

NATIONAL CONSUMER SUPPORTER TECHNICAL ASSISTANCE CENTER

ASSESSING COMMUNITIES FOR SYSTEMS TRANSFORMATION

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Introduction

The National Mental Health Association's National Consumer Supporter Technical Assistance Center (NCSTAC) has developed *Assessing Communities for Systems Transformation* to assist organizations in implementing its Community Needs Assessment. The Community Needs Assessment is designed to assist mental health stakeholders in determining the current strengths and service gaps of their local mental health system. The information obtained from the Community Needs Assessment will illuminate for stakeholders what needs to be addressed in order to transform their current mental health system into one that supports and promotes recovery.

Contents of this document include:

- Description of Community Needs Assessment stakeholders,
- Tips on how to organize and implement a Community Needs Assessment,
- A sample Community Needs Assessment of a fictional community and;
- An analysis of data provided by the sample Community Needs Assessment.

We hope that the samples provided will help you with analyzing the results of your own assessment. Please keep in mind that the results and description of assessment process are fictional and are designed to serve as one example of how to conduct a Community Needs Assessment. Should you have questions on how to conduct your Community Needs Assessment or how to analyze the results of your Community Needs Assessment, please contact NCSTAC at 1-800-969-NMHA or ConsumerTA@nmha.org. To obtain a copy of the Community Needs Assessment, please visit the NCSTAC website at www.ncstac.org.

The National Mental Health Association's National Consumer Supporter Technical Assistance Center (NCSTAC) is funded through a grant from the Center for Mental Health Services (CMHS) within the federal Substance Abuse and Mental Health Services Administration (SAMHSA). NCSTAC is dedicated to improving the functioning and effectiveness of consumer organizations. NCSTAC strengthens consumer organizations by providing technical assistance in the forms of:

- Assisting consumer/peer-run groups to obtain needed resources;
- Facilitating referrals to consumer/peer-run programs;
- Providing the necessary training, expertise and knowledge to consumers;
- Facilitating in the collection and dissemination of research findings, evaluation and data related to consumer/peer-run programs; and
- Identifying, disseminating and applying best practices on consumer/peer run programs.

Why Conduct a Community Needs Assessment?

Assessments are a good way to gather information about an existing system or organization. In many ways, it is an educational and planning tool since the results can educate community leaders about how citizens view a particular system and identify specific changes to be made.

The purpose of the Community Needs Assessment is to help mental health stakeholders identify what parts of the mental health system are working and what parts need fixing. For example, in examining gaps in services, the information could be used to persuade decision makers that more consumer-run services need to be implemented. It could also be used to illustrate the need for more outreach to diverse ethnic groups.

The Community Needs Assessment results will provide you with a thorough understanding of your community's planning and financing mechanisms. Such information can help you identify strategies to transform your mental health system. Ultimately, the Community Needs Assessment will provide a clear roadmap for systems change.

Who Should Be Involved? Ideas for Obtaining Community Input

As is the case with many coalition* building activities, you will want to have a wide range of community representatives participating in the Community Needs Assessment. It is essential that the viewpoint of consumers and consumer groups be represented. While the following list doesn't mention all the possible players, it does identify key stakeholders who should be invited to participate in the Community Needs Assessment process:

- Persons with mental illness
- Family and extended family members
- Mental health advocacy organizations
- Key decision makers such as mental health representatives from local government and state legislative offices
- Mental health providers
- Faith-based organizations
- Healers from diverse cultural communities such as the Latino "botanica"
- Representative from the corrections system
- Representatives from the substance abuse treatment system
- Representatives from diverse cultural and ethnic populations within the community
- Representatives from gay, lesbian, bi-sexual and transgender communities

*Coalition refers to a group of organizations that work together toward a common purpose, i.e. conduction a Community Needs Assessment

Indian Health Services
For Native American communities, mental health services are covered under Indian Health Services and not the public mental health system. If the assessment will be incorporating the needs of First Nation individual's, there should be representation from Indian Health Services.

- Representatives from the health care system
- Representatives from the business communities including ethnic businesses

Culture matters: Stakeholder involvement will be impacted by the cultural composition of the community. For example, in the Native American community, stakeholder involvement must include a voice from all generations; an elder, a respected female leader, a respected male leader and a youth representative.

Methods for Conducting Community Needs Assessment

Gathering the Data

Gathering the data for the Community Needs Assessment can be accomplished in a variety of ways. The format you choose will depend on your time frame and the strengths and the cultural composition of your coalition.

Group Discussion Format: The Community Needs Assessment can be implemented by conducting organized group discussions. This format provides rich information about the experiences of individuals receiving mental health services. Such an approach can help identify consumer preferences, unmet needs and existing service quality. When leading or facilitating such a group discussion, please keep the following guidelines in mind:

- **Identify group size:** The ideal group size is 8-10
- **Set the meeting particulars:** Select a date, time and meeting place for the discussion. The meeting place should be comfortable and accessible by public transportation.
- **Provide ground rules of discussion:** Common ground rules include: speak one at a time and respect other people's views, try to stay on topic, try not to repeat what has already been said.
- **Identify interpreters:** Identify ahead of time whether or not you will need language interpreters. In order to elicit as much feedback as possible, try to have interpreters who are the same ethnicity as individuals requesting the interpreters.
- **Stimulate discussion:** Whenever possible, ask open ended questions such as, "What do people think about the availability of peer-run programs in our community?"
- **Focus the discussion:** It is important that the discussion stay focused on systems, services and values. The nature of these discussions prompts individuals to talk about their experiences in the mental health system. While this information is critical to the assessment process, try to strike a balance between sharing individual experiences and discussing the existing mental health system.
- **Actively involve participants:** Ask follow-up questions of the group and of individuals, such as, "Mary, tell me more about why you think we need more peer-run programs" or "Is there anyone in the group who has a different opinion?"

- **Remain neutral:** Be sure not to judge opinions or inject your own into the discussion.
- **Closing the meeting:** Before ending the meeting, ask if anyone has additional comments. Remember to thank people for their participation.
- **Working with larger groups:** For larger groups like a community forum, the same ground rules of discussion still apply but your role as a facilitator will be to obtain input from as many people as possible and while moving through the agenda items. It may not be realistic to get comments from everyone in the audience. You may want to enlist an additional person to record comments.

Individual or Survey Response: Another method to use for conducting the Community Needs Assessment is to ask people to complete the assessment on an individual basis. While this method may not provide as much detailed information as a group format, it is quicker and easier to administer since time is not spent facilitating or organizing meetings. Should you opt for using an individual response method, please keep the following guidelines in mind:

- Ensure that you have a diverse group of respondents (consumers, providers, family members, key community decision makers etc)
- Enlist coalition members to distribute the assessment
- Make sure that the contact information for mailing assessments is correct
- Know your audience: While it is important to maximize community input, you will want to know who you are hearing from
- When using mailing lists, make sure addresses are up to date
- Allow a reasonable time for individuals to complete and return the assessment
- Recruit individuals to provide follow-up with individuals completing the assessment
- Identify one person or agency as the repository for all responses

How to Answer “Hard Data” Questions: Some portions of the assessment ask for hard data (i.e. demographics, budget info, etc.). The answers to these questions may not be easily answered through an individual survey or group format, since finding the answers requires some research. One option to address this is to identify several individuals in the coalition to research the answers to these questions. Another option might be to ask a local college if they have any students who might be interested in researching these questions.

Analyzing the Results

Knowing what information you want to gather will help in determining how you want to analyze the results of the assessment. Therefore, before sending out the Community Needs Assessment, review it to see that it asks the questions you would like to have answered. If the questions are not in the Community Needs Assessment, revise it accordingly.

When analyzing the results, ask yourself the following questions:

- What patterns emerge?
- What are the common themes?

- If there are conflicting sets of data such as lack of agreement around a particular assessment item, are there obvious reasons for the disagreement?
- What is the data revealing in terms of developing an action plan for the coalition?
- What additional research might be helpful?

Whether or not the Community Needs Assessment is conducted individually or in a group format, the coalition as a whole must reach consensus on the trends identified in the Community Needs Assessment as well as any action steps resulting from the Community Needs Assessment. This can be accomplished by bringing the coalition together to discuss the preliminary results of the Community Needs Assessment.

Developing a Plan

Based on the data, you will want to develop some preliminary goals and objectives towards improving your mental health system. Developing a plan for system change will take time and, unfortunately, is beyond the scope of this document. However, we want you to be aware that this is the next step in changing your mental health system. As you move forward with your plan, remember to develop clear timelines for the goals and objectives. Review the plan periodically and revise it accordingly.

Strategies for Conducting A Community Needs Assessment

Conducting a Community Needs Assessment takes time, resources and organization. To help you implement a thoughtful and organized assessment, we have developed a planning template which can be found on the next page. The template provides suggested assessment activities as well as tracking mechanisms for who is responsible, when the activity should be completed and what resources are needed to complete the task. We realize that each community will have their own time frame and ideas about who should carry out each activity. The template is provided purely as a way to think about organizing your assessment process. Feel free to make modifications as needed.

Prior to conducting your community assessment, you will need to identify who will be participating in the assessment. The cultural composition of the stakeholders will have an impact on the overall assessment process, how decisions about consensus are made and how stakeholders will provide input. For example, if a community assessment is being conducted in a Native American community, permission to conduct the Community Needs Assessment must be sought from the Tribal Council.

Culture matters: Members of the Latino community might feel more comfortable providing input in a large community forum as opposed to a small group discussion. Members of Native American communities may talk more openly if a talking circle method is incorporated. A talking circle is a concept in which each person has a chance to speak, they may choose or not choose to speak, but they have the option of deciding how they will use that time.

Planning Activities	Group/Person Responsible	Time Frame	Resources Needed
Establish goals and objectives of the coalition.			
Obtain consensus or agreement from coalition members on how the assessment is will implemented. Keep in mind the cultural composition of community.			
Discuss what type of data to be collected and how to analyze the results of the assessment			
Establish a realistic timeline for conducting the assessment and analyzing the results			
Define the roles and responsibilities of coalition members regarding assessment implementation.			
If necessary, make changes/adaptations to assessment to meet the needs of the community.			
Ensure that the Community Needs Assessment is available in alternative formats (i.e. different languages, Braille, etc)			
When applicable, identify ways to advertise public events or discussions relating to the Community Needs Assessment			

Organizing Activities	Group/Person Responsible	Time Frame	Resources Needed
Convene regular coalition meetings to discuss progress of Community Needs Assessment			
Arrange a time and place of coalition meetings which are convenient to stakeholders			

Organizing Activities	Group/Person Responsible	Time Frame	Resources Needed
For Discussion Format: Arrange dates, time and place for group discussions			
Establish clear lines of communication; i.e. weekly updates via email and regular mail			
Provide food and refreshments at coalition meetings			

Implementation Activities	Group/Person Responsible	Time Frame	Resources Needed
Provide outreach to members of diverse racial and ethnic communities and invite them to participate in the assessment process			
Obtain input from additional stakeholder groups such as criminal justice, substance abuse and healthcare systems			
Invite key decision makers to participate in assessment process			
Provide transportation vouchers for individuals who lack financial means to attend meetings			
For Surveys: Distribute Community Needs Assessment via email or regular mail			
For Surveys: Provide follow-up phone calls to maximize participation			
For Group Discussions: Hold several rounds of meetings at different times and locations to ensure adequate participation			
Research demographic information and structure of community mental health system			
Advertise information about the Community Needs Assessment in mental health centers, drop in centers, local prison, churches, newspapers etc.			

Implementation Activities	Group/Person Responsible	Time Frame	Resources Needed
Collect and receive assessment results			
Analyze assessment data			

Follow-Up Activities	Group/Person Responsible	Time Frame	Resources Needed
Develop and disseminate Community Needs Assessment report			
Submit press release to local newspapers about final results of Community Needs Assessment.			
Develop action plan for systems change based on Community Needs Assessment			

Sample Assessment: Atlantis County Mental Health Consumers Association*

The Atlantis County Mental Health Consumers Association (ACMHCA) convened a county wide coalition of mental health consumers, family members, advocates and providers for the purpose of conducting a Community Needs Assessment. Results of the assessment were used to develop a plan to transform the Atlantis County mental health system into one which is recovery oriented and consumer and family driven.

Distributing and Conducting the Assessment

ACMHCA distributed the Community Needs Assessment among coalition members and additional stakeholder groups. Each member of the coalition was charged with completing the assessment with their organization and then submitting the results back to ACMHCA. Emphasis was placed on reaching out to consumer groups and drop-in centers. In addition, outreach was conducted to include leaders of various cultural and ethnic communities.

When using the Community Needs Assessment, the ACMHCA coalition decided to make several alterations to the assessment to meet their community needs. The specific adaptations were:

- Translating the Community Needs Assessment into Spanish
- Adding a “comments” section

Stakeholder organizations were instructed to reach consensus on each of the Community Needs Assessment items using a group discussion format. On items where there was lack of agreement among group members, organizations were encouraged to document the differing opinions. Organizations were also encouraged to submit any data that supported their views/opinions.

In addition to input from stakeholder organizations, three separate community forums were conducted. During these forums, a facilitator led a discussion among participants to reach consensus on each of the assessment items. The facilitator was identified through a local college.

To answer questions requiring hard data, ACMHCA formed a subcommittee to research the questions asked in the sections titled “Community Demographics” and “Organization of Services and Funding.” Over half of the individuals in the subcommittee were consumers.

As organizations and groups completed the assessment, results were forwarded to ACMHCA. The results of the community forums were also tallied and sent to ACMHCA.

After receiving and tabulating all the results of all the assessments, ACMHCA convened a meeting of the stakeholders to present a summary of the results of the Community Needs Assessment. A summary of the final results was also submitted to local newspapers in the form of a press release.

*Fictional name and consumer group

NCSTAC SAMPLE COMMUNITY NEEDS ASSESSMENT

Please read and answer the following questions based on your experience of the local community mental health service system and the community it serves.

Community Demographics

As you venture into improving the mental health services in your area, it is imperative that you take into consideration the demographics of the community that you will be serving. Many demographic groups are underserved in communities because there is a lack of appropriate services for populations from diverse communities. Utilizing your experience, determine the make-up of your community by identifying the presence of the people in the following groups in your community. Give each of the groups a percentage of which they make up the population. (The total percentages for each category of race/ethnicity, gender, age and insurance status should equal 100 %.) This information may be accessed through your local county or city website. In addition, you can use the U.S. Census information at: <http://quickfacts.census.gov/qfd/>

ACMHCA RESULTS

CD-1. Race/Ethnicity

Caucasian	<u>70 %</u>
African American	<u>9 %</u>
American Indian/Alaska Native	<u>1 %</u>
Native Hawaiian/Pacific Islander	<u>1 %</u>
Asian	<u>3 %</u>
Hispanic/Latino	<u>16 %</u>
Other	<u> </u>
Total	<u>100 %</u>

CD-2. Gender

Males	<u>49.5%</u>
Females	<u>50.5%</u>

CD-3. Age

Under 18	<u>27 %</u>
19-25	<u>6 %</u>
26-35	<u>17 %</u>
36-50	<u>20 %</u>
50-65	<u>18 %</u>
66 and older	<u>12 %</u>

CD-5 Insurance Status*

Privately Insured	<u>65 %</u>
Uninsured	<u>13 %</u>
Medicaid	<u>10 %</u>
Medicare	<u>12 %</u>

*Information on Insurance Status can be found at the Kaiser Family Foundation
<http://www.statehealthfacts.org/>

Consumer Leadership

Using the following table, rate the amount of consumer involvement in your community as it pertains to mental health systems transformation.

ACMHCA RESULTS (X= Average response)

Involvement	Always	Sometimes	Rarely	Never
C-1. People who identify as consumers are present on coalitions, task forces, Boards, etc. that meet to discuss mental health issues.		X		
C-2. People who identify as consumers actively participate in coalitions, task forces, Boards, etc. that meet to discuss mental health issues.			X	
C-3. People who identify as consumers serve in leadership roles on coalitions, task forces, boards, etc. in the community.			X	
C-4. People who identify as consumers are seen as experts and are respected by mental health providers.			X	
C-5. People who identify as consumers are employed in mental health programs.		X		
C-6. People who identify as consumers are employed as decision-makers of mental health services (i.e. Ombudsman programs, Executive Directors, management in mental health agencies, etc.).			X	
C-7. People who identify as consumers are employed in policy-making positions (i.e. working at the state level-office of consumer affairs etc).		X		

Additional Comments:

Item C7: There is disagreement among stakeholders about the level of influence the Office of Consumer Affairs has on mental health services. Some stakeholders believe that the current structure of the office of consumer affairs does not effectively advocate for persons with mental illness and that it needs to be housed in an independent organization.

Item C3: There is token representation of consumers on advisory boards. Only one consumer is represented in the county mental health board. This individual reports that her suggestions are frequently ignored.

Gaps in Services

In order to determine what services are most needed in your community at this time, read through the following list of services. Using the scale below, please rate the service availability in the community, service accessibility (i.e. can an individual receive a service when she or he needs to), service choice of provider and the ability of the service to meet the cultural and linguistic need of an individual (cultural responsiveness).

Service Scale
 0= Service has *virtually no* availability, accessibility, provider choice and cultural responsiveness
 1= Service has *limited* availability, accessibility, provider choice and cultural responsiveness
 2=Service has *adequate* availability, accessibility, provider choice and cultural responsiveness
 3=Service has *outstanding* availability, accessibility, provider choice and cultural responsiveness

In the last column, rank the importance or priority level of each service. In other words, the service ranked number one should be the most important service to the individual(s) or group (s) completing the assessment.

ACMHA RESULTS (Numbers indicate the average response of service scale)

Service	Available	Accessible	Choice of Provider	Culturally Responsive	Rank Importance
S-1. A wide range of peer support services/groups (including self-help, WRAP etc.	.3	.25	.3	0	6
S-2. Safe, affordable housing options	0	0	0	0	1
S-3. Employment Services	2.6	.2	1.7	0	2
S-4. Education Services	1.6	.4	1.4	.3	13

Service	Available	Accessible	Choice of Provider	Culturally Responsive	Rank Importance
S-5. Outreach and continuum of services for individuals who are homeless and have a mental illness or co-occurring disorder.	.5	.3	0	0	8
S-6. Integrated services for people with mental illness and substance abuse/addiction problems.	2.0	2.0	.1	.1	10
S-7. Opportunities to develop advanced-directives	.4	.4	.4	0	7
S-8 Transportation Services	.9	.9	.9	0	3
S-9. Opportunities for socialization/recreation	1.9	1.9	1.9	.1	12
S-10. Mobile Crisis Services	2.0	1.6	0	0	17
S-11. Substance Abuse/Addiction Service (detox and rehab.)	2.0	.4	.2	.1	14
S-12 Psychiatrist	2.0	2.0	2.0	.4	4
S-13 Psychotherapy Services	2.0	2.0	2.0	.4	15
S-14. Ombudsman program	1.8	1.8	.3	.1	9
S-15. Prevention and screening services	1.9	.3	.2	.1	16
S-16 Alternatives to hospitalization (i.e. crises beds)	1.8	.1	.1	1.4	11
S-17 Crises Intervention Services (Police Dept)	1.4	1.4	.4	1.4	18

S-189 Jail Diversion Programs	1.7	1.6	.2	.2	19
S- 19 Community Re-entry Programs	.1	.1	0	0	20
S-20 Trauma Informed Services*	.3	.2	.2	0	5

*Services delivered in a manner as to prevent inadvertent re-traumatization of individuals who have experienced trauma.

Additional Comments:

Item S-3: Stakeholders commented on the range of employment services. There are four psychiatric rehabilitation providers and one drop-in center that offer employment services. This is definitely seen as a strength.

Item S-2: Housing opportunities are virtually non-existent for persons with mental illness. Very few vouchers have been distributed recently and when the vouchers are available, they are not widely advertised. Wait lists for subsidized housing increased by 15% last year. The average person receiving Supplemental Security Income (SSI) in Atlantis County needs to use to use 90% of his or her monthly income to pay for a one-bedroom apartment that is not subsidized.

Culturally Responsive Services: 90 percent of the services listed had an average rating of “virtually no cultural responsiveness”. Only two types of services had an average rating of “limited cultural responsiveness”. This highlights a need to ensure that mental health services address the cultural and linguistic needs of diverse populations. Interestingly, the two services which did cater to the needs of various cultures and ethnicities were crisis oriented.

Barriers to Receiving Recovery-Oriented Services

Now that you have determined the gaps in services, you must determine what the barriers are in terms of receiving services that are available in the community. What are the greatest barriers in your community that prevent people from receiving appropriate mental health treatment?

Determine the significance of each barrier below.

ACMHA RESULTS (X=Average Response)

Barrier	Not a Barrier	Sometimes a Barrier	Often a Barrier
B-1. Long waiting lists			X
B-2. No outreach to people who are homeless		X	
B-3. Lack of insurance	X		
B-4. Refusal by providers to accept clients with Medicaid/Medicare because the reimbursement rate is too low			X
B-5. People needing services do not have a permanent address		X	
B-6. Language/cultural/sexual orientation barriers (specify barrier): <u>language</u>			X
B-7. Restrictive Medication Policies (e.g. formularies, monthly limits)	X		
B-8. People needing services cannot afford co-pay		X	
B-9. Refusal by providers to accept privately paid insurance		X	
B-10. High turnover of staff		X	
B-11. Lack of child care services		X	
B-12. Limited hours of operation	X		
B-13. Lack of transportation		X	
B-14. Stigma, discrimination and prejudice			X
B-15. No outreach to people in the criminal justice system	X		
B-16. Individual does not meet behavioral criteria for program (criteria set too high or too low)		X	

Barrier	Not a Barrier	Sometimes a Barrier	Often a Barrier
B-17. Lack of appropriately trained staff, including cross training in substance abuse/addiction issues	X		

Additional Comments

Item B-10: There is discrepancy among stakeholders as to how great a barrier staff turnover is. In agencies where there is high turnover it is a significant barrier for individuals receiving services. Yet the assessment results yielded greater representation from agencies with little staff turnover.

Item B-13: The majority of the county is fairly accessible by public transportation. Some portions of the county are very accessible by transportation. However, in areas where there is very little public transportation, individuals have great difficulty accessing services.

Item B-6: Results of the assessment indicate an extremely large language barrier among the Latino community. 80% of respondents who are Latino indicated that language was “often a barrier”. During one of the community forums, this barrier was highlighted when there was no interpreter for the meeting.

Organization of Services and Funding

Organization and Structure of Mental Health Services

F-1. Are mental health services in your community locally or state-controlled and planned?

Services are controlled through local mental health authorities (county level)

F-2. How are mental health services in your community structured?

A. Community Mental Health Centers?

B. Private Managed Care Organizations/Private Contracted Clinics?

C. Other? - Services are structured and funded through county mental health authorities. Funding flows from the state to the county mental health authority.

F-3. Does planning for local mental health services include consumer and family involvement?

Up until a few years ago, there was very little consumer and family involvement. This has started to change. As reflected in the Consumer Leadership portion of the assessment, the county recently started to recognize the need to involve consumers at all levels. Currently, consumer and family members have token representation on provider advisory boards and mental health boards. Consumers report that their input into issues is often ignored. Only one consumer is on the local county board which oversees the county mental health service system.

F-4. Is the state mental health agency a stand-alone agency or is it part of a larger agency?

Department Mental Health is a stand alone agency.

F-5. Are the mental health components of Medicaid governed by the state mental health agency or Medicaid? If the latter, how involved is the state mental health agency in decision making?

The state mental health agency governs the mental health components of Medicaid. The state mental health agency and the state Medicaid office have a good working relationship. As a result, many of the “optional” services under Medicaid are covered.

F-6. Are substance abuse services governed by the mental health authority or is it a stand-alone agency? If it is a stand-alone agency, what is its relationship to the state mental health agency?

The Office of Substance Abuse is a stand alone agency and does not have the same organizational stature as the Department of Mental Health. Yet these two offices work closely which has resulted in funding for programs to work with individuals with co-occurring mental health and substance use disorders.

F-7. How responsive are state/local mental health authorities, the governor's office and/or the state legislature to requests to improve mental health services?

State and local mental health authorities have a fairly good relationship with the legislature. However, the legislature is frequently at odds with the Governor's office. Therefore, when legislation is passed, it has usually undergone several compromises to get the bill to a point where the Governor's office and the legislature can agree.

Additional Comments: None

Funding and Budgetary Information

F-8. What percentage of the state mental health agency's budget is spent on inpatient care for persons with mental illness?

42 percent

F-9. What percentage of the state mental health agency's budget is spent on community-based services for people with mental illness?

58 percent of funding goes into community-based services.

F-10. What are the current spending trends in state and county mental health budgets?

At the state level, there is increasing pressure to cut Medicaid services. A tax cut was passed this past year and mental health services are currently being targeted as a possible service area to cut. Fortunately, mental health advocacy and consumer groups have launched an aggressive campaign to prevent cuts in funding.

Despite the targeted cuts and pressure to reduce Medicaid, there is a political will at the county level to increase the amount of community based services for persons with mental illness. County administrators have an interest in improving mental health services in Atlantis County.

F-11. Medicaid “Optional Services”

Does the state Medicaid Program cover . . .	Yes or No	If yes, any limitations/restrictions?
Targeted Case Management	Y	
Inpatient Psychiatric Services for people under 21	Y	
Inpatient and Nursing Facility Services (People 65 and older)	Y	
Home and Community-Based Services (under a waiver)	Y	Includes psychosocial services for elderly/disabled individuals; MR eligibles; individuals with head or spinal cord injuries
Rehabilitative Service (Rehabilitation Option)	Y	

Additional Comments: None

Analysis

Community Demographics: ACMHCA compared their demographic information with national figures. This was done by using U.S. census information. For insurance information they consulted the Kaiser Family Foundation at <http://www.statehealthfacts.org>.

After comparing their demographics with national averages, they found that Atlantis County has a higher than average representation of Latinos in their community. Demographics regarding gender and age were similar to the national average. Regarding health insurance, the number of individuals uninsured was lower than average and the number of individuals on Medicare is higher than average.

Consumer Leadership: Consumers are identified as only “sometimes” or “rarely” involved in leadership roles. This indicates that while some work has been done in the area of consumer leadership, there is still much more work to be done. Issues of consumer leadership and involvement are raised repeatedly by consumers and consumer organizations. As mentioned in the previous section, there is only one consumer who serves on the county mental health board. With the exception of a local drop in center, there are no peer support positions within traditional mental health providers. 80 percent of respondents stated that consumers rarely hold participated or served in leadership roles on coalitions, task forces or boards. 95 percent of respondents stated that consumers rarely were employed as decision makers of mental health services. Recommendations from the assessment must simultaneously address the gaps in services as well as the lack of consumer leadership and involvement in the delivery of mental health services.

Gaps in Service:

Below is a summary of the data drawn from the assessment. Items in italics refer to noteworthy findings.

Availability

25% of services listed had an average rating of “virtually unavailable”
15 % of services listed had an average rating of “limited availability”
55 % of services listed had an average rating of “adequate availability”
5% of services listed had an average rating of “outstanding availability”

Accessibility

55% of services listed had an average ranking of “virtually inaccessible”
10% of services listed had an average rating of “limited accessibility”
35% of services listed had an average rating if “adequate accessibility”
0% of services listed had an average rating of “outstanding accessibility”

Choice of Provider

70% of services listed had an average rating of “virtually no provider choice”
10% of services listed had an average rating of “limited provider choice”
20% of services listed had an average rating of “adequate provider choice”
0% of services listed had an average rating of “outstanding provider choice”

Cultural Responsiveness

90% of services listed had an average rating of “virtually no cultural responsiveness”
10% of services listed had an average rating of “limited cultural responsiveness”
0% of services listed had an average rating of “adequate cultural responsiveness”
0% of services listed had an average rating of “outstanding cultural responsiveness”

Importance

Characteristics of Service	Services ranked most important (1-10)	Services ranked less important (11-20)
Adequate or Outstanding Availability	40%	80%
Adequate or Outstanding Accessibility	30%	40%
Adequate or Outstanding Choice of Provider	20%	20%
Adequate or Outstanding Cultural Responsiveness	0%	0%
Virtually No or Limited Availability	60%	20%
Virtually No or Limited Accessibility	70%	60%
Virtually No or Limited Choice of Provider	80%	80%
Virtually No or Limited Cultural Responsiveness	100%	100%

In reviewing the data provided, several conclusions could be drawn:

Establishment of housing for persons with mental illness needs to be a priority –Given the facts that housing is consistently ranked as the most important service for persons with mental illnesses and that safe affordable housing is currently not available, housing must become a number one priority for the Atlantis County mental health system. As mentioned earlier, the average person on SSI in Atlantis County must use 90 percent of his or her monthly income to pay for a one bedroom apartment.

There are large gaps regarding the delivery of culturally competent services. 90 percent of service listed are described a having “virtually no cultural responsiveness”. 10 percent of services are described as having “limited cultural responsiveness”. The only services described as having any level of culturally responsiveness are not ranked by the community as the most important. This information is extremely significant given the large Latino representation in the community. In addition, the services which are viewed as culturally competent are responding to “crises” (alter to hospitalization and Crises Intervention Services).

Services described as “important” to consumers are not being funded – Only 40 percent of the ten most important services had an average rating of adequate or outstanding availability in the community. Only 20 percent of the top ten most important services received an average rating of adequate or outstanding choice of provider.

Services are available in the community, but need improvement in terms of accessibility, provider choice and cultural responsiveness – Over half of the services listed are available in the community. While this may be seen as a positive, a more accurate description might be that services are present but need improvement in their quality. 70 percent of services listed have an average rating of “virtually no provider choice” and 65 percent of services listed received an average rating of either “virtually inaccessible” or “limited accessibility”.

Barriers to Receiving Recovery Oriented Services:

- 24% of items are were reported as “Often a Barrier”
- 47% of items were reported as “Sometimes a Barrier”
- 29% of items were reported as “Not a Barrier”

Stakeholders expressed differing opinions about how much of a barrier particular items were. For example, stakeholder views of transportation and staff turnover varied depending upon where the service is delivered. Some agencies are located in parts of the county which are inaccessible via public transportation. Some organizations report high levels of staff turnover. While staff turnover is not a widespread problem (according to the assessment), agencies which report high turnover should identify ways to retain qualified staff.

Organization of Services and Funding: Summary of Findings

- Services are organized through local county entities.
- Both mental health and substance abuse are stand alone entities, but substance abuse does not have the same stature as mental health.
- Service providers and administrators are starting to recognize the value of consumer driven services.
- Legislature has good relationship with mental health advocates, but is at odds with Governor.
- At the state level, there is increased support for cutting mental health services while the county supports increasing community-based services.

Organizationally speaking, services are decentralized which means that the quality and quantity of services varies from county to county. The same is true for consumer and family involvement.

Stakeholders should take advantage of the fact that services are locally controlled to implement a pilot program. Suggestions include a housing program, or seed money for providing training on trauma informed services.

The Office of Substance Abuse is a stand alone entity but does not have the same stature as mental health. However, this county has a fair amount of substance abuse services – most likely the result of strong advocacy efforts.

Since the Legislature and the Governor do not have a strong relationship, creating change through legislation is not recommended for this county. Instead, change must occur locally.

Quality of Services: The following conclusions were drawn about the quality of services in the Atlantic county mental health system:

- Mental health services assist consumers in meeting their most basic needs (with the exception of housing).
- Consumers report that emergency services such as mobile crisis units and jail diversion programs have been helpful in crisis situations.
- A hierarchy still exists between staff and consumers at many mental health providers.
- Individuals from diverse racial and ethnic backgrounds do not have their basic needs met through existing mental health services.

Strengths of Community:

- Significant numbers of employment programs
- Strong funding through Medicaid
- Strong advocacy groups
- Recognition by county that services need to be consumer and family driven
- Decentralized services lends itself to innovation

Liabilities of Community

- Lack of consumer leadership
- Lack of housing opportunities
- Inconsistencies in the quality of service delivery
- Services do not address needs of diverse cultures
- Increasing pressure to cut Medicaid and mental health services

Next Steps

Now that ACMHCA has analyzed the data from their Community Needs Assessment, they have identified the strengths and weaknesses of their mental health system as well potential mechanisms for change. For example, they recognize that change will not occur through legislation and that a more likely scenario is to advocate for a county sponsored pilot program. As with most assessments, many different gaps were identified. ACMHCA now needs to prioritize these gaps and develop a plan to reduce or eliminate them. A successful action plan will utilize existing community strengths.

The following is an example goals that ACMHCA *could* develop based on the Community Needs Assessment results. The purpose of displaying these goals is to provide the reader with an idea of how the analysis of the data drives the goals for systems change and reform.

Goal One: Develop safe, affordable and housing and support services for persons with mental illness

There was agreement among stakeholders that safe, affordable housing is the number one issue for consumers of Atlantis County. Stakeholders agreed that developing a proposal for a pilot project of consumer-run housing would have the dual effect of increasing safe and affordable housing for persons with mental illness and increasing consumer leadership.

Goal Two: Increase consumer leadership at all levels

The decision to increase consumer leadership was based on results which documented a universal lack of consumer involvement in all areas. In addition, there has been increasing pressure to cut services. By involving more consumers in the implementation and design of mental health services, no additional programs are being formed, but a voice for reform will emerge from within the mental health system.

Goal Three: All mental health services for residents of Atlantis County will meet an individual's cultural and linguistic needs

Given the large representation of Latinos in Atlantis County, stakeholders agreed that providers need to reach out to members of diverse communities. In order for this goal to be accomplished, both provider and advocacy organizations must develop strategies for hiring and retaining individuals of different cultures. In addition, mental health providers and advocates will need to develop stronger relationships

Conclusion

It is our hope that the Atlantis example has provided you with a better understanding on how to conduct a Community Needs Assessment and analyze and interpret the results. Keep in mind that each community is different and will yield different assessment strategies and results. The Atlantis example is designed as a guide for communities to use when conducting their own assessment.

The groundwork has been laid for creating systems change that will ultimately transform the Atlantis mental health system into one which promotes and supports recovery. As is true in any community, this will take a coordinated effort among all stakeholders. When stakeholders and community unite, the possibilities for positive systems change are infinite.