raise the bed limit above [sixteen] to a number that would allow larger facilities to fall outside of the scope of the IMD exclusion.”²⁹⁰ Either of these options would be a reasonable, but significant, step in curing the mental health system across the country.

Minnesota is certainly not immune to such discriminatory exclusion. Rates of Medical Assistance—“Minnesota’s Medicaid program for people with low income”²⁹¹—are especially low for mental health services in Minnesota, failing to even cover the basic costs of providing care.²⁹² These low reimbursement rates are absolutely unacceptable and place a substantial financial burden on mental health providers throughout the state.²⁹³ The financial burden negatively impacts these providers’ ability to adequately pay their staff and, in turn, places an additional strain on both staff recruitment and staff retention in community-based mental health programs across the state.²⁹⁴

D. Expand the Mental Health Workforce in Minnesota

“We cannot build our mental health system without also building our mental health workforce.”²⁹⁵ This is not surprising as we must have competent staff, including providers and mental health professionals, to appropriately care for psychiatric patients at all levels of service. “In order to meet this need, Minnesota will have to address low reimbursement rates, challenges meeting licensure requirements, and the unique challenges developing a diverse workforce in rural and urban areas.”²⁹⁶

NAMI has created several legislative goals to address the crucial expansion of the mental health workforce in Minnesota, including:

- increasing exposure and early recruitment;
- improving collection and dissemination of mental health workforce data at all levels;
- ensuring access to and affordability of supervisory hours to become licensed;

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *Medical Assistance (MA)*, MINN. DEP’T HUM. SERVS. (Apr. 5, 2016),

<https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> [<https://perma.cc/MX74-BEGL>].

²⁹² NAT’L ALL. MENTAL ILLNESS, *supra* note 256.

²⁹³ NAT’L ALL. MENTAL ILLNESS, *supra* note 256. “The floor for mental health rates under Medical Assistance . . . must not be lower than [the] fee for service. . .” *Id.*

²⁹⁴ *Id.*

²⁹⁵ *Id.*

²⁹⁶ *Id.*

- increasing the overall number of mental health professionals;
- increasing the number of licensed mental health professionals from diverse communities;
- improving and expanding cultural competency and awareness training;
- creating career ladders; and
- addressing medical licensure questions.²⁹⁷

Increasing exposure to the mental health profession must start at the high school level with career days, enrichment programs, and panels of mental health professionals willing to speak about their careers.²⁹⁸ Early recruitment must continue into undergraduate and graduate learning by examining program requirements and increasing mental health experiences for both nursing and medical school students.²⁹⁹ This will allow us to better steer people into mental health fields, as well as through continuing education for already licensed nurses and providers.³⁰⁰

Improving collection and dissemination of mental health workforce data will help to identify gaps in the current licensure procedures and overall passage rates.³⁰¹ Identifying these gaps will allow the licensing boards to make necessary modifications and improve mental health licensing across the state, especially with diverse populations.³⁰²

Ensuring access to and affordability of supervisory hours to become licensed is a crucial requirement to expanding the mental health workforce.³⁰³ Providers should not be expected to supervise clinical trainees for free, but the trainees often cannot afford to pay for the supervision either.³⁰⁴ We must provide funding for supervisors, both for providing the supervision and for becoming licensed to supervise.³⁰⁵ Medical Assistance actually reimburses services provided by trainees under the supervision of a mental health professional.³⁰⁶ Third-party payers and commercial insurers should also be required to reimburse in this way for supervision and internships.³⁰⁷

Increasing the overall number of mental health professionals will require examining the availability and requirements of higher-level mental

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ *Id.*

³⁰¹ *Id.*

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ *Id.* (including continuing education hours, exam fees, and licensure fees).

³⁰⁶ *Id.*

³⁰⁷ *Id.*

health degree programs throughout the state.³⁰⁸ We must expand psychiatric nurse practitioner programs, social work programs, and mental health programs across the state, especially in rural areas.³⁰⁹ We must also expand weekend and online master's programs to increase accessibility for non-traditional students.³¹⁰

Increasing the number of licensed mental health professionals from diverse communities requires unique training programs with pathways to licensure specifically targeted at these students.³¹¹ One alternative pathway may include not requiring the national exam for licensure of mental health professionals.³¹² Additionally, we must also provide scholarship options and increase loan forgiveness programs for underserved communities.³¹³

Improving and expanding cultural competency and awareness training is necessary to better serve our communities.³¹⁴ We must establish such training requirements across the spectrum of mental health education.³¹⁵ Furthermore, mental health professionals should also be expected to complete continuing education hours in cultural competency and awareness.³¹⁶

Creating career ladders is another crucial element in expanding the mental health workforce.³¹⁷ We must identify gaps in the current educational and licensure procedures which hinder career advancement in the mental health profession.³¹⁸ We must further work to improve and develop a system which more easily allows people to advance from entry-level positions to paraprofessional positions to licensure as independent professionals.³¹⁹

Lastly, we must address discriminatory medical licensure questions.³²⁰ Many of the licensing boards include a question about the individual's mental health or previous treatment of such.³²¹ These questions discriminate against applicants with mental illness and create a negative perception that providers cannot have a mental illness.³²² These questions must be revised to "foster an environment where doctors feel comfortable accessing

³⁰⁸ *Id.*

³⁰⁹ *Id.*

³¹⁰ *Id.*

³¹¹ *Id.*

³¹² *Id.*

³¹³ *Id.*

³¹⁴ *Id.*

³¹⁵ *Id.* (including core cultural competency components in licensing, accreditation, supervision, training, and education requirements).

³¹⁶ *Id.*

³¹⁷ *Id.*

³¹⁸ *Id.*

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ *Id.*

³²² *Id.*

treatment [for] their mental illness without threatening their careers.”³²³ Each of these are necessary factors in expanding the mental health workforce within Minnesota and, thus, reforming the state’s mental health system as a whole.

V. CONCLUSION

The frequent boarding of mental health patients in Minnesota emergency departments is devastating.³²⁴ “Without concerted effort, these patients are likely to have prolonged stays that are inefficient at best and harmful at worst,” according to the ACEP.³²⁵ However, this problem can be alleviated. As emphasized by HHS, “[t]his is a systems issue that manifests itself in the [emergency departments], which is a common pathway for the problem; but the real problem is about capacity in other parts of the system, adequate funding, and being able to move patients to the level of care they need.”³²⁶

Mental health crises are steadily on the rise, yet the number of mental health programs continue to decline across the state.³²⁷ Minnesota has “never really had enough inpatient psych[iatric] beds.”³²⁸ Nonetheless, we must reform Minnesota’s mental health system across the spectrum to expand *all* levels of service.³²⁹ This includes both inpatient psychiatric beds, as well as less intensive levels of care such as “step-down” programs, partial hospitalization, day treatment, urgent care and walk-in services, crisis response, stabilization, and observation services.³³⁰ However, this reform simply cannot happen without adequate funding³³¹ and a competent workforce to provide optimal care.³³² We must incentivize psychiatric bed development by increasing insurance reimbursements³³³ and expand the mental health workforce throughout Minnesota in order to properly meet the needs of the entire mental health community.³³⁴

We will never be able to solve the glaring problem of emergency room boarding if we do not first solve the vexing problem of an inadequate mental health system. We are unquestionably failing our communities if we do not prioritize the mental health of our populace. Mental illness is prevalent in

³²³ *Id.*

³²⁴ *See supra* Part II.

³²⁵ Simon et al., *supra* note 41.

³²⁶ BENDER ET AL., *supra* note 7.

³²⁷ *See supra* Part II, Section A.

³²⁸ Brooks, *supra* note 23.

³²⁹ *See supra* Part IV, Section B.

³³⁰ *Id.*

³³¹ *See supra* Part IV, Section C.

³³² *See supra* Part IV, Section D.

³³³ *See supra* Part IV, Section C.

³³⁴ *See supra* Part IV, Section D.

our society and should not be discriminated against. We must invoke change to this futile system before it is too late.