Managing Mentally Ill, Nuisance Offenders: The Consequences of Restricted Civil Commitment and Decentralized Funding

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Prepared for presentation at the Annual Meetings of the American Society of Criminology, New Orleans, November 4-7, 1992

Abstract

High rates of mental illness among the growing, visible, urban homeless population provoke public pressure to "do something" to eliminate this "public nuisance." Conviction and jailing on misdemeanor charges provides only temporary incarceration in already overcrowded local jails, while, since the 1970s, restrictive commitment standards have limited the availability of civil commitment to hospitalize non-violent mentally ill people.

To encourage development of community-based mental health services and reduce the fiscal domination of state mental hospitals, some states have decentralized funding of mental health services. Under decentralization county officials make commitment decisions and distribute funds to state hospitals and community programs, on a fee-for-service basis.

Many political compromises were required to pass this decentralizing legislation in Ohio. One such compromise has the state retaining financial responsibility only for those state hospital patients committed through criminal processes. The resulting structure of financing and decision making may encourage some local officials to use criminal commitment procedures to manage nuisance offenders.

Introduction

High rates of mental illness among the growing, visible, urban homeless population provoke public pressure to "do something" to reduce this "public nuisance." Three options are available to criminal justice and mental health officials:

(1) People living on public streets may be charged with violation of ordinances prohibiting such minor offenses as indecent exposure (for relieving themselves in a doorway). Conviction and jailing on misdemeanor charges provides only temporary incarceration in already overcrowded local jails, which are, at best, unsuitable facilities for providing care for people with serious mental illness.

(2) Street people suffering from mental illness may be hospitalized in state facilities, involuntarily if they refuse to go willingly. From the early 19th century until the 1970s, state mental hospitals provided a place to treat, at best, or "dump," at worst, people who were seriously mentally ill and defined as being public nuisances. Since the 1970s, however, restrictive commitment standards have limited the availability of civil commitment to hospitalize non-violent mentally ill people.

(3) The remaining alternative is "criminal commitment," whereby mentally ill street people are charged with violations of state laws or municipal ordinances, declared incompetent to stand trial (IST) or not guilty by reason of insanity (NGRI), and involuntarily hospitalized.

This study deals with the third alternative, the use of criminal commitment procedures to manage mentally ill misdemeanants. Criminal commitment might appear to be an excessively harsh or cumbersome response to misdemeanor offenses, but the highly restrictive standards for civil commitment, coupled with financial incentives to committing counties, may be encouraging the use of criminal commitment.

Many research studies have evaluated the characteristics of people committed as NGRI and IST and the outcomes of these commitments. Few, however, examine the economic and political structures underlying decisions to commit mentally ill people as incompetent. That is the purpose of this study.

Decentralizing State Funding in Ohio

The resident patient census of state mental hospitals peaked in 1955, and patients left state hospitals in droves beginning in the 1970s. State funds for services to mentally ill people mostly stayed with the state hospitals, however.

As recently as 1988 in the U.S. there were 407,427 patient care "episodes" (i.e. patients enrolled at the beginning of the year plus admissions during the year) in state mental hospitals and 5,134,826 patient care episodes at psychiatric outpatient clinics and multiservice mental health organizations, a ratio of 1 to 12.6 (NIMH, 1992, p. 9). In the same year state governments spent $5.4 billion on state mental hospitals and $2.5 billion on all freestanding psychiatric outpatient clinics and multiservice mental health organizations, a ratio of 2.2 to 1 (NIMH, 1991, p. 12). This is a clear disparity between the predominant locus of service and the primary organizational recipients of state funds. This disparity exists for a variety of reasons that are beyond the scope of this

paper. For this study, it is sufficient to state that reallocation of funds, to ensure that money follows service recipients, has been politically difficult.

To encourage development of community-based mental health services and reduce the fiscal dominance of state mental hospitals, Ohio is currently decentralizing funding of mental health services. Under decentralization county officials determine how funds will be apportioned between state hospitals and community programs, on a fee-for-service basis.

Ohio's 88 counties are organized into 53 community mental health boards--larger counties have their own boards, while some smaller, adjacent counties are grouped under a single board. Each of these boards has responsibility for overall coordination of publicly funded mental health services within its jurisdiction.

The Ohio Mental Health Act of 1988 provided for redistribution of funds previously given directly to state mental hospitals. Under Administrative Line Item 408 (ALI 408) of the Mental Health Act, each county can choose to receive funds from the state to use for inpatient care at state hospitals or to develop community-based programs. The state's contribution to community-based mental health programs was $120 million in 1990 (Ohio Department of Mental Health, 1991). In 1990 nearly $19 million was made available in ALI 408 electable funds. This figure increased to over $39 million in 1991 (Study Committee on Mental Health Services, 1991).

The amount of ALI 408 funds a county could receive in 1989 was 0 - 10% of the funds it had used for inpatient care in an average previous year. For a period of six years after the implementation of the act the maximum percentage that a county may elect increases, until 1995, when it reaches 100%:

Fiscal Year	Maximum Electable Percentage
1990	10%
1991	20
1992	40
1993	60
1994	80
1995	100

Alternatively, each county can choose to have the state continue to pay for inpatient care directly. If a board chooses to receive no funds, the cost of hospitalization for residents committed from the county is borne directly by the state and there is no transfer of funds to the county.

Political compromises were required to pass this complex decentralizing legislation in Ohio. One such compromise required the state to retain financial responsibility for those state hospital patients committed through criminal processes. The resulting structure of financing and decision making may encourage some local officials to use criminal commitment procedures to manage nuisance offenders.

Rational Mental Health Decision-Making at the County Level

Particularly when financial resources are limited, the local officials responsible for distributing those resources may be expected to provide services in the most cost-efficient manner. Local mental health officials control disbursement of certain classes of funds. They would rationally seek equivalent services for their clients funded by other sources.

The state is an obvious source of among the alternative sources of mental health services. When mental health funding is structured so the state has exclusive financial

responsibility for certain types of services, local officials are likely to shift their clients to state-funded services.

The Ohio Mental Health Act of 1988 created such an incentive structure. Under the Act, the state retains sole financial responsibility for hospitalization of "forensic" clients (those committed by a criminal court after being found NGRI and IST). Financial responsibility for hospitalization of people committed under in other legal categories falls to the county mental health boards, who receive partial funding from the state. Counties have responsibility for outpatient care of all clients, including those who receive outpatient care after being declared IST or NGRI.

It is financially rational for county mental health officials to seek forensic commitments for their clients who require hospitalization--commitment to a regular state mental hospital cost an average of $211 per day in 1990. By obtaining a forensic commitment for a mentally ill person, county officials can secure the inpatient treatment they consider necessary at no cost to the county.

Since the funding structure superceded by the 1988 Act provided no such incentive, we would expect to experience increased use of forensic commitments once the 1988 Act became effective:

Hypothesis #1: The number and proportion of forensic commitments will increase under the funding structure established by the Mental Health Act of 1988, compared to the proceeding period covered by the earlier, centralized funding structure.

The incentive to use forensic commitments increases each year, beginning in 1990 and reaching a maximum in 1995, as increasing amounts of discretionary funds are made available to the counties:

Hypothesis #2: As the proportion of ALI 408 funds made available to counties increases each year between 1990 and 1995, the number and proportion of forensic commitments will increase statewide.

Mental health officials of each county are not equally motivated to use the forensic commitment strategy to shift the cost of mental health care to the state. The incentive to seek a forensic commitment of a mental health client is directly related to the percentage of ALI 408 funds chosen by a county. Counties that choose to have the state continue to pay all the costs of hospitalization in state facilities have no financial incentive to seek the forensic route, because the state pays the full cost regardless of the legal classification of the commitment. On the other hand, counties choosing to receive the maximum percentage of ALI 408 funds have the greatest incentive to have their clients classified as forensic, to obtain state-paid hospitalization, rather than carrying the full cost of hospitalization themselves.

Hypothesis #3: Counties that elect a larger proportion of ALI 408 funds will obtain a larger proportion of forensic commitments than will counties electing a smaller proportion of these funds.

As some counties opt out and other counties elect the (increasing) maximum amount of money, the range of percentages of ALI 408 funds that will be elected in the coming years will expand. The financial incentive to counties to seek forensic commitments will therefore increase more for some counties than for others during the period 1990-1995.

Methods

The data examined in this study are officially reported statistics provided by the Ohio Department of Mental Health, aggregated on two levels. At the higher level of aggregation are statewide reports of numbers of commitments to public mental hospitals by legal classification of commitment. At the lower level of aggregation are (unpublished) reports of commitments by legal classification by county. The county-level data cover only the ten largest counties in Ohio. These ten counties were

responsible for 70% of all commitments in 1990 (69% in 1991), and 79% of all forensic commitments in 1990 (84% in 1991).

Unfortunately, these data are contaminated for the purposes of the present study. They include all forensic commitments, regardless of the criminal offense of the defendants. That means that felony defendants are included with the misdemeanants who are the subjects of our current interest. The data came from the mental health system, not the criminal courts, and no information was available about crimes charged.

The problem of data contamination is serious for both NGRI and IST subjects. In 1987, only 5% of the *resident* NGRI population of state hospitals had been charged with misdemeanors, while 24% of the largest subclass of IST subjects were charged with misdemeanors (Ohio Department of Mental Health, 1990, Appendix C.) In the absence of an update of these 1987 data, it is not possible to know the mix of offenses among *admissions, and* whether the mix of offense types had changed between 1987 and 1991.

Results

Hypothesis #1 (The number and proportion of forensic admissions will increase under the Mental Health Act of 1988, compared to the prior period):

Figures #2 and #2 display the pattern of mental health admissions for a 10-year period, eight years before the Act too effect and two years under the Act. These figures show that the change in funding structure had little impact on the number of forensic commitments in Ohio (see Figure 1).

Since the proportion of NGRI commitments is small and stable, IST and NGRI commitments are added to yield a single measure of forensic commitments. The stability of these absolute numbers provides some reassurance that the data contamination described above did not obscure changes in the use of forensic admissions.

The proportion that forensic commitments comprise relative to all commitments also remained stable (see Figure 2). Hypothesis #1 finds no support in these data.

Hypothesis #2 (The number and proportion of forensic commitments will increase statewide with the proportion of ALI 408 funds made available):

As the proportion of ALI 408 funds increased from 10% in 1990 to 20% in 1991, a greater incentive existed for counties to elect these funds and conserve them by making greater use of forensic commitments. Figures #1 and #2 show that the number and proportion of forensic commitments appeared unaffected by the increase in electable funds, providing no support for Hypothesis #2.

Hypothesis #3 (The number and proportion of forensic commitments will increase with the proportion of ALI 408 funds elected by the counties):

Table #1 displays, for each of the ten largest Ohio counties, the admission types and proportion of ALI 408 funds elected. In 1990, though counties could elect up to 10% of these funds, they actually elected an average of 7.6%. Fifteen counties opted out entirely in 1990. Among the ten largest counties forensic commitments ranged from .5% to 13.8% of all public mental hospital admissions. The relationship between proportions of forensic commitments and funds elected in 1990 is displayed in Figure #3. The correlation between proportion of funds elected and proportion of forensic admissions was small and non-significant ($r=.049$).

In 1991 counties could elect up to 20% of ALI 408 funds, creating a potentially greater incentive to save money by choosing the forensic route. Statewide, the counties elected an average of 18.1% of these funds, with 11 counties opting out. Among the ten largest counties, the number and proportion of forensic admissions actually dropped slightly from the previous year. The relationship between proportions of forensic commitments and funds elected in 1991 is displayed in Figure #4. The correlation between proportion of funds elected and proportion of forensic admissions was non-

significant and in the opposite direction from that hypothesized (r=-.290). Hypothesis #2 finds no support in either the 1990 or the 1991 data.

Hamilton County (Cincinnati) is a statistical and programmatic anomaly. With only 4% of the state's population, it was responsible for a vastly disproportionate share of forensic commitments (42% of all forensic commitments in 1990, and 38% in 1991). This extensive use of forensic commitment in Hamilton County did not begin when the Mental Health Act took effect, however. Hamilton County's commitment pattern follows the general historical trend of the rest of the state. The heavy use of forensic commitment in Hamilton County predates the 1988 Mental Health Act by many years (see Figure 5). Clearly, considerations other than funding arrangements drive the policy to use forensic commitments in Hamilton County.

Discussion

The first two years of operation under Ohio's Mental Health Act of 1988 have had no apparent impact on the use of forensic commitments by Ohio's counties. The observed pattern of commitment types has followed a stable trend beginning a decade earlier. This stability has been maintained despite growing financial incentives to counties to make greater use of forensic commitments. Such stability may be reassuring to state mental health officials, and to those naive people who believe decisions in the mental health arena are driven solely by clients' interests; but it is puzzling from an organizational perspective. Several explanations are possible:

(1) The financial advantage of forensic commitment may not have been clear to county mental health officials. This seems unlikely, given the extended discussion about the issue that preceeded passage of the 1988 Act and the great pressure to stretch county mental health budgets during this period of economic hardship.

(2) The magnitude of the financial advantage may be too small for individual counties to warrant changing familiar practices and arrangements with the clinicians and

court officials, whose cooperation would be necessary to secure forensic commitments. The financial advantage of forensic commitments will increase over the next few years, so the incentive to alter traditional practices and organizational relationships will also increase. Changes in these practices may yet occur.

(3) *A forensic commitment may be the most rational way to provide services while conserving county funds, but only from the perspective of county mental health officials.* The decision to commit a person involuntarily is ultimately made by a county or municipal judge, not a mental health official. The processes involved in securing a forensic commitment typically involve the cooperation of a county or municipal prosecutor. A locally elected prosecutor or judge may be aware of the differential impact to the county mental health budget of various types of mental health commitments. The type of commitment obtained has no impact, however, on the budget of the county criminal justice system. The prosecutor and judge therefore are insulated from organizational pressures to prefer one type of commitment over another.

The heavy, but stable, use of forensic commitments in Hamilton County is an interesting example of an unusual choice of alternative dispositions within a local legal culture. The use of forensic commitments is based on long-standing practices of court officials. Commitments to the state mental hospital as IST have long been a way Cincinnati deals with many mentally ill street people who have committed minor legal infractions.

These potential explanations and adaptations remain available for exploration during the next few years, as Ohio continues to decentralize the funding of mental health services.

The Ohio Department of Mental Health has proposed legislative changes to permit county mental health boards the option of electing distribution of ALI 408 funds for inpatient care of people found NGRI and IST (Ohio Department of Mental Health, 1990, p. 36). The consequence of this proposal, should it become law, would be to

eliminate the financial advantage to county boards of forensic admission over regular civil admission.

References

National Institute of Mental Health. Statistical Note No. 199; Expenditures and Sources of Funds for Mental Health Organizations: United States and Each State, 1988. Rockville, MD: U.S. Department of Health and Human Services, 1991.

National Institute of Mental Health. Statistical Note No. 204; Patient Care Episodes in Mental Health Organizations, United States: Selected Years from 1955 to 1988. Rockville, MD: U.S. Department of Health and Human Services, 1992.

Ohio Department of Mental Health. Annual Report for Fiscal Year 1990. Columbus, OH: 1991.

Ohio Department of Mental Health. Locally Managed Services for Persons Committed as NGRI or Incompetent to Stand Trial. Columbus, OH: 1990

Study Committee on Mental Health Services. Implementation of the Ohio Mental Health Act of 1988; Comprehensive Preliminary Report, 1991. Ohio State University. Columbus, OH: 1991.

Table 1.
NGRI and IST Commitments from 10 Largest Ohio Counties

1990

County	Total Admissions	NGRI & IST	NGRI & IST (%)	% ALI 408 Funds Elected
Butler	187	11	5.9%	0.0%
Cuyahoga	2788	37	1.3%	2.1%
Franklin	749	36	4.8%	10.0%
Hamilton	1503	208	13.8%	10.0%
Lorain	220	3	1.4%	10.0%
Lucas	460	32	7.0%	9.1%
Mahoning	641	3	0.5%	10.0%
Montgomery	466	39	8.4%	4.4%
Stark	635	6	0.9%	6.1%
Summit	655	16	2.4%	9.2%
Totals	8304	391	4.7%	7.1%
State Totals	11844	496	4.2%	

1991

County	Total Admissions	NGRI & IST	NGRI & IST (%)	% ALI 408 Funds Elected
Butler	139	3	2.2%	8.6%
Cuyahoga	2844	43	1.5%	20.0%
Franklin	738	40	5.4%	20.0%
Hamilton	1479	174	11.8%	12.0%
Lorain	234	5	2.1%	20.0%
Lucas	403	42	10.4%	20.0%
Mahoning	655	4	0.6%	17.6%
Montgomery	448	42	9.4%	13.4%
Stark	708	7	1.0%	20.0%
Summit	593	21	3.5%	20.0%
Totals	8241	381	4.6%	17.2%
State Totals	11901	453	3.8%	

Figure 1.

Ohio Public Mental Hospital
Forensic Admissions, 1982-1991

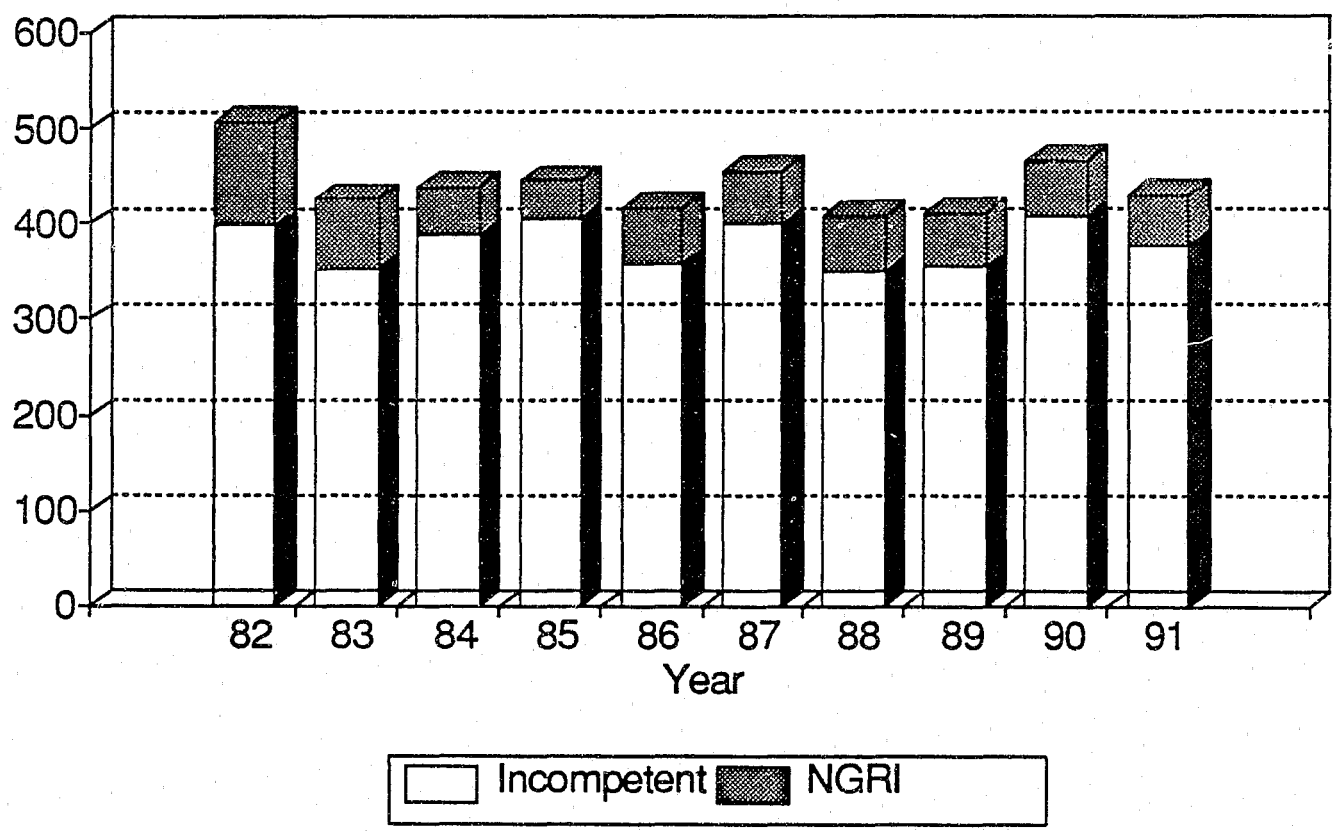

Figure 2.

Ohio Public Mental Hospital Admissions

By Admission Type, 1982-1991

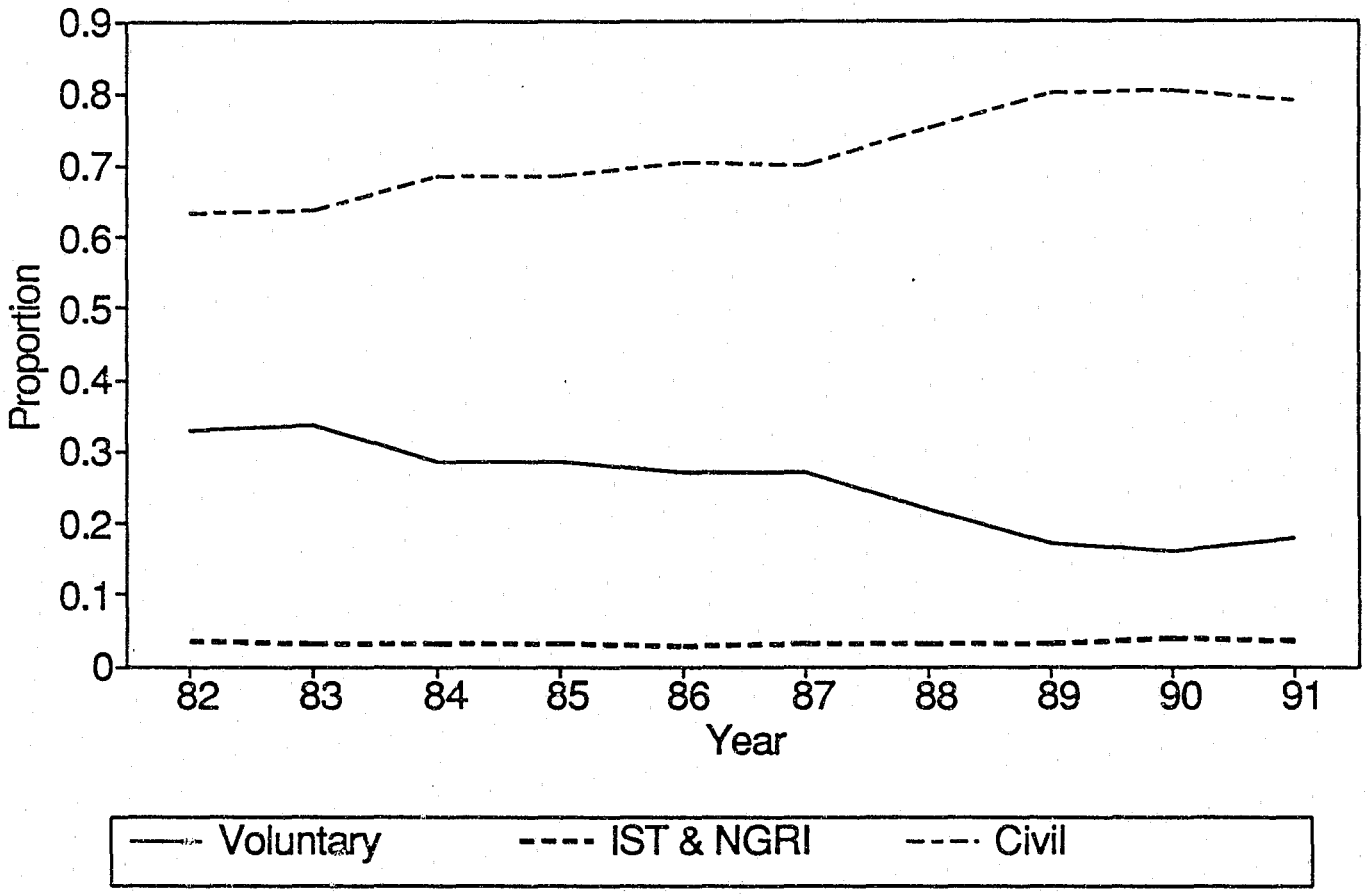

Figure 3.

Proportion of Forensic Admissions

By Proportion of Funds Elected, 1990

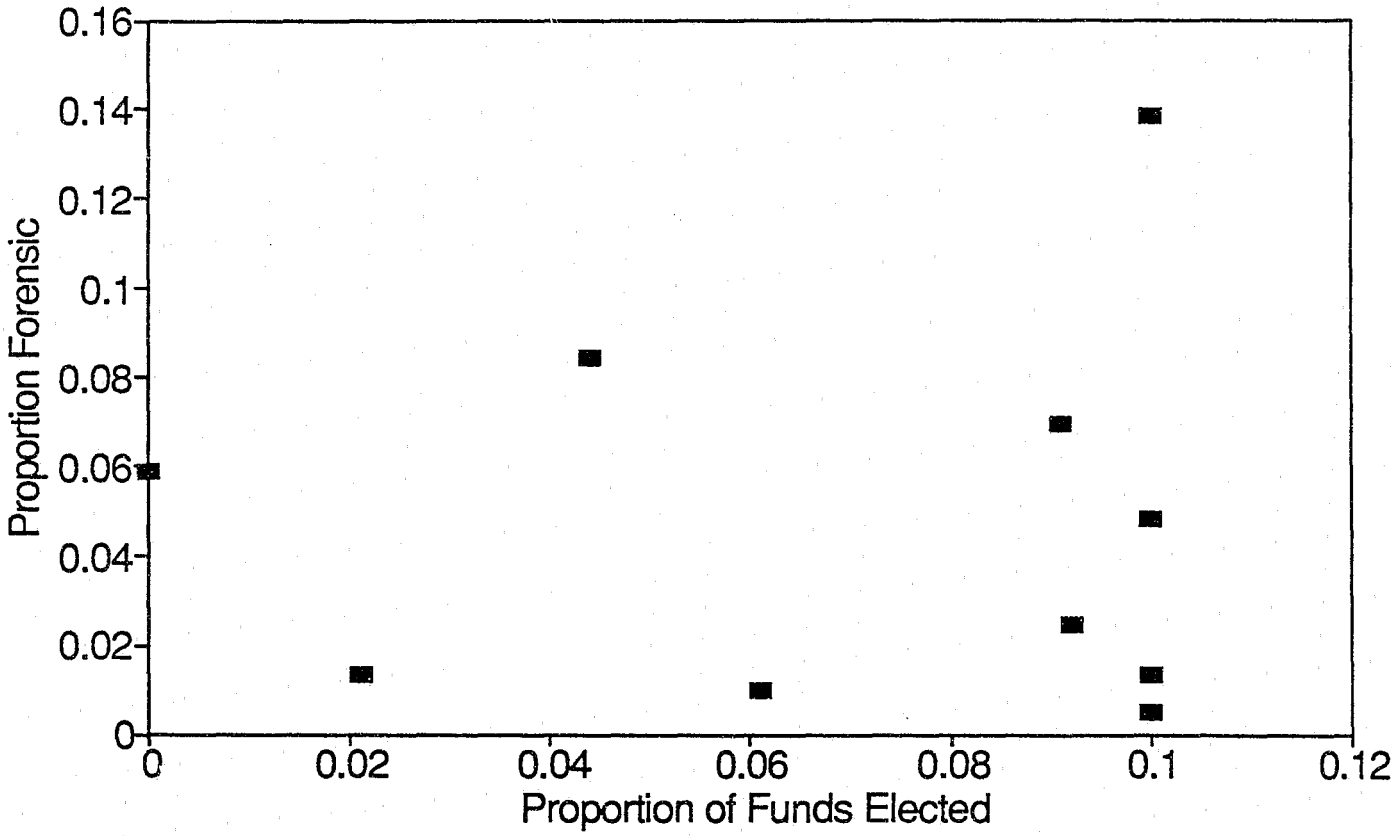

Figure 4.

Proportion of Forensic Admissions

By Proportion of Funds Elected, 1991

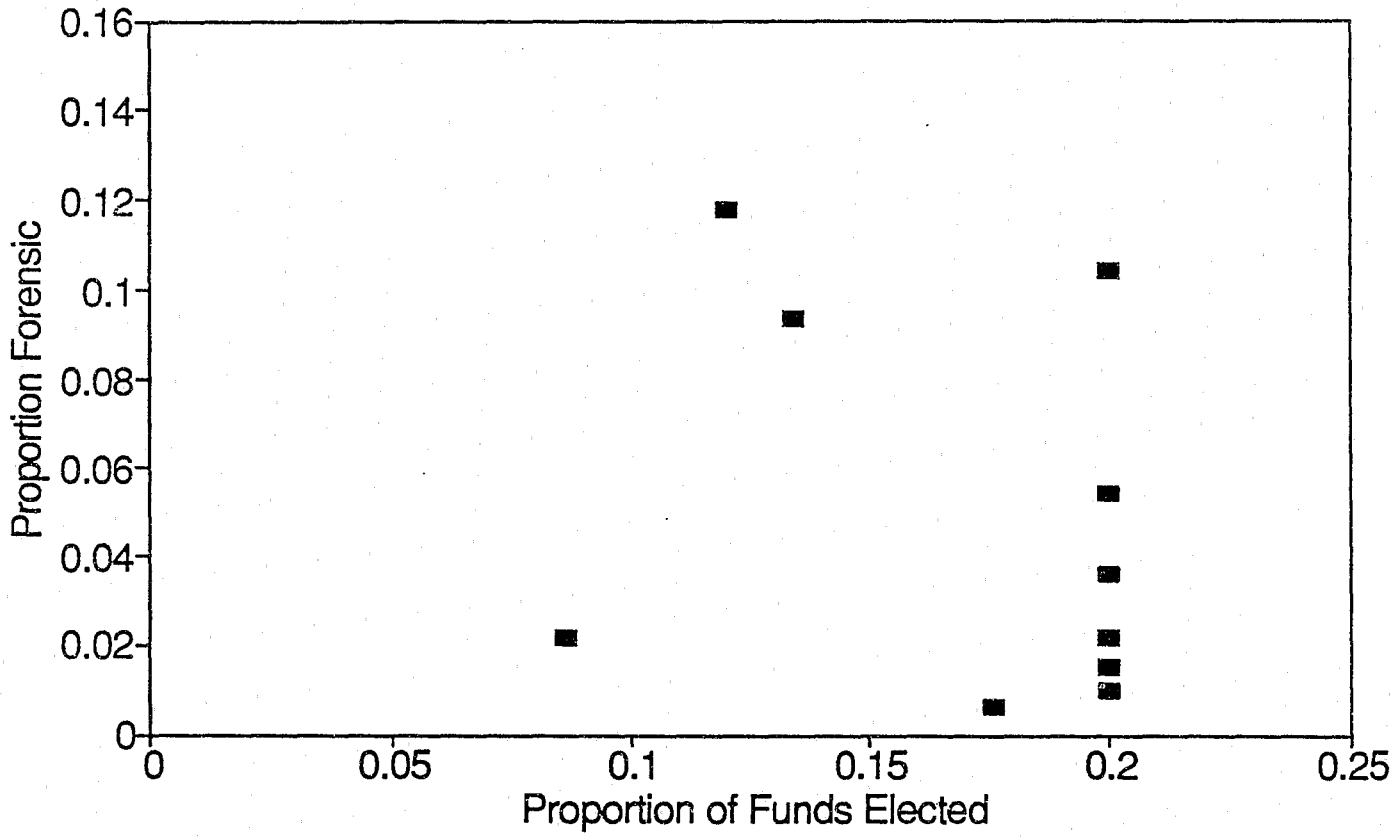

Figure 5.

Public Mental Hospital Admissions

Hamilton County Ohio, 1982-1991