

Fiscal Decentralization of Public Mental Health Care and the Robert Wood Johnson Foundation Program on Chronic Mental Illness

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THE PERFORMANCE OF LOCAL PUBLIC MENTAL health systems has been repeatedly criticized over the past 15 years (Mechanic and Rochefort 1990). Local mental health systems have fallen short of expectations along several dimensions of performance set by federal and state policy. The most frequently cited disappointments are (1) the emphasis on expensive and restrictive state mental hospital care (Frank 1991); (2) the neglect of care for individuals with the most severe mental disorders (U.S. General Accounting Office 1977; National Institute of Mental Health 1991); (3) the fragmentation of services; and (4) the reluctance to adopt innovative treatment technologies (Stein 1991; Mechanic 1991). Organizational change has been recommended to remedy this state of affairs; the innovation that has received the most attention is the creation of community local mental health authorities (LMHAs), particularly in urban areas (Mechanic 1991). The purpose of the Robert Wood Johnson Foundation (RWJF) Program on Chronic Mental Illness (PCMI) was to evaluate the performance issues listed above by establishing central mental health authorities in selected sites around the country.

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LMHAs are similar in concept to "special districts" for managing the delivery of public education, water, and transportation services (Bollens 1969). The idea behind LMHAs was to create a single local public authority that is responsible for the clinical, administrative, and financial aspects of public mental health care (Shore and Cohen 1990). Such an organizational structure means that state governments delegate substantial managerial responsibility for mental health care to localities. Delegating authority to LMHAs has been posited as a way to reduce fragmentation of services for the severely mentally ill and to increase local flexibility in their use of public monies for the delivery of mental health services. This puts the budget for local mental health care in one set of hands. The hope is that this arrangement will avoid the cost shifting, bureaucratic duplication, and transaction costs associated with the current fragmented mental health system. While increasing local control and responsibility, LMHAs decrease the state's control and responsibility. Thus, states that choose decentralized systems must simultaneously select regulatory and financing mechanisms that will enable localities to maintain adequate and cost-effective services for the mentally ill.

In this article we review three sets of economic issues that accompany the creation of LMHAs, drawing on data from the RWJF program sites in Ohio and Texas to provide empirical evidence. Because the goal of the RWJF program was to establish LMHAs, these issues were clearly central in evaluating the program. First, we consider whether the state designed its local mental health system with the aim of increasing efficiency or of enhancing its own political gains. Second, we examine state fiscal policies for reducing use of public mental hospitals and allowing new dollars to follow former state hospital patients into community treatment programs. Third, we look at the consequences of redistributing control and responsibility for managing public mental health care to the local level: localities may experience an increased financial burden, and the state's role may be transformed from one of allocation to one of distribution. That is, as it plays a diminished part in general funding, the state may become more active in guaranteeing equity.

This article consists of six sections. In the second section we discuss the evolution of LMHAs. The role of the state in designing and financing LMHAs is outlined in the third section. The fourth section is an analysis of the distributive role of the state. The issues are discussed and summarized in the final section.

The Historical Evolution of Local Mental Health Systems: A Profile

Decentralization of mental health systems has been the policy of states since the 1950s. Beginning in 1946, the federal government, through passage of the National Mental Health Act, began making grants to states for the purpose of developing local, community-based, outpatient mental health treatment programs. Initially the grants were small. For example, in 1948, \$3.5 million was distributed to the states (Grob 1991). There were two responses to this grant program: (1) the number of outpatient clinics receiving support from state governments rapidly grew, and (2) states began developing mechanisms to manage local mental health care (Grob 1991). States like New York and California initiated closed-ended matching grants to localities (cities and counties in New York and counties in California) that established community mental health treatment programs. Localities in both states responded quickly to the new incentives and developed local mental health programs. New York and California both began their grant programs by specifying a 50-50 state-to-local match, and New York has continued this practice. In California, however, the match was changed to 75-25 in 1963 and 90-10 in 1969. The 90-10 match remained in place until 1991. The differences in matching schemes may imply different levels of interjurisdictional spillover effects in the two states.

The passage of the Community Mental Health Centers (CMHC) Act of 1963 injected new federal money into the development of community-based mental health treatment programs. Unlike the National Mental Health Act, the CMHC Act bypassed state governments and created comprehensive clinics to serve "catchment areas" with populations of 75,000 to 200,000. The decision to exclude state government from management of CMHCs had several consequences; most significantly, efforts to reduce the size of state mental hospital systems were not coordinated with the services delegated to CHMCs. A related issue was the considerable divergence between the populations selected for treatment by the state government and those treated by CMHCs (Dorris and McGuire 1981): CMHCs thus devoted relatively little effort to treatment of the most severely mentally disabled and focused instead on treating new populations with relatively mild disorders. This history highlights a basic conflict between the state mental health policy goals and the behavior of

local mental health systems. The divergence of policy goals is at the heart of what we view as the principal agent problem in public mental health (see Gaynor [1990] for an overview and Frank and Gaynor [1991, 1993b] for theoretical treatments of this issue).

In the early 1980s, most control of community-based mental health programs was returned to the states. The creation of block grants by the Reagan administration served both to reduce federal commitments to community-based mental health care and to provide states with greater authority over use of federal funds (Rochefort and Logan 1989). The result is that community mental health centers have become more dependent on state funding policies. For example, in 1991 CMHCs surveyed by the National Council of CMHCs received 41 percent of their revenues from state government, 7 percent from block grants (this includes both the alcohol, drug abuse, and mental health [ADM] and social services block grants, which provided 5 percent and 2 percent of revenues, respectively), 16 percent from Medicaid, and 20 percent from local government and user fees. Thus, 64 percent of CMHC revenues are currently controlled by the states (state, block grant, and Medicaid funds). One might expect this shift in funding control to lead to a closer alignment of the goals of state government and local public mental health systems. Such realignment has been impeded by the structure of financial incentives, which have not been greatly altered despite a considerable shift in the source of funds (Gaynor 1990; Frank and Gaynor 1991, 1993b). For example, in most states, public mental hospitals can be used by local programs "free of charge," thereby creating an incentive to overuse these resources.

Lessons on the Role of the State

The U.S. federalist system of government provides states with two roles in determining the structure of their mental health systems. First, because state governments choose the constitutional structure of local governments, they have a decisive voice in structuring local mental health systems. This is not to suggest that local governments are entirely the creatures of state authority, but rather that the states set the ground rules. Conversely, local feedback or pressure can influence the state's choice of local structures. Second, states act as payors/providers in the service systems. Decisions at the state level concerning forms of financing

and their own provision of mental health services profoundly affect the structure of local mental health systems.

In this discussion, we will confine ourselves to issues relevant to the RWJF program, rather than exploring the diverse state roles. We will review the lessons to be drawn from these two areas of state activity.

State Choice of Organizational Form for Local Mental Health Systems

Two issues predominate when state governments choose the organizational form of local public mental health systems:

1. What organizational forms foster efficiency?
2. What determines the choice of organizational form for local mental health systems—for example, is efficiency a consideration? Do states design local mental health systems for their own benefit or that of the localities?

States managing public mental health care must deal with the tension between having to be accountable for the performance of mental health providers and recognizing that variations in local conditions mean that the activities of local mental health providers are perhaps best managed locally. Accountability is especially important because of the substantial resources states direct toward community treatment of the mentally ill. For example, the state of California spent \$1.2 billion in state general funds on mental health care in 1990. Of that total, \$778.9 million was allocated to community treatment programs (State of California 1991). Virginia, a much smaller state, spent \$250 million on mental health in 1990; of this, \$68.3 million went toward community treatment (the remainder was applied to institutional treatment and central administration).

Accountability is important to states as well because, in the mental health area, the actions of one locality can affect others. The view that the mentally ill are undesirable members of a community stems in part from the stigma of mental illness (President's Commission on Mental Health 1978), but it also derives from the fact that a substantial portion of the homeless population is mentally ill and evidences higher rates of antisocial behavior (Link, Andrews, and Cullen 1992). Thus, communities have a strong incentive to pursue strategies that minimize the num-

ber of mentally ill individuals in residence. The best way to accomplish this is to withhold publicly financed treatment services for severe mental illnesses. The state therefore plays an important role in ensuring that communities make available a minimal level of service through, for example, the use of matching grants.

The literature on public administration (Banfield 1969) identifies four main goals in the creation of “special districts” (a direct analog to LMHAs):

1. political accountability
2. professional management
3. responsiveness to state government
4. local autonomy.

It is clear that goals (1) and (2) conflict, as do (3) and (4). Both conflicts can be viewed within a principal-agent framework.

The classic principal-agent conflict is characterized by the divergent preferences of the principal and agent and by asymmetric information that permits the agent to pursue goals that are privately beneficial but publicly detrimental. Community mental health policy for a state government fits this formulation well. The history of mental health care in the United States reflects the conflict between state policy goals and local preferences. We do not wish to imply that state governments are benevolent. Recent U.S. mental health history is also a record of attempts by state government to shift costs to both federal and local governments. Because it is difficult to observe and verify the costs and quality of local services and the mental health needs of local populations, state government must balance accountability of local mental health systems against administrative costs. For example, small states may be able to achieve a high degree of accountability at a modest cost by central administration of direct contracts with providers. The costs of this kind of administration are likely to expand for larger states that require more providers.

Delegation thus appears to be most advantageous when services are complex, requiring a large number and variety of contracts that are expensive and difficult to administer. Delegation also may be appealing if considerable variations in local conditions within the jurisdiction of the principal (a state in this case) demand close monitoring and continual communication with many different kinds of organizations, assuming that complete contracts cannot be written.

In addition to considering "social efficiency" in creating organizational structure, state governments may also decide matters on the basis of "private efficiency." State governments may respond to voter misperceptions or institutional rigidities by minimizing on-budget costs, even if such action results in higher total social costs. For example, if the political system enacts tax policies that do not permit optimal expenditure levels on mental health, bureaucrats may then shift costs in order to expand their budgets to efficient levels. It has been suggested that the expansion of "special district governments," such as LMHAs, can be explained by a desire to circumvent debt and spending limits on state and local governments (Zax 1988). Because state mental health expenditures typically constitute between 2 and 6 percent of state budgets, and total local expenditures range from 10 percent to more than 100 percent of state expenditures, the financial consequences of cost-shifting behavior can be considerable. LMHAs are attractive to states because they can make claims on a wide range of revenue sources through their ability to levy taxes and incur debt.

In another article (Frank and Gaynor 1993a), we attempt to test these hypotheses concerning how states choose the organizational form for local mental health systems. Using data from 48 states, we find that contracting costs appear to be important, a fact that is consistent with the notion that efficiency considerations are important to the structure of local mental health systems chosen by states. We also find that states are influenced by their own private agendas, leading them to create LMHAs partly to avoid tax and debt limits by shifting costs to localities. Thus, states appear to design local mental health systems both to achieve efficiency and to pursue their own goals. LMHAs therefore must be evaluated in the context of their state environment.

The State as Regulator/Payor

States determine the structure of local mental health systems in their capacities as payor, direct contractor, and owner and operator of facilities (see Frank and Gaynor [1993a] for a typology and more detail). We will not elaborate on these functions here because they do not correspond to activities at the RWJF program sites.

Starting in the 1980s, as federal financing of mental health decreased, state financing became a more important source of funds for public

mental health care. In 1986, approximately 54 percent of expenditures in the specialty mental health sector were controlled by state governments, either directly or indirectly (Frank 1991). The two major sources of state-controlled funds for the local public mental health sector are transfers of funds by state governments, both directly and through Medicaid funding. We illuminate the issues associated with state transfers to localities by viewing them through the prism of the experiences of two states that had sites participating in the RWJF project.

In 1986 about 36 percent of direct state expenditures on mental health care (excluding Medicaid) consisted of transfers to LMHAs or local providers (Frank 1991). The trend in the public mental health sector has been toward more decentralization of decision making, a trend that carries with it expanded "contractual" arrangements between state and local governments. Increasingly, states have used the terms of financial transfers to localities as tools for pursuing their policy objectives vis-à-vis provision of community mental health care and use of the state hospital.

One of the most prominent criticisms of the public mental health system is that "dollars do not follow the patients" (Frazier 1988). Although roughly 75 percent of public mental health care is provided in the community (National Institute of Mental Health 1987), somewhere between 57 percent (Frank 1991) and 65 percent (National Association of State Mental Health Program Directors 1990) of state dollars are spent on care in state mental hospitals. Although no one can clearly state what the "right" proportion of expenditure on state mental hospitals is, the consensus is that the current percentage is too high. This criticism is buttressed by the observation that the states usually described as having model public mental health systems (e.g., Wisconsin, Rhode Island, Vermont, and Colorado) also spend far less than the national average on state mental hospitals.

A second major criticism of the public mental health system is that too few resources are devoted to the care of the most severely ill (U.S. General Accounting Office 1977). Community programs facing excess demand while trying to maintain strong professional staffs are not inclined to focus attention on the severely mentally ill. Patients with severe disorders are often difficult to manage clinically and require a broad range of human services in addition to mental health care.

Public funding of individual providers of mental health services is primarily accomplished via explicit or implicit contracting with either state or local government. The specific methods of transferring funds to local

providers commonly include line-item grants (where program activities are defined), grants based on projected volumes and unit costs, and historical budgets with cost-of-living increases. None of these arrangements gives providers a strong incentive to adopt innovative methods of organizing treatment services. Instead, these grant mechanisms tend to perpetuate historical patterns of care. In particular, line-item grants and those specifying volumes and unit costs tend to require the provision of certain patterns of service in order to meet the terms of the grant allocations. Thus, so long as the volume of services is close to the projected levels and complaints from clients are not extreme, providers are unlikely to incur financial penalties. Even in states with strong quality-assurance programs, the focus is generally on record keeping and monitoring the types of activities carried out by program staff, not on the nature of care received by individual clients.

In sum, divergent goals and difficulties in measuring and monitoring system performance allow local programs to pursue agendas that differ from those of state government, which pays for most of the care. One way to motivate local mental health programs (the agents) to realign their objectives is to exploit the financial incentives that govern their exchange with the principals.

We will turn to an exploration of some innovative attempts initiated by the RWJF demonstrations in the states of Ohio and Texas to solve these problems, and we will discuss the lessons that can be learned from these efforts.

Mechanic (1989) has observed that the mental health community has focused its financing policy on block grants and Medicare. Although these are important sources of support for mental health care, their total dollars and breadth of impact are secondary. State governments have available to them the important policy lever of intergovernmental transfers to local mental health programs (including contracts with individual providers). These tools can be used to counter criticisms of the public mental health services system.

In order to achieve the primary policy objectives of reducing the emphasis on institutional care and increasing the resources devoted to community care of individuals with severe mental illness, the current economic incentives of treatment patterns must be turned around (see Gaynor [1990] and Frank and Gaynor [1991, 1993b]). In most states, local mental health providers view the state hospital as a "free good."

Community programs neither lose nor gain financially according to their use of state mental hospitals. In fact, they often benefit because they do not have to treat difficult and costly patients. Thus, they have an incentive to refer the most difficult clients to state mental hospitals. At the same time, because the relationship between treatment and mental health outcome is uncertain, and because it is difficult to observe patient types, state policy makers cannot ascertain the "right" number of public mental hospital beds.

Capacity constraints on the number of beds have been used in California and Colorado. Yet because the "right" number is not known, choosing the wrong number of beds may be costly both economically and politically. The use of capacity constraints would require substantial shrinking of state mental hospital systems over a short period of time, often a politically difficult feat (Frank and Welch 1982).

One alternative to capacity constraints that would offer a more gradual and less visible approach to public hospital system shrinkage is the use of the incentives contained in intergovernmental (state-to-local) transfers. Another is for the state to contract directly with providers or to engage in offering services itself. Making the local mental health program fiscally responsible for the cost of using the state hospital will move the level of hospital use toward "socially efficient" patterns of treatment that reduce use of state hospital care. Under such schemes, local programs would be allocated budget increases equal to the costs of their traditional use of state hospitals, making the system budget neutral in the long run. In the short run, state government may have to permit increased mental health expenditures in order to smooth the phase-down of state hospitals and enable communities to invest resources in developing community programs.

Given evidence that localities and providers prefer to avoid treating severely mentally ill clients in community programs (Segal, Baumahl, and Moutes 1980; U.S. General Accounting Office 1977), requiring localities to bear the costs of state hospital treatment will lower the use of hospital care, but it may not lead to efficient spending on resources for the most severely ill individuals because of the localities' desire to avoid treating these cases altogether. In order to create a positive incentive for treating this population, localities could simultaneously be paid for treating severely ill individuals and taxed additionally for their use of mental hospitals (Frank and Gaynor 1991, 1993b).

Two of the RWJF site states decided to use intergovernmental transfers to create financial incentives for altering the patterns of service utilization in the public sector (Taube and Goldman 1989; Gaynor 1990). The cases we discuss below illustrate two questions:

1. Which set of incentive arrangements is most powerful?
2. How might local programs respond to the incentives in performance contracts, and what types of incentives are most effective?

The Lesson from Ohio. Ohio has recently instituted important innovations in the public financing of mental health services. The Ohio Mental Health Act of 1988 took effect in July 1989. Two key components are particularly relevant:

1. a mechanism for making the local mental health authority bear the consequences of state hospital utilization
2. an existing subsidy program for treating severely mentally disabled patients in the community

The local mental health authority in Ohio is a county board (or sometimes a multicounty board) acting as a quasi-public agency that is invested with the power to directly levy a property tax to fund mental health services. This tax is voted on by county referendum.

State Hospital Funding Innovation. Over a six-year period a block grant is being phased in that will make the locality responsible for all costs of state hospital care. The amount of the block grant to the local board is set relative to the historical use of the state mental hospitals by residents of the geographic area for which the board is responsible. The local mental health board is charged the average cost of a day of hospital care for each day of care received by residents of its area.

Local mental health boards since 1987 have been given a bonus payment linked to the number of patients they enroll in their treatment programs who are classified as severely mentally disabled according to criteria established under a certification process. These criteria are consistent with definitions of severe mental illness that are currently in use (Goldman, Gatozzi, and Taube 1981; Schinnar et al. 1990).

Although the Ohio system has not been fully phased in, some data have emerged from its initial period. Note that there are two groups of

local mental health authorities in Ohio: those that participated in the Mental Health Act of 1988 and those that did not. Table 1 presents data on state hospital days for all LMHAs, participating LMHAs, and nonparticipating LMHAs, and figure 1 illustrates these same data. Prior to implementation of the Mental Health Act of 1988, there was a modest downward trend (annual reductions ranging from 2 percent to 5 percent) in the total use of state hospital care in the state. During the first year for which localities faced new financial arrangements with the state (1990 and 1991), there were substantial reductions in the total number of days of state mental hospital care (15.6 percent and 14.8 percent, respectively).

A comparison of the participating and nonparticipating LMHAs suggests that the changes in overall inpatient days probably overstate the impact of the new financial incentives. In 1989 the difference was seven percentage points (17.5–10.5). Therefore the state's interest in reducing

TABLE 1
Trends in State Mental Hospital Days and Number of Severely
Mentally Disabled Enrolled in Ohio

	1986	1987	1988	1989	1990	1991
State mental hospital days per 100,000 population ^a						
All boards	10,236	10,213	10,143	9,841	8,308	7,078
Percent change		-0.2	-0.6	-3.0	-15.6	-14.8
Participants ^b	10,983	10,805	10,360	9,941	8,203	[7,423]
Percent change		-1.6	-4.1	-4.1	-17.5	-
Nonparticipants	8,341	8,712	9,592	9,588	8,573	[5,876]
Percent change		+4.7	+10.1	-0.0	-10.5	-
Number of severely mentally disabled enrolled per 100,000 population	228.73	229.68	274.30	320.44	323.83	
Percent change		+0.4	+19.4	+16.8	+1.1	-

^a The days per 100,000 population figures are population-weighted averages of the days per 100,000 population for each board.

^b Participants and nonparticipants for the years 1986–90 are classified by whether those boards participated in 1990. The 1991 figures are for actual participation status in 1991. *Source:* Ohio Department of Mental Health.

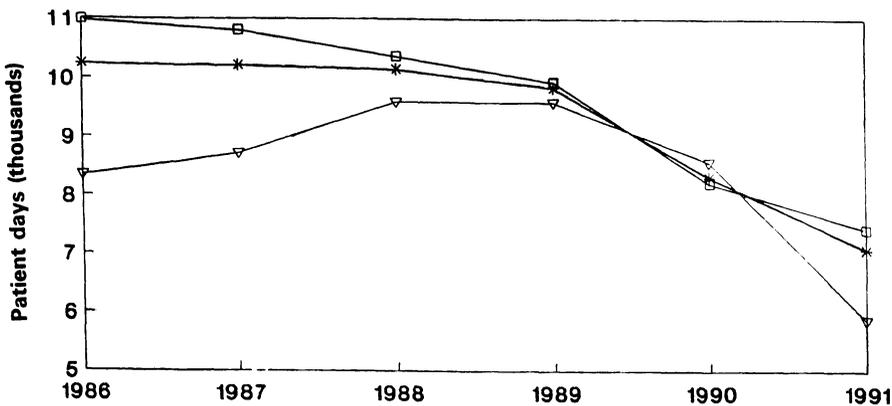


FIG. 1. State mental hospital days in Ohio. —*—, all boards; —□—, participants; —▽—, nonparticipants.

Source: Ohio Department of Mental Health.

state hospital use appears to have influenced the behavior of all boards. The financial incentives, however, appear to have had a significant incremental effect beyond the general trend. During fiscal years 1990 and 1991, only 10 percent and 20 percent of the historical use of state hospitals was transferred as a block grant, which meant that the amount of "at risk" money was relatively small. The block grant rose to 40 percent of the historical use in 1991 and 60 percent in 1992. Thus the incentives are growing and will probably lead to larger reductions in subsequent years. This may not happen if the capacity for substitution peaked in the early years. Alternatively, boards may have anticipated the increased incentives and responded in advance. Although these descriptive analyses do not control for many factors that influence state hospital utilization, in some of our other work multivariate statistical analyses reveal similar patterns (Frank and Gaynor n.d.).

Existing Subsidy. The incentive to expand care to the severely mentally disabled also appears to have elicited a strong supply response from local mental health authorities. The number of clients classified as severely mentally disabled enrolled in community programs rose from 229 per 100,000 population prior to the new financial incentives to 320 in the period subsequent to the policy change. (These data appear in the fourth row of table 1 and in figure 2.) The change in enrollment represents an increase of 34 percent during the initial five-year period of the policy. Without controlling for other relevant factors we cannot ascribe

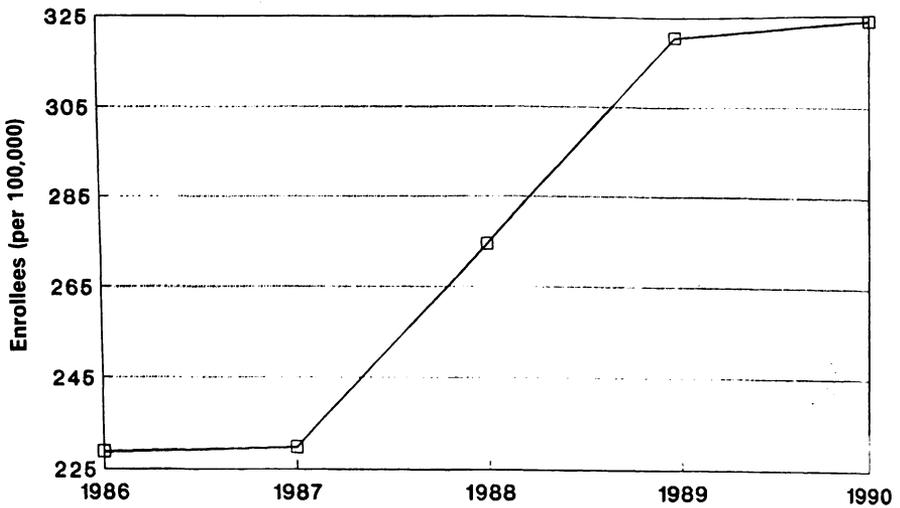


FIG. 2. Number of severely mentally disabled enrolled in Ohio per 100,000. Source: Ohio Department of Mental Health.

the entire enrollment change to the policy, but the pattern is certainly consistent with its having a significant impact. Again, our other work found similar patterns in multivariate analyses (Frank and Gaynor n.d.).

It should be noted that the RWJF sites in Ohio did not respond as strongly as other boards to the financial incentive to enroll severely mentally disabled individuals. Upon investigation we discovered that the RWJF sites did not pass along the financial incentives to their providers via the contracting process for reasons that are not clear. One possible explanation may be the large number of new policy changes concurrently taking place at the RWJF sites.

The financial incentive linked to the severely mentally disabled was based on *enrollment* and not treatment. Some data reported by the Ohio Department of Mental Health offer further insight into the nature of the supply response. Roth et al. (1991) analyzed a sample of 4,346 severely mentally disabled clients in Ohio drawn between July 1988 and June 1989. Roughly 48 percent of the sample received less than eight hours of mental health services per year. Another 23 percent of the sample received about four hours of medical services per year. These data suggest that a significant portion of individuals certified as severely mentally disabled in the state of Ohio received minimum levels of treatment, which is consistent with program incentives but contrary to its intent.

Because we do not have information on treatment prior to the subsidy program, we do not know if treatment decreased after the subsidy was implemented; it may have already been at minimal levels.

The Lesson from Texas. The state of Texas has also instituted an incentive scheme, called the 35.50 program, which is linked to intergovernmental transfers of state mental health dollars. Each local program receives \$35.50 for every day of reduced state mental hospital utilization below a historically based target. The amount of the bonus was altered in 1987 to avoid penalizing local programs that had historically been low utilizers of state hospital services. Thus, local mental health programs receive a bonus for "good performance." The size of the bonus is small, however, and no financial penalties are attached to failing to meet the target level of state hospital utilization. The Texas program therefore offers a small carrot and no stick. The state of Texas experienced a 25 percent drop in the average number of residents in state mental hospitals between September 1983 and September 1987 (Ganju and Bouchard 1990). However, the quarterly rate of decline in the average number of state hospital residents *fell* in the first quarter of 1985, after the 35.50 program was implemented, raising doubts about how much the incentive system actually reduced state mental hospital use. Figure 3 presents the time trend in the utilization of state hospital days per capita following initiation of the 35.50 policy in 1984. In the two years following enactment of the policy, total days of public inpatient care per capita declined 25 percent. We estimate that this is roughly double the secular downward trend that amounted to an approximately 13.6 percent decline in days from 1984 to 1986. It is consistent with a significant impact of financial incentives on LMHA behavior.

The Distributive Function of State Government

Decentralization of clinical, financial, and administrative authority for community mental health services from states to LMHAs shifts the roles of both local and state government. Local governments play a more active role in program design and have more direct responsibility for the mental health of the population. Decisions about program design often require new financial commitments by localities. We have already touched on the possibility that decentralization is accompanied by cost

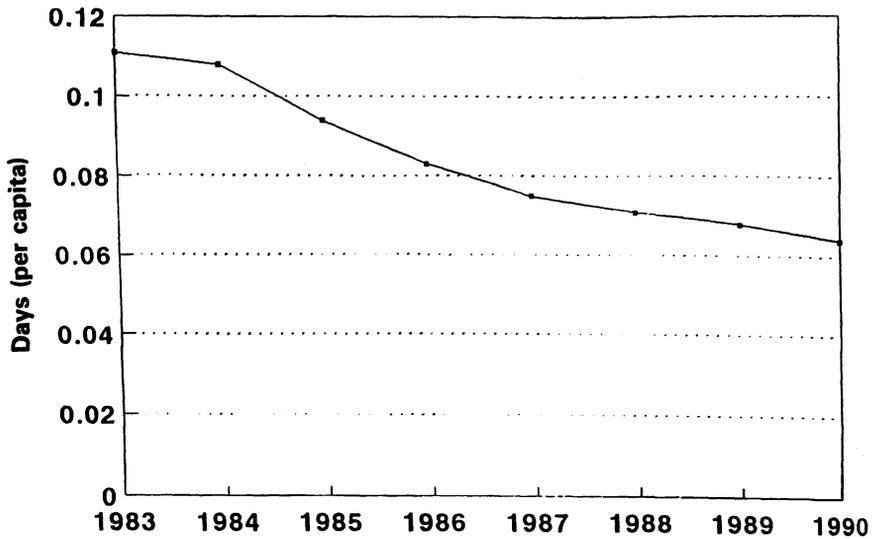


FIG. 3. State hospital days per capita in Texas following the initiation of the 35.50 policy.

Source: Texas Department of Mental Health and Mental Retardation.

shifting. There is some evidence that this is the case. In addition, as the state's role diminishes, it is less equipped to reduce spillover effects across communities. If the mentally ill are viewed as undesirable because of their behavior and/or their concomitant public expense, localities may encourage them to go elsewhere, either passively, by providing too few services, or actively. The incentive to do so rises as the burden on localities increases and grows less equal. So far we have discussed the state's role in achieving efficiency and pursuing pecuniary objectives. The state also has a part to play in affecting the distribution of income.

State actions regarding financing policy may affect not only the overall level of expenditures on local public mental health care, but also the distribution of expenditure within a state. In what follows, we examine inequality in mental health expenditures across local districts in Ohio and Texas during a period of decentralization.

Ohio

Each of the local mental health boards in Ohio is a quasi-independent special district. This means that the boards have the authority to levy property taxes to fund mental health services; thus they have a great deal

of flexibility in designing public mental health services. Fiscal flexibility accompanied by a state policy of financial decentralization (the Mental Health Act of 1988) suggests that Ohio may represent a relatively aggressive case of decentralization.

Figure 4 presents the local share of total mental health expenditures in the state for the years 1980 through 1990. During the decade of the 1980s, localities increased their share of expenditures from 31.7 percent to 41.5 percent. Total expenditures per capita grew faster than the rate of general inflation. For example, during the 1980s, state expenditures rose roughly 59 percent, the rate of growth in the Consumer Price Index, in contrast to community-based expenditures, which grew 110 percent during the same period. Therefore, much of the growth in total resources devoted to mental health care was caused by expanded commitments from localities.

Table 2 presents information on the local share of expenses for boards with populations whose per capita incomes fall in the top and bottom quartiles of the boards in Ohio. The top panel of table 2 reports the ratio of local expenditures to total mental health expenditures for the lowest and highest income quartiles. The first row of the top panel shows that the local share of total expenses rose for the boards with the lowest

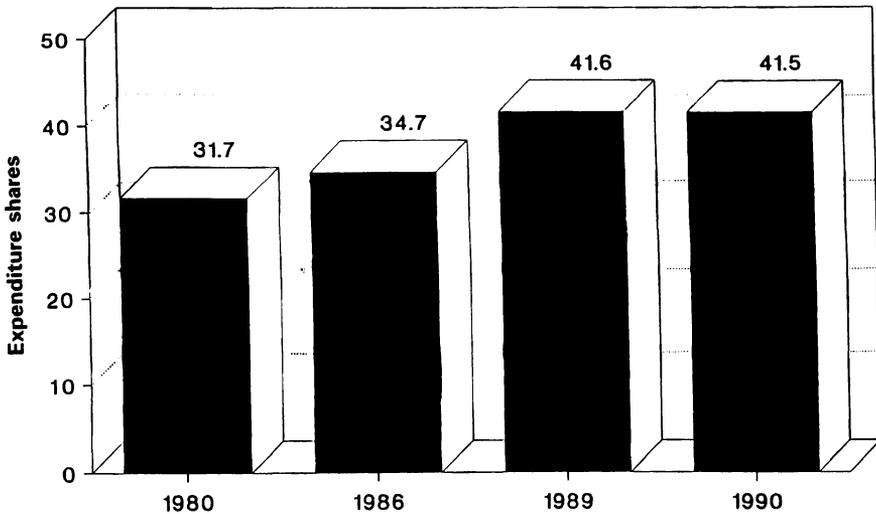


FIG. 4. Local share of total mental health expenditures in Ohio from 1980 through 1990.

Source: Ohio Department of Mental Health.

TABLE 2
Ohio Budget Shares by Income Level

Public mental health expenditures	1986	1987	1988	1989	1990
Ratio of local to total					
(1) Lowest income quartile	0.166	0.196	0.258	0.278	0.250
(2) Highest income quartile	0.375	0.419	0.443	0.445	0.457
Ratio of (1) to (2)	0.442	0.467	0.582	0.613	0.547
Ratio of local to state					
(3) Lowest income quartile	0.472	0.506	0.786	0.904	0.711
(4) Highest income quartile	1.137	1.441	1.689	1.731	1.688
Ratio of (3) to (4)	0.415	0.351	0.465	0.522	0.421

Source: Ohio Department of Mental Health.

per capita income—from 16.6 percent in 1986 to 25.0 percent in 1990. This growth represents a 50.6 percent increase in the local share. Boards with per capita incomes in the highest quartile saw their local share of total mental health expenditures grow from 37.5 percent in 1986 to 45.7 percent in 1990, an 18.6 percent increase. The third row, which presents the ratio of the lowest quartile local share to that of the highest quartile, shows that the boards with the lowest per capita income increased their spending more rapidly than did those with the highest incomes.

The second panel reports the ratios of local to state expenditures. The second panel again shows a dramatic rise in local relative to state fiscal efforts for boards whose populations fall in the lowest per capita income quartile. However, it is interesting to note that between 1989 and 1990 the state appears to have shifted funds to lower-income boards as evidenced by the fall in the ratio of local to state expenditures from 0.904 to 0.711 for the bottom-quartile boards. The evidence suggests that decentralization in Ohio has meant that localities have increased their fiscal efforts. In fact, virtually all real increases in expenditures stem from increased local contributions, while the state's role in fostering equity by income class appears to be modest. There is, however, some evidence of a recent attempt to play a more redistributive role between 1989 and 1990, perhaps because the lowest-income boards used more state mental hospital services in the past. The Mental Health Act of 1988 could therefore have the effect of providing poorer communities with larger block grants.

Texas

The local share of total mental health expenditures in the state for 1983–90 is illustrated in figure 5. The local share grew from 16.4 percent in 1983 to 20.8 percent in 1988, dropping back to 16 percent by 1990. All this activity is mostly the result of movements in local expenditures. State expenditures grew slightly from 1983 to 1986 and did not vary much thereafter.

Table 3 contains the ratios of local expenditures for public mental health care relative to both total and state expenditures for boards in the lowest and highest quartiles of the per capita income distribution. The local share of total mental health expenditures in Texas ranged between 9 percent and 30 percent by income class over the period 1983 through 1990. This represents a substantially lower level of effort than was found in Ohio. Unlike Ohio, the expenditure shares of boards in both the lowest and highest quartiles did not exhibit a clear upward or downward trend over the period from 1983 through 1990. Although there are year-to-year fluctuations, the trend for local shares of expenses in Texas is constant.

There are a number of possible explanations for the apparent lack of change. First, although the 35.50 program changed public mental

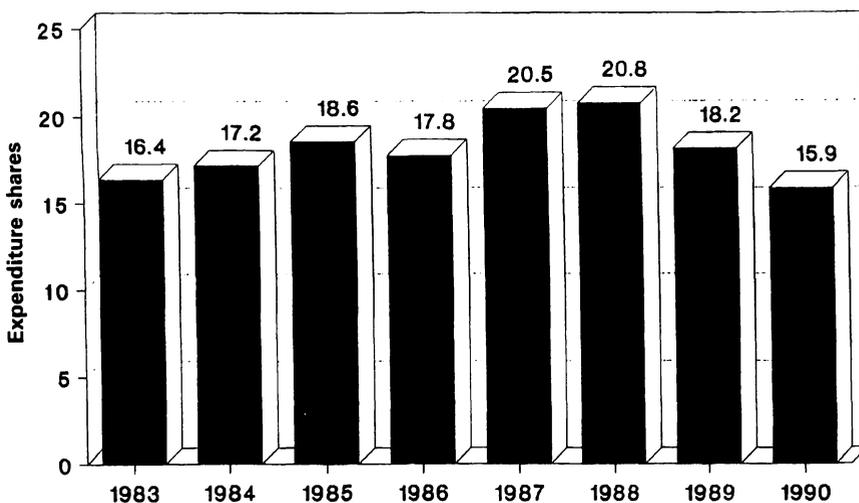


FIG. 5. Local share of total mental health expenditures in Texas from 1983 to 1990.

Source: Texas Department of Mental Health and Mental Retardation.

TABLE 3
Texas Budget Shares by Income Level

Public mental health expenditures	1983	1984	1985	1986	1987	1988	1989	1990
Ratio of local to total								
(1) Lowest income quartile	0.09	0.10	0.14	0.12	0.11	0.13	0.11	0.10
(2) Highest income quartile	0.25	0.24	0.23	0.26	0.28	0.26	0.30	0.24
Ratio of (1) to (2)	0.36	0.42	0.61	0.46	0.39	0.50	0.37	0.42
Ratio of local to state								
(3) Lowest income quartile	0.17	0.19	0.24	0.20	0.19	0.25	0.18	0.14
(4) Highest income quartile	0.47	0.42	0.38	0.49	0.50	0.48	0.58	0.40
Ratio of (3) to (4)	0.36	0.45	0.63	0.41	0.38	0.52	0.31	0.35

Source: Texas Department of Mental Health and Mental Retardation.

health financing over this period, the incentives were fairly modest and not all localities were affected. Those localities served by a state-owned community mental health clinic were unaffected by the 35.50 policy. Second, unlike Ohio, LMHAs in Texas do not have the ability to submit levies for public approval, which means they cannot directly raise tax revenues. Because boards in Texas must request funds from local governments, their access to local dollars is limited and is less likely to respond to changes that only affect the mental health boards. For example, the Austin mental health board, which participated in the RWJ/PCMI, has to negotiate with both city and county governments to obtain local dollars.

Discussion

In the federalist form of government, each governing level has developed a sphere of public service for which it is responsible. At the core of the RWJ/PCMI is a shift in the roles and responsibilities assigned to state and local governments. Successful community mental health care is seen as requiring both aggressive local management of treatment and the resources for delivering mental health care, which include funds currently devoted to care delivered in public mental hospitals. The RWJF program and several of the accompanying state policy initiatives are aimed at creating the types of change in intergovernmental relations that would permit local management of public mental health care.

Our analysis of state choice of organizational form for local public mental health systems suggests that states' motives in designing local mental health systems may not be entirely benign. Efficiency considerations are important, but systems are also structured to promote state goals that may be detrimental to its population. In particular, because LMHAs present the state with opportunities for cost shifting, they may experience difficulties in pursuing their goals successfully.

The lessons from the creation of financial incentives to reduce state mental hospital utilization suggest that localities respond even to modest incentives (as in the case of Texas). The Ohio Mental Health Act of 1988 reduced state hospital days almost 8 percent above the comparison group in the first year, and this trend continued in subsequent years (Frank and Gaynor n.d.). The Texas 35.50 program, which had weaker incentives to reduce hospital days, was associated with a 13 percent reduction in these days relative to the secular trend over the first three years of the policy.

In Ohio, the state also created a financial reward for enrolling severely mentally ill individuals in treatment programs. Overall, the LMHAs responded strongly to the incentive to enroll the target population. Unfortunately, the dramatic expansion in enrollment was not accompanied by a corresponding increase in treatment. Moreover, the response was significantly reduced when incentives were not written into the contract between LMHAs and service providers.

Our analysis of the distributional consequences of fiscal decentralization offers both a hopeful note and a warning to policy makers. Ohio's example suggests that an aggressive approach to decentralization results in localities accepting greater responsibility for the mentally ill and increasing their level of fiscal effort. Expansion in local financing of mental health care became possible because a political and legal structure facilitated local financing of mental health through the option to levy property taxes directly for mental health care.

The approach in Texas to fiscal decentralization was far less aggressive than the one in Ohio. The process of funding mental health at the local level is also considerably more complicated than in Ohio, as it requires negotiating with several parts of local government. Thus, in Texas, we observed a much lower level of fiscal effort to fund mental health care by localities subsequent to the implementation of the 35.50 program than we saw in Ohio.

In both Texas and Ohio state expenditures comprise a larger share of total mental health expenditures in the poorest regions of the state.

Thus both states have played an historical role in advancing greater equity in mental health financing. Surprisingly, however, there is only slight evidence to support the notion that when localities increased funding substantially in Ohio, the state then reallocated more state funds for its poorest regions.

We conclude with the following observations. First, financial incentives to reduce state hospital use and direct more resources to the community had their desired impact. More resources for treatment of mental disorder in the community became available, and state hospital care was deemphasized in both states. Although we do not know the final impact on patients, this finding is nevertheless significant. For 30 years a major policy goal in mental health has been to make the dollars follow the patients; the Ohio and Texas policies advance that goal. Second, fiscal decentralization led to localities increasing their fiscal efforts. Texas and Ohio did not shift into increasing the state's redistributive role in mental health care financing, with the result that fiscal inequality is greater between poorer and wealthier localities. Such an outcome may be an unintended consequence of the RWJF model. As local fiscal effort assumes greater importance, we need to study local financing of mental health services in order to understand how they work.

Finally, the RWJF demonstrations provide valuable lessons in the context of national policy. Since the adoption of P.L.99-660, Congress has been increasing the pressure on state governments to enrich community-based mental health services for the severely mentally ill. The experiences in Texas and Ohio offer insights into policies aimed at shifting more resources into community mental health systems.

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