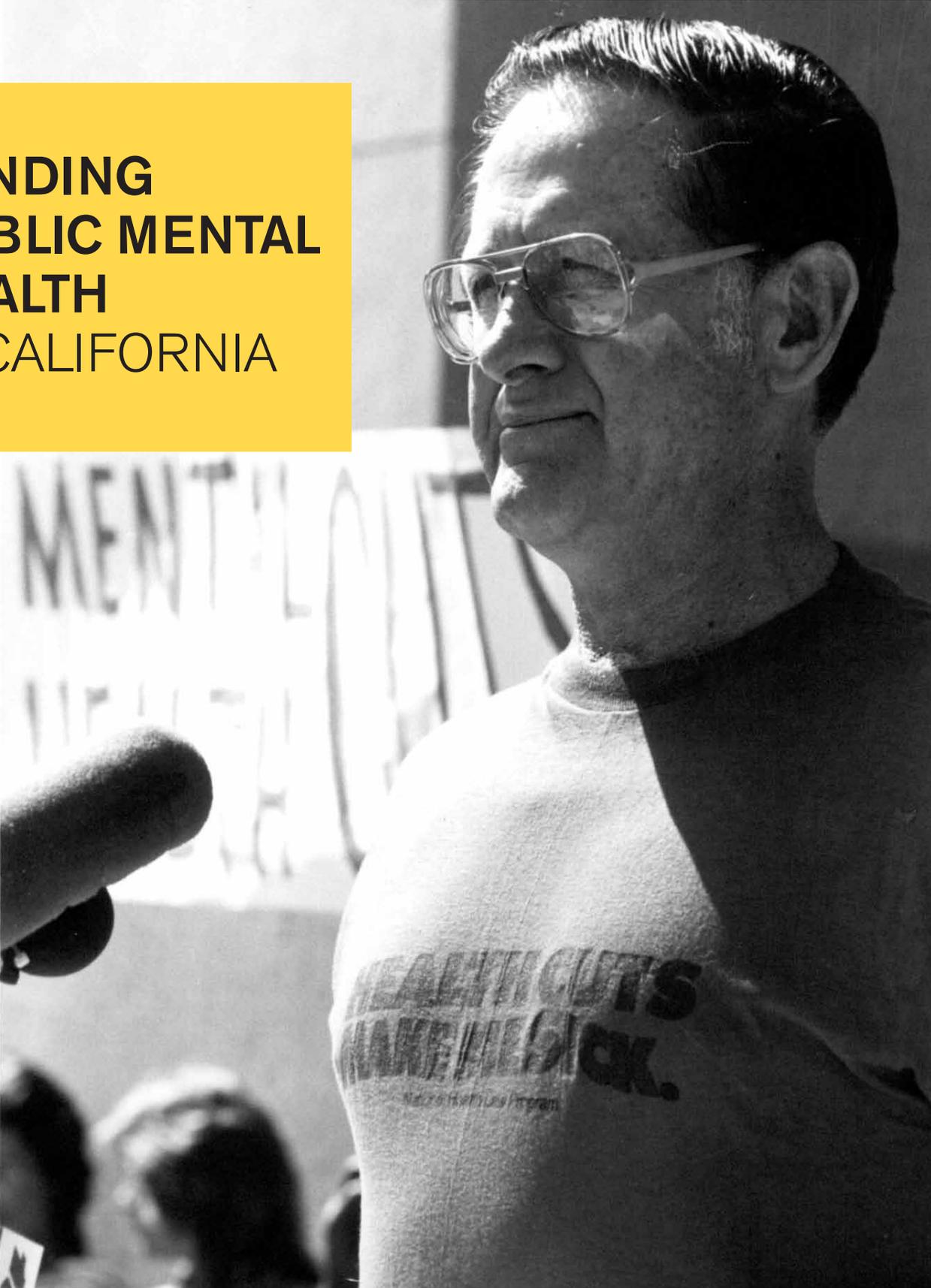


**FUNDING  
PUBLIC MENTAL  
HEALTH  
IN CALIFORNIA**



## Introduction

The history of the mental health budget in California and in Los Angeles County is the story of balancing acts and budget shortfalls in a system with continually changing moral and financial burdens. As philosophies of care have evolved at the State level, LAC-DMH has struggled to meet new mandates, at the same time as it has faced rising costs and demands for care. Responding to reform efforts by the legislature and the voters, the County has been forced to patch services together to meet the eligibility and use guidelines of categorical, reimbursement, and special revenue sources. Despite repeated efforts at reform, the funding and provision of these services remain inadequate in the face of the desperate need.

## Deinstitutionalization and the Transfer of Responsibility

The early years of the mental health system in California were characterized by state-run psychiatric hospitalization. People with severe mental illness were offered little hope for recovery, and many were placed indefinitely in these institutions. The first such facility – Stockton State Hospital – opened in 1853. By the end of 1957, a total of 14 state hospitals housed a population of 36,319.

In the early 1950s, however, the introduction of chlorpromazine (Thorazine) and its sister drugs opened up new possibilities for treating severe mental illness in the community. In response to this trend, California legislators enacted the 1957 **Short-Doyle Act**, which stipulated major changes in the funding responsibility and provision of mental health care. The legislation was based in the idea that, with most mental illness could be treated with psychoactive drugs in the community and that increased availability of community services would encourage people to voluntarily seek treatment earlier and achieve a fuller and more rapid recovery. The bill provided 50% matching state funds to cities or counties for most mental health programs. In 1963, the State increased its match for local Short-Doyle programs to 75%, and broadened the types of programs that were eligible for state funding.

**By 1967, about 87%** of the state population had access to local Short-Doyle programs.

In 1968, the pivotal **Lanterman-Petris-Short Act** (LPS) became the aggressive next step in shifting to community-based care. The law required that a judicial hearing be held to determine whether a person could be involuntarily hospitalized, greatly reducing the frequency of such commitments. In addition, LPS required all counties in California with populations over 100,000 to establish mental health programs, and the law increased the state funding match for local programs to 90%. The Reagan and subsequent state administrations promoted the trend to community-based care by closing nine state hospitals; only five remain in operation today. Between 1957 and 1984, the California state hospital population **dropped 84%**. Together, these developments placed the primary clinical responsibility for mental health care on the counties, which were forced to rely for the bulk of their funding on the State.

The envisioned success of this “deinstitutionalization” rested largely on the assumption that as hospitals closed, the funds saved from their closure would “follow the patient” into the community. But in 1972 and 1973, California governor Ronald Reagan vetoed two funding provisions designed to protect these savings for mental health, beginning an ongoing pattern of funding diversions and shortfalls. At the same time, many California counties had not developed extensive mental health programs prior to 1957 and were **struggling to cover the steadily growing outpatient population**. Although the philosophy that motivated deinstitutionalization was sound in principle – the belief that people could be successfully treated in less restrictive settings at a far lower cost – its implementation left counties with a clinical burden that was grossly disproportionate to the funding they actually received.

## Medi-Cal

The movement to community-based mental health care was born in the 1960s, an era in which social reformers strove to cast a wide government net to catch people who fell through the social cracks in the private health care system. In 1965, Congress passed Public Law 89-97, the Medicare and Medicaid Amendments to the Social Security Act. Medicare provided health care coverage for people over 65 and for people with certain disabilities, while Medicaid offered federal matching funds to States that established health care programs for the indigent. Medicaid reimbursements for mental health services covered psychiatric hospitalization, care in a nursing facility, and other services from psychologists and psychiatrists. In 1966, California implemented its Medicaid program, the California Medical Assistance Program, or **Medi-Cal**. Initially, mental health coverage comprised a small sector of the program, although as the number of deinstitutionalized patients grew, the State’s matching burden was correspondingly larger. The Federal programs drove the pauperization of the mentally ill – detaching them from family support – and the limitation of services to those that were reimbursable. Clinics had incentives to provide cost-effective services to the “worried well,” rather than to the more seriously ill, who required more expensive care.

Subsequent changes to Medi-Cal expanded the types of services covered. Beginning in 1971, counties could receive federal matching funds for some services in Short-Doyle programs provided to people who were eligible for Medi-Cal. Additional changes in 1988 and 1993 broadened the range of so-called Short-Doyle Medi-Cal (SD/MC) services that could be reimbursed. Although these additions offered significant improvements for people eligible for these services, the Medi-Cal program reinforced the piecemeal character of mental health funding in California.

## Proposition 13

In 1978, the California state budget entered perilous waters when angry voters passed Proposition 13, a ballot initiative that capped property taxes. Motivated by concerns about wasteful state spending, the initiative increased the counties’ financial dependency on the State at the same time that their **responsibility for mental health care surged upward**.

Because the measure limited property taxes at both state and county levels, the **budgetary cushion that had previously allowed LA County to implement programs neglected by the state mental health budget** – programs for which the County was forced to spend beyond its required 10% match to State funds – evaporated. At the State level, the drop in revenue led to **major cuts** in mental health allocations.

## Realignment

California lawmakers attempted to assuage the ongoing crisis in 1990 with the California Realignment Act, AB 1288 (also known as the Bronzan-McCorquodale **Act**). The law shifted control of mental health, social and health service programs to the counties, provided counties with a more stable revenue stream from taxes and vehicle registration fees, and changed the state-county funding ratios. Realignment ushered in some positive reforms. A State **report from 2003** found that since 1991, access to community mental health care had improved and that the funding of less expensive and less restrictive outpatient programs had increased compared to funding for more expensive and restrictive inpatient programs (realizing the philosophy and intent of the Short-Doyle Act in 1957 and subsequent reform efforts). Moreover, the first decade after the passage of Realignment was a creative period characterized by heavy consumer involvement in the design of innovative programs.

Although Realignment enabled the counties to fund some improvements in care, the scope of its reforms remained limited relative to the depth of dysfunction it was intended to repair. Indeed, a **1991 report by the California Legislative Analyst's Office** that examined the realignment proposal warned that the program was unlikely to provide long-term, stable funding for mental health. In a **2000 report**, the Little Hoover Commission concluded that even though total realignment funds had kept pace with increases in population, service usage, and cost of living, mental health funds under realignment had not, as caseloads had expanded in all social service programs. In addition, the level of funds from the new revenue streams fell short of expectations, as the recession in the early 1990s decreased revenue from both state taxes and vehicle fees. After stabilizing in the early 2000s, these revenue sources have again declined in the 2008-10 recession. Despite lawmakers' good intentions, Realignment failed to bring about fundamental change in the funding of mental health; it merely applied a band aid to slow the bleeding of State funds from these programs.

## MHSA

The passage of Proposition 63 – the 2005 Mental Health Services Act [MHSA] – marked a major new effort to redesign California's mental health care system. Although credited with fostering a number of **innovative programs**, the MHSA, like other sources of funding before it, is only a life vest for mental health services in California, as a recession-starved state budget has led to cutbacks in all social services. At the same time, the stipulations for MHSA funding challenge providers to offer the same coverage to the same populations as under the earlier system. Instead of providing a true enhancement to existing programs, as it was intended to, the MHSA has instead become the latest in a series of life supports for California's continually hemorrhaging mental health care system.