Patterns of Community Services Over Nine Years

A major component of both the SIS and the LCO research has been the examination of changes in patterns of services being received by consumers in Ohio=s community mental health system. It was predicted that the Mental Health Act of 1988 would affect community services such that larger amounts of service and more diverse patterns of services would be observed over time.

In order to examine service patterns, a random sample of community service records of 508 certified adults was drawn from the Department=s MHIS database in each year following the Mental Health Act. Each sample included approximately 10 percent of Ohio=s open records for adult consumers with SMD. A statistical technique called K-Means Cluster Analysis was used to identify patterns of services that consumers were receiving. The cluster analyses revealed a similar configuration of service patterns in every year; however, significant changes were observed in the size and composition of each cluster over time (see Table 1).

Table 1. Percentages of Adults with SMD in Service Clusters by Year

Fiscal Year	1989	1990	1991	1992	1993	1994	1995	1996	1997
N	4226	4292	4278	4279	4335	4463	4544	4766	4781
Few Services Cluster	47.7	47.8	52.8	53.1	46.0	46.7	47.0	54.8	53.9
Medical Clusters	22.9	22.9	12.9	9.9	9.5	12.9	17.0	10.2	11.1
Other Clusters	19.8	20.0	24.3	27.1	33.3	31.3	27.5	28.5	26.4
Custom Care Group	9.6	9.2	10.1	9.9	11.1	9.2	8.5	6.5	8.6

Note Table values for each year represent the percentage of the sample in each cluster type. Other Clusters included single and multiple service clusters.

The largest cluster identified in every year, the AFew Services Cluster≅, was composed of persons receiving very few services of any kind--an average of 13 units per year, compared to 70 units for the overall sample. (For this analysis, a unit was considered one day of any day-measured service, one hour of any hour-measured service except Medical /Somatic or 15 minutes of Medical/Somatic. Hence, if a consumer received three hours of Case Management/CSP and two hours of Medical/Somatic in a given year, that would equal 11 units of service.) It was hoped that the proportion of consumers receiving few services would decrease following the Mental Health Act. Results revealed the size of this cluster actually increasing in the past two years, although the amount of service received by members of this cluster also increased from approximately eight units in 1989 to 13 units in 1997.

Another grouping, the ACustom Care Group≅, included approximately 10 percent or less of the population in each year. This category was composed of many small clusters of individuals receiving large amounts of highly individualized services.

A third type of cluster identified in each year, the AMedical Cluster≅, included individuals who received monthly medication check-ups and little else. The proportion of individuals in this cluster dropped significantly following the Mental Health Act, increased in 1995, then dropped back to a relatively low level in 1996 and 1997. There was also an increase in the diversity of services received by individuals in this cluster over time, indicating that consumers were receiving medical service in combination with some other services, rather than medical service alone. Thus, service providers seemed to be moving away from medication management alone as a service modality.

Corresponding to the decrease in the ≅Medical Cluster≅, there was an increase in a set of moderately-sized clusters designated as the AOther Clusters.≅ This category included individuals receiving greater than average amounts of one or more services. The proportions of individuals in this category increased following the Mental Health Act and remained at a relatively a high level. The composition of the clusters that characterized this grouping also changed. In 1989, four out of the five clusters in this grouping were characterized by one single service (e.g., case management or day service). In 1997, six of the eight clusters in this category were characterized by multiple services. Thus, this category of clusters increased in both size and diversity.

Overall, changes in service patterns suggest that the greatest impact of the Mental Health Act of 1988 occurred between 1989 and 1993. During that time, service patterns appeared to become more complex and individualized. Since 1993, there have been few significant changes, and in 1996 and 1997, there was a downward shift--a drop in the proportion of people in the most intense and diverse clusters (the AOther Clusters and the Custom Care Group≅), and an increase in the proportion of people in the AFew Services Cluster≅.

We continue to be puzzled by the erosion in service delivery patterns, in light of increasing financial resources in local community mental health systems during this period of time. The erosion has happened in the overall picture as well as in individual service clusters. For example, the average number of service units in the AFew Services≅ cluster had risen to 16 by 1995, but decreased to 13 in 1997. One hypothesis has been that boards may have decreased their reporting to MHIS by 1997, in anticipation of MACSIS. If that were the case, there would likely have been a change in the percentage of MHIS units versus those service units being reported to the Office of Fiscal Administration, however the percentage did not substantially change over an eight-year period. The absolute number of service units went down in 1997. Coupled with an increase in the 508 count, this yielded a lower average number of units per client. However, 1997 was a year in which there was another large increase in dollars coming to local systems as a result of the Mental Health Act and the subsequent 1994 settlement agreement. Hence, it remains difficult to explain the overall drop in services, and we would invite dialogue from local systems that might aid us in an interpretation of this finding.

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