

THE IMPACT OF REALIGNMENT ON THE CLIENT POPULATION IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

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ABSTRACT: This study examined whether decentralization of California's public mental health system under program realignment has changed the composition of the client population, with greater attention toward inclusion of persons with a severe mental illness. Clients' demographic and clinical status were compared before and after realignment. The study sample consisted of 75,951 clients, representing 1.5 million adults who accessed the public mental health services in California during a 6-year study period. The post-realignment client population had lower functional status, more unemployment, and lower levels of education—all indicating greater functional impairment. They were more likely to suffer from an affective disorder, but they were less likely to have either a non-psychotic disorder or schizophrenia. The study found no evidence suggesting that realignment jeopardized access to the public mental health system in California, and it indicated at least the possibility that it promoted greater access by clients with greater functional impairment.

KEY WORDS: California; managed care; mental health policy; mental health services; the mentally ill.

Program realignment, a legislative act that went into effect on July 1, 1991, in California, was designed to enable the state's mental health system to meet the growing demand for services in the face of a large and growing budget deficit. A central piece of the legislation granted local

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mental health authorities greater fiscal and administrative responsibility for managing mental health services (Masland, 1997). Categorical restrictions imposed by the state were eliminated, and local mental health authorities were allowed to use designated funds flexibly. Sources of financing of mental health services were consolidated into a dedicated sales tax to be redistributed to equalize funding levels among counties; but the recession of the early 1990s thwarted this intention.

Under realignment, local mental health authorities assumed full responsibility for providing mental health services. Implementing realignment shifted the control and risk from state government to local mental health authorities at the county level. Recent studies have shown that realignment achieved its primary purpose: Mental health expenditures dropped dramatically (Scheffler et al., 1998, 2000).

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Decentralizing the public mental health system, as carried out under realignment, sparked a debate similar to that aroused by other attempts to contain costs and to introduce flexibility into mental health programs and systems. Critics argued that under a risk-based arrangement, a substantial number of clients, especially those most difficult or costly to serve, would be shifted out of the system.

Proponents of realignment pointed to its potential advantages. They contended that the greater financial and administrative power granted under realignment would enable local mental health authorities to not only preserve the client population at previous levels, but also to enlarge the number of clients by reaching out to formerly untreated groups. The reasons they cited were twofold. Local mental health authorities were considered to have detailed knowledge of the local market and clinical population, and therefore were seen as more capable than state government of efficiently managing resources and responding to local conditions.

Moreover, the net financial impact of realignment was to provide additional funds for mental health treatment. Thus, local mental health authorities might gain new resources, not only from their efforts at cost containment motivated by exposure to risk and facilitated by increased programmatic flexibility, but also from the introduction of new revenues, which they were obliged to reinvest.

Ultimately, local mental health authorities were not permitted to avoid difficult-to-treat clients as a strategy to contain costs. For the first time, program realignment specified a target population of high-priority recipients. As the Bronzan-McCorquodale Act states, "Persons with serious men-

tal illness have severe, disabling conditions that require treatment,” and they should be given “a high priority for receiving available services” (West Group, 1998).

Empirical evidence is scarce concerning movement of the client population under efforts at cost containment. Scheffler and colleagues (2000) found that use of state hospital services was supplanted by less costly outpatient services under realignment, indicating a flow of clients from state hospitals to outpatient services within the mental health system. On the other hand, a study of Utah’s prepaid mental health plan reported that while inpatient admission was significantly reduced, the use of outpatient services did not significantly increase. One possible explanation is that clients left inpatient services, but did not seek outpatient services as a substitute (Stoner, Manning, Christianson, Gray, & Marriott, 1997). However, neither study focused directly on the possibility of shifts in the client population.

Access to services in a decentralized system is an issue that directly concerns the well-being of persons served by the public mental health system. Concern is greatest about the fate of persons with severe and persistent mental illness who were assigned a high priority for receiving services, but who are also more likely to be costly and difficult to treat. There is a need to directly evaluate the representation of the most vulnerable clients because financial incentives might overcome state mandate.

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We examined demographic and clinical characteristics of the client population in the early years after realignment. Our intention was to determine whether the caseload of the public mental health system had changed. We were particularly interested in the representation of persons with greater functional impairment.

METHODS

Research Design

This study used a pre/post design to compare clients’ demographic and clinical characteristics between the pre- and post-realignment periods. Because realignment was effective statewide in the public mental health system, there was no geographic area nor public mental health system in California to serve as a control for the comparison. Nevertheless, the study

assumed stability of the population with mental illness in California over the realignment period. Since realignment became effective in 1991, California's economy has been booming, and migration has been constant. Therefore, we had no reason to assume that the mental health status of the population changed significantly during our study period.

In this study, the pre-realignment period included Fiscal Year 1988–1990 and the post-realignment period included FY 1992–1994. The *t*-test and chi-square test were performed to compare pre- and post-realignment differences in client composition. Regression analyses were also performed to examine patterns of change in demographic and clinical characteristics over time, using three pre-realignment and three post-realignment years as independent variables. This approach permitted us to begin disentangling the changes attributable to realignment from the general trends in caseload composition.

Data Source

The Client Data System (CDS), obtained from the California State Department of Mental Health, was used in this study. The data were compiled by each county and were reported to the state's Department of Mental Health, which maintains the data system. The CDS is an administrative setup that records each visit of clients who have ever used community mental health services in California. In this data set, clients who were admitted to state hospitals are not included and those who stayed at the Institute for Mental Disease are partially included. However, in the post-realignment period, the number of clients who were shifted from either a state hospital or the Institute for Mental Disease to local mental health services was about 1% of the statewide client population. Therefore, it is unlikely that the exclusion of these clients in this study had a tangible effect on our analysis of changes in the composition of this client population.

The CDS data contain extensive client-level information on client demographics, clinical diagnosis, severity of impairment, and utilization of services. In this study, we examined the CDS data over a 6-year period (FY 88–90 and FY 92–94). During this period, the total number of clients who accessed California's public mental health services at the age of 18 or older and whose ethnic status was White, Black, Hispanic, or Asian, was a quarter million per year. Nearly 1.5 million of these clients who ever accessed California's public mental health system during the 6-year period were studied.

Sampling

With this client population as the sampling frame, a representative client sample from each fiscal year was selected by stratified random sam-

pling. Stratification was used to reduce standard errors and to ensure that gender, ethnicity, and diagnosis were proportionally represented in the sample. We created 32 strata by multiplying levels of gender (male, female) by levels of ethnicity (White, Black, Hispanic, Asian) by levels of diagnosis (schizophrenia, mood disorders, substance use disorder, and others), and then we sorted the sample into each stratum. We then randomly selected a 5% sample from each of 32 strata. This selection process was repeated for each fiscal year.

Demographic and Clinical Variables

Client demographic variables included age, gender, ethnicity, educational attainment, and employment status. Age was classified into four groups: young (ages 18–30), middle-aged (ages 31–50), young-old (ages 51–64), and old-old (age 65 and over). Gender and employment status were binary variables. Ethnicity referred to four ethnic groups: White, Black, Hispanic, and Asian. Educational attainment was assessed by grade levels on a 21-point scale in which 0 indicated kindergarten and 20 indicated the highest education level. For a large number of clients (22–36% across years) who had unknown educational status, the missing values were replaced by mean scores of each year. This option was considered preferable to focusing only on clients for whom complete data were available and thereby sacrificing representativeness.

Clinical variables consisted of functional impairment and psychiatric diagnosis. Functional impairment was measured by Global Assessment of Functioning (GAF), a 100-point scale administered at admission, with higher scores indicating higher functional ability. About 13% to 18% of clients had missing values across years on this variable, which were replaced by mean scores of each year. Psychiatric diagnosis was the principal admission diagnosis for which a client was admitted to mental health services. Because schizophrenia, mood disorder, and substance use disorder are costly and major disorders, diagnoses were assigned to one of these categories or to the category of “others” according to the last diagnosis each client received in a year. The diagnostic category of “others” contained a large portion of clients with anxiety disorder, adjustment disorder, or other disorders that are less severe than psychotic disorders; therefore, it can be considered a category of mild mental disorders.

RESULTS

Descriptive Statistics

The sample contained 12,919 clients in FY 88; 12,735 in FY 89; 12,387 in FY 90; 12,447 in FY 92; 12,643 in FY 93; and 12,820 in FY 94. A total

of 38,041 clients from the pre-realignment period and 37,910 from the post-realignment period were examined. Descriptive statistics of variables are presented in Table 1.

The number of clients who were served in the public mental health system was stable over the realignment period. Based on the real number of clients, the average drop per year was 1,071 persons after realignment, which equals 0.4% of the pre-realignment client population.

Changes in Caseload Characteristics

With respect to functional status and clinical status, clients seen after realignment exhibited a significantly lower educational level ($p < .01$) and a significantly higher rate of unemployment ($p < .01$) than clients seen before realignment. Globally rated functional status was significantly lower ($p \leq .01$). Chi-square tests on individual diagnostic categories indicated that, compared to the pre-realignment period, the diagnosis of mood disorders increased by 5.4% ($\chi^2 = 263.7$, $df = 1$, $p < .01$), the diagnosis of "other" disorders—presumably less severe mental disorders—decreased by 3.9% ($\chi^2 = 113.1$, $df = 1$, $p < .01$), while the diagnosis of schizophrenia also decreased by 1.3% ($\chi^2 = 22.8$, $df = 1$, $p < .01$) in the post-realignment period.

The use of *t*-tests and chi-square tests revealed significant differences in demographic status between the pre- and post-realignment periods. As Table 2 shows, clients' age levels were significantly different ($p \leq .01$) before and after realignment. A chi-square test on each age group showed that the percentage of middle-aged clients (31–50) was significantly higher ($\chi^2 = 76.9$, $df = 1$, $p < .01$) and the percentage of young and old-old clients (18–30 or 65 and above) was significantly lower ($\chi^2 = 48.3$ and $\chi^2 = 41.9$, $df = 1$, $p < .01$, respectively) in the post- than in the pre-realignment period. The proportion of male clients increased and the proportion of female clients decreased significantly ($p \leq .01$) in the post-realignment client population. Ethnic composition significantly changed as well ($p \leq .01$). A chi-square test on each ethnic group showed that the proportion of White clients was significantly smaller ($\chi^2 = 98.9$, $df = 1$, $p < .01$) and the proportions of Hispanic and Asian clients were significantly larger ($\chi^2 = 10.3$ and $\chi^2 = 189.9$, $df = 1$, $p < .01$, respectively) after realignment.

Yearly Changes

Aggregate changes, like those considered above, cannot rule out the possibility that events and trends other than realignment were responsible for observed changes in caseloads. Changes in underlying characteristics of the state population, as well as ongoing trends in recruitment and help-seeking activities, represent rival explanatory hypotheses. Patterns of change over time portrayed in Table 1 suggest the possibility that broader trends indeed might have been operating.

TABLE 1
Descriptive Statistics of Demographics and Clinical Variables

| Variable | 1988 | | 1989 | | 1990 | | 1992 | | 1993 | | 1994 | |
|-----------------------------|--------|------|--------|------|--------|------|--------|------|--------|------|--------|------|
| | n | % | n | % | n | % | n | % | n | % | n | % |
| <i>Age</i> | | | | | | | | | | | | |
| 18-30 | 4,061 | 31.4 | 3,826 | 30.0 | 3,481 | 28.1 | 3,498 | 28.1 | 3,500 | 27.7 | 3,466 | 27.0 |
| 31-50 | 6,246 | 48.3 | 6,338 | 49.8 | 6,257 | 50.5 | 6,390 | 51.3 | 6,734 | 53.3 | 6,858 | 53.5 |
| 51-64 | 1,541 | 11.9 | 1,603 | 12.6 | 1,710 | 13.8 | 1,665 | 13.4 | 1,599 | 12.6 | 1,693 | 13.2 |
| 65+ | 1,071 | 8.3 | 968 | 7.6 | 939 | 7.6 | 894 | 7.2 | 810 | 6.4 | 803 | 6.3 |
| <i>Gender</i> | | | | | | | | | | | | |
| Male | 6,284 | 48.6 | 6,299 | 49.5 | 6,207 | 50.1 | 6,389 | 51.3 | 6,512 | 51.5 | 6,611 | 51.6 |
| Female | 6,635 | 51.4 | 6,436 | 50.5 | 6,180 | 49.9 | 6,058 | 48.7 | 6,131 | 48.5 | 6,209 | 48.4 |
| <i>Ethnicity</i> | | | | | | | | | | | | |
| White | 8,338 | 64.5 | 7,940 | 62.3 | 7,583 | 61.2 | 7,456 | 59.9 | 7,474 | 59.1 | 7,514 | 58.6 |
| Black | 2,025 | 15.7 | 2,077 | 16.3 | 2,095 | 16.9 | 2,055 | 16.5 | 2,084 | 16.5 | 2,165 | 16.9 |
| Hispanic | 2,039 | 15.8 | 2,149 | 16.9 | 2,086 | 16.8 | 2,132 | 17.1 | 2,200 | 17.4 | 2,252 | 17.6 |
| Asian | 517 | 4.0 | 569 | 4.5 | 623 | 5.0 | 804 | 6.5 | 885 | 7.0 | 889 | 6.9 |
| <i>Employment</i> | | | | | | | | | | | | |
| Employed | 8,736 | 67.6 | 8,561 | 67.2 | 8,513 | 68.7 | 8,141 | 65.4 | 8,334 | 65.9 | 8,103 | 63.2 |
| Unemployed | 4,183 | 32.4 | 4,174 | 32.8 | 3,874 | 31.3 | 4,306 | 34.6 | 4,309 | 34.1 | 4,717 | 36.8 |
| <i>Diagnosis</i> | | | | | | | | | | | | |
| Schizophrenia | 2,437 | 18.9 | 2,416 | 19.0 | 2,314 | 18.7 | 2,263 | 18.2 | 2,226 | 17.6 | 2,147 | 16.7 |
| Mood disorder | 3,411 | 26.4 | 3,516 | 27.6 | 3,510 | 28.3 | 3,934 | 31.6 | 4,156 | 32.9 | 4,361 | 34.0 |
| Substance use | 564 | 4.3 | 556 | 4.4 | 503 | 4.1 | 482 | 3.9 | 496 | 3.9 | 557 | 4.3 |
| Others | 6,507 | 50.4 | 6,247 | 49.0 | 6,060 | 48.9 | 5,768 | 46.3 | 5,765 | 45.6 | 5,755 | 44.9 |
| <i>Level of Education</i> | 12,919 | | 12,735 | | 12,387 | | 12,447 | | 12,643 | | 12,820 | |
| Mean (range 0-21) | 11.3 | | 11.0 | | 10.6 | | 9.9 | | 10.2 | | 10.2 | |
| <i>Level of functioning</i> | 12,919 | | 12,735 | | 12,387 | | 12,447 | | 12,643 | | 12,820 | |
| Mean (range 0-100) | 44.5 | | 44.4 | | 44.0 | | 43.9 | | 42.8 | | 43.6 | |

TABLE 2
Change of Clients' Demographic and Clinical Characteristics Under Realignment

| Variable | Pre-Realignment (1988-1990) | | | Post-Realignment (1992-1994) | | | Comparison | | |
|-----------------------------|-----------------------------|--------|------|------------------------------|--------|------|--------------|--------|---------------------|
| | N | n | % | N | n | % | χ^2 / t | df | Sublevel Comparison |
| <i>Age</i> | | | | | | | | | |
| 18-30 | 38,041 | 11,368 | 29.9 | 37,910 | 10,464 | 27.6 | 112.3** | 3 | pre > post |
| 31-50 | | 18,841 | 49.5 | | 19,982 | 52.7 | | | pre < post |
| 51-64 | | 4,854 | 12.8 | | 4,957 | 13.1 | | | |
| 65+ | | 2,978 | 7.8 | | 2,507 | 6.6 | | | pre > post |
| <i>Gender</i> | | | | | | | | | |
| Male | 38,041 | 18,790 | 49.4 | 37,910 | 19,512 | 51.5 | 32.7** | 1 | |
| Female | | 19,251 | 50.6 | | 18,398 | 48.5 | | | |
| <i>Ethnicity</i> | | | | | | | | | |
| White | 38,041 | 23,861 | 62.7 | 37,910 | 22,444 | 59.2 | 227.7** | 3 | pre > post |
| Black | | 6,197 | 16.3 | | 6,304 | 16.6 | | | |
| Hispanic | | 6,274 | 16.5 | | 6,584 | 17.4 | | | pre < post |
| Asian | | 1,709 | 4.5 | | 2,578 | 6.8 | | | pre < post |
| <i>Employment</i> | | | | | | | | | |
| Employed | 38,041 | 25,810 | 67.8 | 37,910 | 24,578 | 64.8 | 77.3** | 1 | |
| Unemployed | | 12,231 | 32.2 | | 13,332 | 35.2 | | | |
| <i>Diagnosis</i> | | | | | | | | | |
| Schizophrenia | 38,041 | 7,167 | 18.8 | 37,910 | 6,636 | 17.5 | 264.4** | 3 | pre > post |
| Mood disorders | | 10,437 | 27.4 | | 12,451 | 32.8 | | | pre < post |
| Substance use | | 1,623 | 4.3 | | 1,535 | 4.1 | | | |
| Others | | 18,814 | 49.5 | | 17,288 | 45.6 | | | pre > post |
| <i>Level of Education</i> | | | | | | | | | |
| Mean (range 0-21) | 38,041 | 11.0 | | 37,910 | 10.1 | | 32.9** | 72,100 | |
| SD | | 3.3 | | | 4.1 | | | | |
| <i>Level of functioning</i> | | | | | | | | | |
| Mean (range 0-100) | 38,041 | 44.3 | | 37,910 | 43.4 | | 8.6** | 75,390 | |
| SD | | 14.5 | | | 13.2 | | | | |

** $p \leq .01$.

To provide a more fine-grained analysis of patterns of change, regression analysis was conducted in which functional status and clinical indicators served as dependent variables. The pre- and post-realignment years served as independent variables along with remaining demographic and clinical status variables as covariates. Years were represented as dummy variables coded such that the last pre-realignment year, 1990, was a reference group.

The findings indicate that the percentages of unemployed clients were slightly higher during the two preceding years than during the final year before realignment (Odds Ratio=1.04; OR=1.06) and were higher still during the three post-realignment years (OR=1.18; OR=1.11; OR=1.27). Education was higher during the years preceding the final pre-realignment years ($b=0.62$; $b=0.44$) and was lower during all post-realignment years ($b=-0.68$; $b=-0.38$; $b=-0.35$), suggesting a somewhat continuing pattern of decline. A similar pattern of decline was held for the proportion of the caseload diagnosed with schizophrenia (OR=1.05; OR=1.05; OR=0.96; OR=0.90; OR=0.86), and a reverse pattern of increase for the proportion diagnosed with a mood disorder (OR=0.87; OR=0.94; OR=1.20; OR=1.28; OR=1.33). Average ratings of functional status were greater during the early pre-realignment years ($b=0.33$; $b=0.36$), and lesser during the later post-realignment years ($b=-1.10$; $b=-0.25$). There was no difference between the year immediately preceding and the year following realignment. With respect to ethnicity, Asian Americans were a significantly lower proportion of the caseload during the early pre-realignment years and were a significantly higher proportion during the post-realignment years; the rate of increase was relatively steady. On the other hand, the pre- and post-realignment caseload proportions for Hispanics were not significantly different.

DISCUSSION

There were significant changes in the clients' demographic and clinical characteristics in California's public mental health system over the realignment period. After realignment, the client population exhibited a significantly lower level of education, a higher unemployment rate, a higher level of functional impairment, and a higher percentage of severe psychiatric diagnoses than before realignment. The client population also contained significantly more middle-aged and fewer young or old clients, more male clients, and more Asian clients.

Consistent with the mandate of realignment, that local mental health authorities focus their services more on the neediest clients, there was an increase in clients at lower levels of functioning. Greater attention was

given to clients with mood disorders and slightly less attention to clients with schizophrenia. Overall, however, for clients with less serious diagnoses, the proportion shrank.

Indeed, the ratio of psychiatric diagnoses was changed substantially. During the post-realignment period, the rate of mood disorders—a major severe mental disorder—increased by 5.4%. Although the rate of schizophrenia diagnosis dropped by 1.3%, “other” psychiatric diagnosis—presumably mild mental disorders such as anxiety and adjustment disorder—decreased by 3.9%.

On the other hand, it seems that many of the changes in clients’ demographic and clinical characteristics took place, in any event, due to changes in the underlying population or changes in outreach and help-seeking by clients with more serious mental illness and greater functional disability. The relatively large increase in unemployed clients, and the decline in level of globally rated functioning, which followed two-year plateaus, are consistent with realignment itself, which intends to include clients with greater functional disability. However, they are not entirely incompatible with the existence of more general trends. A cautious conclusion is that realignment did not arrest more general trends, and it might have accentuated them.

A more definitive conclusion is possible regarding the fears of realignment’s detractors: The evidence failed to support them. There was no indication that more disabled and difficult to treat clients were being avoided. Such clients did not decline as a proportion of the caseload—as noted previously, they increased. This study disconfirmed the expectation that under pressure to contain costs, these clients would be forced from the system.

Shifts in relative proportions took place in a context of relative stability in the size of the caseload. If clients were displaced, it was those who were less disabled rather than those who were more disabled.

There was no indication that more disabled and difficult to treat clients were being avoided.

Associated with the enhanced severity of the post-realignment client population was a higher percentage of the middle-aged, male, and Asian clients. To examine whether this demographic change in the client population was due to realignment, the findings must be considered in the context of population change in California. Table 3 presents a picture of general trends in California’s population over the realignment period 1988–1994 (Kehew, 1995). The young age group (18–30 or 18–34) declined simultaneously in the client and general populations, but the mid-

TABLE 3
Demographics of California Population Over the Pre- and Post-Realignment Periods

| <i>Variable Period</i> | <i>1988 Pre</i> | <i>1989 Pre</i> | <i>1990 Pre</i> | <i>1992 Post</i> | <i>1993 Post</i> | <i>1994 Post</i> |
|-------------------------|-----------------|-----------------|-----------------|------------------|------------------|------------------|
| <i>Total Population</i> | 28,393,148 | 29,142,279 | 29,976,003 | 31,300,134 | 31,906,308 | 32,520,140 |
| <i>Percentages</i> | | | | | | |
| <i>Male</i> | 49.92 | 49.99 | 50.06 | 50.10 | 50.11 | 50.13 |
| <i>Age</i> | | | | | | |
| 1-17 | 26.55 | 26.32 | 26.25 | 26.81 | 27.12 | 27.42 |
| 18-34 | 31.22 | 31.11 | 30.70 | 29.16 | 28.32 | 27.52 |
| 35-44 | 14.70 | 15.04 | 15.47 | 16.01 | 16.16 | 16.32 |
| 45-64 | 17.11 | 17.09 | 17.13 | 17.47 | 17.80 | 18.12 |
| 65+ | 10.43 | 10.44 | 10.46 | 10.56 | 10.60 | 10.62 |
| <i>Ethnicity</i> | | | | | | |
| White | 58.59 | 57.95 | 57.38 | 55.47 | 54.67 | 53.85 |
| Black | 7.16 | 7.11 | 7.06 | 7.00 | 6.97 | 6.94 |
| Hispanic | 24.82 | 25.34 | 25.82 | 27.35 | 28.03 | 28.72 |
| Asian | 9.43 | 9.60 | 9.74 | 10.18 | 10.33 | 10.49 |

Source: Kehew (1995).

dle-age group (31–50) increased and the old-old age group decreased in the client population. On the other hand, age groups 35–64 and 65+ remained static in the general population. In other words, the increased percentage of middle-aged clients and the decreased percentage of old-old clients cannot be attributed to change in the general population.

Unlike physical diseases, schizophrenia and mood disorders usually begin in early adulthood and progress into middle age when intensive intervention is sought. The increase in middle-aged clients during the post-realignment period might be explained as a concomitant of the shift toward more disturbed clients.

Finally, the change in ethnic composition is noteworthy. The general trend is that the Hispanic population is growing in California and the non-Hispanic White population is declining; therefore, the lack of increase among Hispanics is surprising. On the other hand, the growth of the Hispanic population is occurring largely in the child population, and children were not considered in the present study.

The proportion of Asian clients grew consistently, equaling if not exceeding their representation in the general population. The increase in Asian clients might be attributable to the advent of culturally competent programming. Awareness and efforts in this direction grew during the early 1990s and may have helped significantly in identifying persons with severe mental illness among non-White groups.

As noted previously, mood disorders were more prevalent, schizophrenia decreased slightly, and “other” disorders dropped substantially after realignment. Several factors can be invoked to account for these phenomena. Since the early 1990s, mental health professionals have become increasingly aware that schizophrenia has been overdiagnosed in the United States relative to its level of diagnosis in Europe. New drugs for the treatment of bipolar disorders have become available. Patients with mood disorders have become more motivated to seek treatment, and doctors have become more likely to treat patients with newer drugs under a diagnosis of mood disorders. Information relating to the *DSM-IV*'s revised diagnostic criteria was disseminated before *DSM-IV* itself was published in 1994; this development might have further encouraged the diagnosis of mood disorders.

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In public mental health, a shift is well under way toward greater local control and flexibility in service delivery and the use of various mechanisms for containing costs. The experience with program realignment in

California suggests that it is possible to meet these objectives and at the same time care for persons who suffer from severe mental illness and notable levels of functional impairment. Pursuing the first of these objectives need not undermine efforts to pursue the second.

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