POLICY BRIEF

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Dear Members of the Behavioral Health Committee,

House Bill 249, changing Ohio's laws concerning involuntary commitment (*civil commitment*), has several issues that go against the intended purpose of the legislation to expand services to Ohioans with mental illnesses.

Ohioans and their families need expanded access to mental health treatment in crisis situations. But House Bill 249 expands instances in which people can have their civil rights and right to deny treatment removed before a crisis event has even occurred. This bill does not expand access to services, but rather allows pre-emptive forceful intervention and potential criminalization rather than continuing to further expand mental health crisis resources.

1) The substantial drop in involuntary commitment at Ohio's psychiatric facilities is driven in-part by our lack of available beds in psychiatric facilities.

Data obtained from the Department of Mental Health and Addiction services by Policy Matters Ohio shows that in the last five years, the number of Ohioans forced into Ohio's six psychiatric hospitals has dropped by 66%.[1] From 2019-23, general hospitals were by far the most common source for involuntary commitment referrals, accounting for 8,587 in that time, nearly 60% of the total.[2]

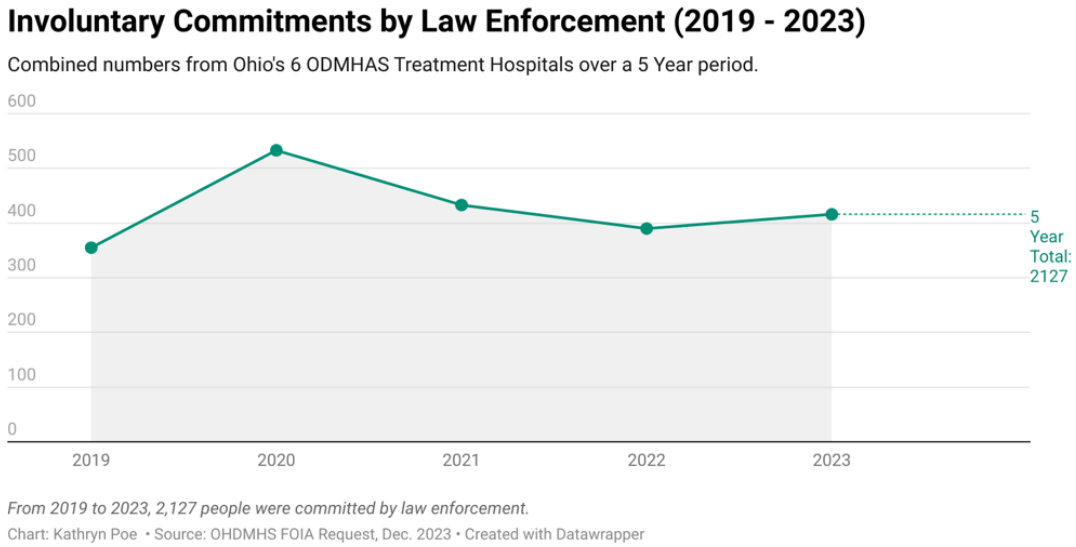
One likely explanation is that Ohio's psychiatric hospitals simply don't have enough room. These hospitals are low on capacity almost entirely because Ohio courts send a relatively high number of people to these facilities for pretrial treatment and assessment to determine if they are competent to stand trial (a practice that is not considered involuntary commitment, and not included in the data).

[1] Data provided by a Freedom of Information Request to the Ohio Department of Mental Health and Addiction Services for 2018 – 2023. For access to the available data, please contact Policy Matters Ohio.
[2] Data provided by a Freedom of Information Request to the Ohio Department of Mental Health and Addiction Services for 2018 – 2023. For access to the available data, please contact Policy Matters Ohio.

As a result, more than 9 of every 10 beds in Ohio's psychiatric hospitals is occupied by someone "sent there by the courts to be restored to competency so they can stand trial."[3] As a result, there is little to no room for Ohioans who need care in other circumstances. If House Bill 249 is enacted, it is unclear where people would go to receive treatment.

2) The lack of a rise in admissions by law enforcement officers in the past 5 years does not indicate a further need to change public policy.

Law enforcement officers made 2,127 involuntary commitments from 2019 - 2023 — 15% of the total commitments. Aside from an uptick in 2020, the annual number of involuntary commitments by law enforcement has remained relatively stable in the last five years.[4] There is no indication based on the available data that there is a sudden increase in law enforcement involvement or a need for additional law enforcement involvement.



3) The lack of publicly available data on involuntary commitment as an evidence-based treatment:

Ohio has six psychiatric hospitals that manage inpatient involuntary commitment cases, each covering a different region: Northwest, Northcoast, Heartland, Twin Valley, Appalachian, and

[3] See The Columbus Dispatch (2024): Ohio Seeks Fixes to Mental Health in Jails: https://www.dispatch.com/story/news/state/2024/02/27/ohio-seeks-fixes-to-jail-mental-health-crisis-and-lack-of-psych-beds/72761274007/

[4] See footnote 1

Summit.[5] From 2019-23, these six hospitals reported **14,405 admissions** for involuntary commitment due to a mental health or substance abuse disorder.[6]

Additional data reporting is needed to improve tracking of involuntary commitment and its impact on wellbeing. In Ohio, it's unknown how many people admitted to general hospitals without being transferred a psychiatric facility, the race and sex of patients committed, and the number of patients who receive voluntary out-patient services for a mental health crisis.

Involuntary commitment is difficult to track for many reasons, but specifically because the definitions of what counts as civil commitment are different from state to state. Even national surveys have noted the notable lack of data on the practice.[7]

4) Evidence supporting involuntary commitment as a treatment is mixed, and evidence-based treatment and screening for other factors such as domestic violence and abuse are not currently required in Ohio.

Involuntary Commitment has mixed results across literature. The effectiveness of the practice is highly dependent on condition, time of commitment, in-patient vs. outpatient use, and other factors like race, sex, and socioeconomic class. Most researchers agree that more research needs to be done in this area and that commitment should only be used as a last resort.[8]

Most of the controversy surrounding the issue is centered around the question of whether mentally ill patients are competent to make their own medical decisions. The assumed inability of patients to make choices in-line with their 'true' or typical wishes is the foundation for most arguments in favor of commitment. However, studies have suggested that people with mental illness still maintain decision-making capacity in many situations but may not be taken seriously during a crisis.[9]

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[5] For an overview of Ohio's System of Hospitals, see this fact sheet from OH MHAS: https://mha.ohio.gov/static/AboutUs/MediaCenter/PublicationsandFactSheets/OhioMHAS-Hospitals-2019.pdf

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[7] Lee, G., & Cohen, D. (2021). Incidences of involuntary psychiatric detentions in 25 US states. *Psychiatric services*, *72*(1), 61-68. Can be found at: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900477
**Ohio was not included in this survey because of the lack of available data*.

[8] Morris, N. P., & Kleinman, R. A. (2023). Taking an evidence-based approach to involuntary psychiatric hospitalization. *Psychiatric Services*, *74*(4), 431-433. Can be found at: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.20220296

[9] Owen, G. S., Szmukler, G., Richardson, G., David, A. S., Raymont, V., Freyenhagen, F., Martin, W., & Hotopf, M. (2013). Decision-making capacity for treatment in psychiatric and medical in-patients: cross-sectional, comparative study. *The British journal of psychiatry : the journal of mental science*, *203*(6), 461–467.

In Ohio, people being evaluated for involuntary commitment are not required to be screened for emotional, physical, or sexual abuse or domestic violence. There is also no requirement that involuntary treatment for a mental health disorder or substance abuse disorder be evidence-based treatment.

Ohio's crises care gap for mental health services is not an unsolvable problem. Ohio has options to close the crisis care gap in services by implementing policies such as:

- Requiring evidence-based practices for involuntary treatment and substance abuse disorder treatment in Ohio.
- Requiring abuse screening, including domestic violence and other kinds of emotional, sexual, and physical abuse, for patients being evaluated for commitment.
- Requiring improved data collection regarding mental health services and commitment, including the number of people admitted to general hospitals pending commitment, the sex and gender of individuals, and the number who are determined not to need intervention after evaluation.
- Expanding access to Mental Health Services for people with certain psychiatric conditions at family members' request during a crisis period, or after a mental health emergency, through developing an 1115 Medicaid Waiver.[10] Despite the Federal ban on Medicaid services while incarcerated, an 1115 waiver could be applied to include inmates who are close to release to ensure support after their release, like requests made by states like Vermont, Utah, Montana.[11]
- Investing in an expansion of Mental Health Services in Ohio's prison system, both for adults and youth, and consider placing a cap percentage on the number of beds in Ohio's six psychiatric institutions that may be used for the criminal legal system. This would place a hold on beds for the public, while allowing the beds to be used for the criminal legal system in some circumstances.

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https://pubmed.ncbi.nlm.nih.gov/23969482/ and Feiring, E., Ugstad, K.N. Interpretations of legal criteria for involuntary psychiatric admission: a qualitative analysis. *BMC Health Serv Res* **14**, 500 (2014). Can be found at: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-014-0500-x

[10] Information on 1115 Medicaid Waivers: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

[11] Haldar and Guth (2021). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. KFF Health News. Can be found at: https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/

[12] Van Lier (2022). Creating a Care Response in Cleveland. Can be found at: https://www.policymattersohio.org/research-policy/quality-ohio/justice-reform/creating-a-care-response-model-in-cleveland-for-those-in-crisis

- Continuing funding for Mental Health Stabilization Centers in Ohio is key to expanding the availability of out-patient services and crisis care. In the 132nd General Assembly (HB 49), a line item was added under Continuum of Care Services that established 1.5 million per year for Mental Health Crisis Stabilization Centers to be built in each of the six regions that were covered by the psychiatric hospitals to provide additional mental health stabilization services. Programs like this are essential to providing out-patient community support programs.
- Creating a Community Crisis Projects Granting program using General Revenue Funds to support community led non-police crisis initiatives all over the state. For example, programs are underway in Cleveland that could be expanded using State resources.[12]