PART III

The Consumer Model of Assessing Community Mental Health Needs

by

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The consumer model presents the program planner with a method of assessing mental health needs using the consumer as the major source of input. The consumer is defined as any community member who resides within a given geographic area. The model supplies information on the priorities of need for additional services by target problem, age group, and geographic area. Within the model, five consumer groups are surveyed:

1. **Mental Health Agencies**—agencies and individuals that directly or indirectly treat people with mental health problems;
2. **Secondary Related Agencies**—agencies that make referrals to mental health services;
3. **High Risk Individuals**—individuals who, because of past or present behavior, are using or have used mental health services;
4. **Community and Civic Groups**—groups within the community that are organized around a common goal or for a specific purpose;
5. **Community-at-Large**—a sample of area residents selected at random who may or may not be associated with any of the other four groups.

In order to determine the feasibility of using the model, consumer groups in the Kearny Mesa subregional area of San Diego County were surveyed. Of the 42 subregional areas in the county, Kearny Mesa was chosen because it closely approximated the sociodemographic characteristics of the overall county population.

QUESTIONNAIRES AND INTERVIEWS

Mental Health Agencies

Included were a school for the emotionally disturbed, a runaway and family crisis center, a private psychiatric hospital, a family services center, training centers for retardates, outpatient clinics, and a residential treatment facility for children. Of the 13 agencies that received the questionnaire, all 13 (100%) returned the completed form.

Secondary Related Agencies

Included were schools, the probation department, the coroner, Juvenile Hall, a general hospital, a convalescent home, a legal services center, a speech and hearing clinic, and an unemployment office. Of the 33 agencies that received a questionnaire, 22 (66.6 percent) returned the completed form.

The questionnaire asked both groups to rank the target problems that required the first, second, and third most immediate attention within three age groups: youth (under 18), adult (18-59), and geriatric (60+). In addition, information was sought regarding the quantity and type of programs already existing in the Kearny Mesa area. Questions were asked about number of persons served, type of problems treated, waiting lists, and age, race, and geographic area served.

Community and Civic Groups

Included were women's auxiliaries of public agencies, a women's social club, a parent-teacher association, men's service organizations, a YMCA, and a boy's club. Of the ten groups mailed a questionnaire, five responded.

The questionnaire required the respondent to check the services that should be made available to a greater number of people in the Kearny Mesa area for the three age groups. In order to insure a representative sampling across ethnic and socio-economic groups, each group was asked to state the race, age, income level, and geographic level of members.

Community-at-Large

Questionnaires were mailed to a sample of residents selected at random from the Haines Directory of Locations, which lists all addresses by street and census tract. Two addresses were selected at random from each street. Because of the cost factor, only 594 households, 16 percent of the Kearny Mesa households, were surveyed. Of the 594 households, 53, or 8.9 percent, returned the questionnaire. The 53 households included 176 individuals, or 3.3 per household.

The questionnaire asked respondents to check the services that should be made available to a greater number of people in the Kearny Mesa area. The questionnaire also asked the consumer to indicate the race, age, income, living arrangement, and type of residence of the family members. One open-ended question was included, which asked the consumer to list the person or persons to whom he would go for help if he had a personal problem.

High Risk Individuals

Trained mental health para-professionals interviewed 134 high risk individuals from 14 mental health agencies and secondary related agencies within the Kearny Mesa area. The interviewers followed written instructions while conducting the interviews. Although the survey was conducted through the use of personal interviews, the consumers were asked the same questions that appeared on the other mailed questionnaires.

The interviewers asked each individual to rank the services that should be made available to a greater number of people in the area, and to indicate his age, race, sex, and place of residence. The interviews lasted from 10 to 30 minutes.

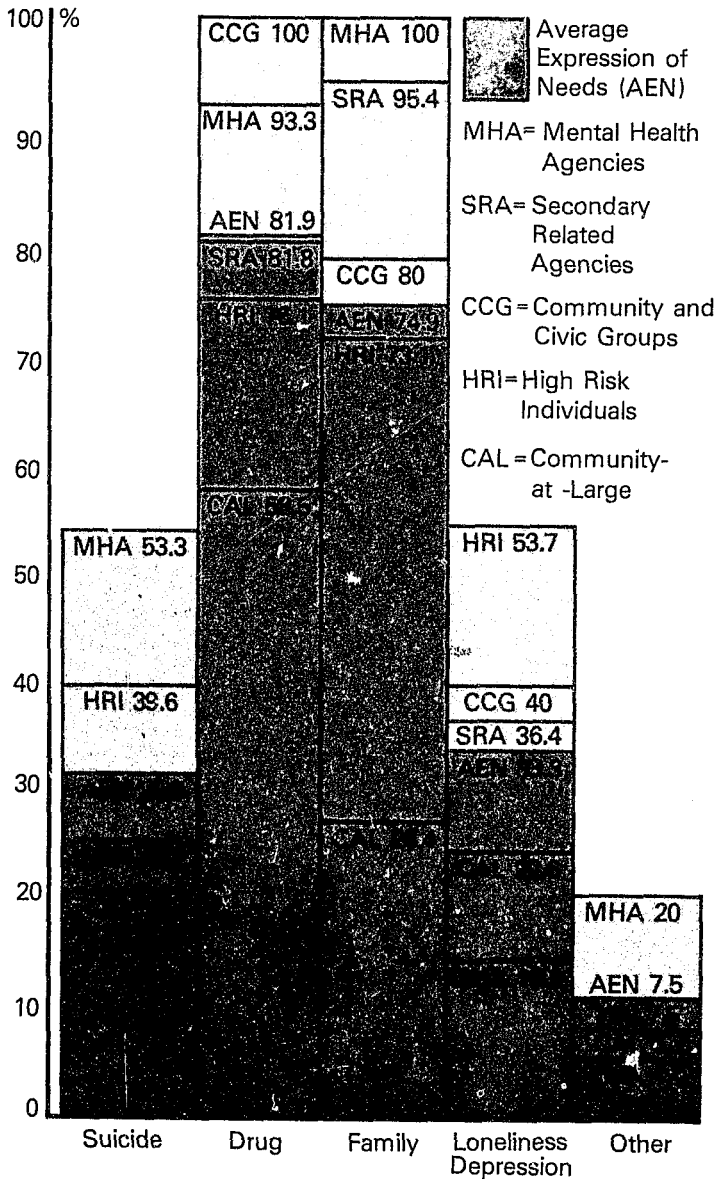
RESULTS

In order to develop an uncomplicated method for setting priorities that could be used by program planners with limited time and expertise, the expressed unmet needs for crisis intervention and mental health services were analyzed for each age group. A frequency distribution and ranking of the needed services were tabulated separately for the five consumer groups surveyed. In addition, an analysis of the Average Expression of Need (AEN) across the five groups provided a means of observing the most frequently mentioned crisis and mental health problems. The AEN was determined by computing the means of the five consumer groups' percentage of expressed need for additional services. Figure 1 depicts the AEN for each consumer group on five problem areas of the under-18 age group; the three most frequently expressed needs, in order of importance, were for services related to drugs (AEN=81.9), family problems (AEN=74.9), and general emotional problems of loneliness and depression (AEN=33.3).

For the adult group, the three most frequently expressed needs were for services related to family and marital problems, general emotional problems, and alcoholism. For the age group 65 years and older, the three most important problems were found to be loneliness and depression, general emotional problems and alcoholism. Each of the five consumer groups was consistent in ranking the above problems for all three age groups as possessing the greatest need for additional services. Whereas the need for additional drug programs was found to diminish inversely with age, the need for programs to combat loneliness and depression increased as the age of the population increased. Of all consumer groups, the mental health agencies, as expected, expressed the greatest need for additional services, whereas the community-at-large expressed the least need.

FIGURE 1

Percentage of Unmet Needs of Youth (<18) as Expressed by Five Consumer Groups in KM for Crisis Intervention Services



CONCLUSIONS AND RECOMMENDATIONS

Because the major goal of this research has been to develop a model of assessing community mental health needs, it is important to evaluate the feasibility of the consumer survey approach, based on the Kearny Mesa pilot study. Several factors must be taken into consideration prior to determining the usefulness of the results for program planning:

1. **Were the findings really expressions of unmet needs or did the consumers respond to the survey on the basis of input from the mass media?** Television, radio, and newspapers constantly refer to the extensive drug problems of youth through public service announcements and special broadcasts. Although there were more than 54 existing drug programs in San Diego County, drug problems were still found to be the need that required the most immediate attention for youth, according to the five consumer groups. It was not determined whether the existing agencies were ineffective in treating the drug problem, whether the general consumers were unaware of the available drug resources, or whether the preventive steps taken by the media to combat drug abuse confounded the survey results.

2. **Should the responses of the five consumer groups be differentially weighed?** In the past, mental health professionals were considered the only group knowledgeable enough to respond to a survey of needs assessment. If a program planner feels that the professional is, in reality, more knowledgeable, he may wish to assign greater weight to the opinions of the mental health agencies than to the opinions of the other four groups. It must be stressed, however, that the mental health agencies were found to express a greater need for additional services across all ages and types of problems than any of the other groups. In 52.7 percent of 39 possible problem areas by age group, the mental health agencies expressed the greatest need for services, compared to 16.7 percent for community and civic groups, 13.9 percent for secondary related agencies, 11.1 percent for high risk individuals, and 5.6 percent for the community-at-large. This "empire building" phenomenon is one of the major reasons why the other groups, in addition to the mental health agencies, were surveyed.

3. **Is the mailed questionnaire method the most valid means of collecting data from the community-at-large for the Consumer Model?** Because of financial limitations, mailing questionnaires to the community-at-large was the only possible alternative for the author to employ. Before using the results for planning, it must be decided whether or not the responses were representative of the population in general. Race and socioeconomic data from the 1970 census can be used as a basis of comparison. It is strongly recommended that different survey approaches such as the personal interview and telephone polling techniques be piloted to determine the most valid and economically feasible method of assessing need.

4. **Are high risk individuals able to comply with the survey instructions?** A great concern of program planners was that high risk individuals were too toxic, retarded, or disturbed to be meaningful sources of input for assessing mental health needs. The interviewers found the reverse to be true. Because high risk individuals were actually experiencing the problems, they provided added insight in answering questionnaires.

5. **Should the questionnaires be changed in any way?** On the basis of the pilot survey, it was felt that the questionnaires should be changed in three ways: first, the secondary related agencies group should be expanded to include family physicians and clergymen, and the community-at-large be expanded to include "natural neighborhood" caregivers, such as bartenders. The physicians, clergy, and bartenders compose the individual natural mental health delivery system, defined by Levy (1974) as the naturally occurring community processes spontaneously structured by crisis situations; second, because the results from the more complex rank-ordering questionnaires (mental health agencies, secondary related agencies, high risk individuals) were identical with the simpler checklist variety of the community and civic groups and community-at-large, it is strongly recommended that rank ordering be abandoned. The rank-ordering caused the mental health agencies and secondary related agencies great difficulty. In fact, the majority completed the questionnaires incorrectly and had to be telephoned for revisions and corrections, causing increased time consumption and decreased patience; finally, the survey questionnaires lacked any mention of indirect mental health services, specifically, consultation and education. Because more and more attention is being focused on primary and secondary prevention, programs are spending large amounts of time educating the public and consulting with community groups on how to actively avoid mental illness. Therefore, it would be meaningful to obtain the consumers' opinion of the priority of indirect mental health services in comparison to the more traditional direct delivery programs.

6. **How can the consumer model be used in several geographic areas?** The consumer model is designed to be used in several geographic areas at the same time. The identical procedure should be followed for each area. The findings can be analyzed and compared on the basis of the top priority needs by age group, and the differing opinions of the five consumer groups across geographic areas. The varying sociodemographic characteristics of each area must be taken into consideration when comparing the data. The location and availability of existing agencies should also be plotted, in addition to the quantity and type of problem areas served.

Because mental health needs change rapidly, it is highly recommended that a consumer-survey update, in conjunction with a social-indicator update,

be conducted annually. The consumer model can become a part of the normal county, city, or program reporting system. To offer feedback to the mental health agencies and secondary related agencies that participate in the survey, summary statistics can be made available that will alleviate a duplication of effort by other community agencies. Results and feedback should also be made available to the interested community and civic groups, high risk individuals, and community-at-large to serve as a means of promoting the mental health services of the community.

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