AN ANALYSIS OF NEED ASSESSMENT
IN THE MENTAL HEALTH CONTEXT

BY

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ABSTRACT

Need assessment methods grew out of the Community Mental Health Centre movement. Developed during a time of rapid expansion of service, there was a focus on providing services matched to the unique needs of a community. In the following years need assessment further developed as a technology and a search began for a 'best model'. This paper argues that a 'best model' is illusionary, a 'best fit' being a more desirable goal. As fiscal constraints have reduced the resources available to consumption Ministries such as Health, need assessment has been increasingly used as an allocative tool. Users of the tool, it is argued, must therefore choose their model with care and an understanding of the values and concepts inherent in each model is seen as necessary for intelligent choice. Finally, an examination of the British Columbia mental health context offers an analysis of some of the factors which have and will affect the use of need assessment in this Province.
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Chapter I: Introduction

A. The Background

Need assessment grew out of the expansion of mental health services to the community. The early 1960’s witnessed a radical shift in the provision of service to the mentally ill which resulted in a widening definition of mental illness. Prior to this time, the bulk of the serious mentally ill had been cared for in large facilities. With the 1960’s came the commitment in the United States to provide a system of community based services. While the main style of service delivery was institutionally based costs and target populations were reasonably predictable. This new commitment to community care opened the arena on both costs and potential patients.

The United States federal government assumed in 1963 partial financial responsibility for providing a system of community mental health facilities. The Community Mental Health Centres (CMHC’s) were entrusted with the responsibility for providing services to specific geographical areas. A basic tenet of the community based movement was that deployment of resources should be based on the needs of that community. Cohen (1974) reports that one of the goals of this movement was a desire to develop and organize local community control over the CMHC’s, so that centre policies were community based and oriented, while reducing use of mental hospitals by providing prompt
response and twenty-four hour service. Need assessment data described and detailed these local needs.

The mandate of the CMHC quickly expanded. By 1970 its responsibilities had expanded from the original focus on the seriously ill to include also alcoholism, children and drug abuse. The costs of such an expanded mandate could not have been envisioned in 1963 when initial funding began. The movement was born in a period of economic abundance as well as increasing social conscience. By the early 1970's the picture had changed dramatically.

The focus on formalized need assessment which developed with the initial community mandate of the CMHC's in the early 1960's became an essential component in the early 1970's as costs rose while national revenues did not and a new age of concern regarding inflation and recession was entered into. The twenty years since the introduction of these expansive health, as well as social, programs has witnessed a shift, from funding such programs out of a sense of abundance and social morals, to an allocation process that reflects finite means, shortage and continual financial justification of expenditures. In the early 1960's a social commitment was sufficient to channel funds into these programs. Twenty years later the guide words throughout North America are rationality and accountability.

The purpose of need assessment has thus changed. Originally developing as a means of directing an expanding
health service to the unique needs of a community, needs assessments are now focussed on the containment of service development and costs. Whereas previously the primary issue was providing services where few existed, need assessments are now increasingly being used to identify specific target groups by which priorities for care can be developed and to justify continuation of existing programs.

B. **History of Community Mental Health Development**

Community mental health services have witnessed a dramatic growth since their conception in the 1960’s. In the United States this is exhibited by the growth in mandate by the CMHC’s and the move to deinstitutionalize the large federal institutions in the 1970’s. Although there has been much criticism of this process (eg. Bassuk and Gerson, 1978) and in particular of the lack of adequate community based resources for these patients, it can not be argued that dramatic expansion has not occurred.

Canada has seen similar developments. As early as the 1940’s a new interest in treating the mentally ill began to develop within general hospitals (Tyhurst, 1963). In 1948 the Canadian Federal Government established a system of Mental Health Grants to the provinces. During the next ten years considerable progress was achieved through the building of clinics, professional training and increased research.
The year 1950 marked the end of what Foulkes (1974) refers to as the "asylum industry". The development of psychotropic drugs was most likely the most significant step towards the development of the community mental health movement.

Allodi and Kedward (1977) stress that community mental health in Canada really began in the 1960’s. The Canadian Mental Health Association sponsored a report, "More for the Mind", in 1963. This report was directed at psychiatrists and emphasized the need for further development of psychiatric units in hospitals, emphasizing the medical domination of the field at the time. The report argued that psychiatric illness should receive the same consideration as those with physical illness under the Hospital Insurance and Diagnostic Services Act. It also attempted to elevate psychiatry as a specialty within medicine and argued for hospital based rather than care through a CMHC. Despite this hospital based focus this report was still a move towards community care in that it not only drew increased attention to the actual treatment as opposed to custody, but also moved this focus from the large institutions to the community based hospitals. In doing so it helped widen the definition and boundaries of mental health services. Its recommendations did much to alter the stigma of mental illness through making treatment more visible and more accessible.
For British Columbia the turn to community based care was initiated largely by the administrative changes of 1959 when Mental Health Services was transferred from the Provincial Secretary's Department to the Department of Health Services and Hospital Insurance, being placed in the same organizational arena as Public Health and Hospital. In 1961 the Burnaby Mental Health Clinic was established. It provided outreach community services through travelling clinics. In 1962 the second CMHC was opened; this one in Kelowna. By 1966, ten CMHC's were operating throughout the province, most with travelling clinics stimulating community demand. By 1975 twenty-five CMHC's were functioning.

Currently community based mental health services in British Columbia include 34 CMHC's with 19 sub-offices around the province, as well as 8 community Care Teams in Vancouver and 3 area teams in Burnaby. Community based inpatient care is available in 27 Psychiatric Units in General Hospitals and at the Burnaby Mental Health complex. In addition to the approximately 4000 general practitioners offering outpatient care there are 280 psychiatrists around the Province. A Community Residential Program, also funded by Mental Health Services, provides community living in a therapeutic environment to approximately 2500 chronically mentally ill individuals.
C. The Effects of Community Development

The development in British Columbia, described in detail above, was repeated to varying degrees across North America during the two decades, 1960-1980. The reasons for and results of this expansion of service to the community are no doubt closely intertwined. An examination of the impact of this process is important to provide a perspective of how these changes contributed to the current demand for service and the changing nature of need assessment.

Likely the most significant result of the move to community mental health was the resulting expansion in the concept of mental illness. This change was not entirely a result of the community based movement - this was an era of several significant changes - but it did provide the means by which these other changes were able to occur. Community based care brought the subject of treatment of mental health into the open. It reduced the stigma and expanded the concept of mental illness from a discrete group of seriously ill to a much larger potential audience who would never have been considered as 'sick' as long as psychiatric illness was synonymous with institutionalization. In the past two decades the legitimate focus of mental health professionals has expanded to embrace the 'distressed and the dissatisfied'. Such problems as marital family discord, parenting skills, grief and separation adjustments, reactive depressions, learning disabilities, hyperactivity, sexual
dysfunction and shyness have all moved under the ever-expanding umbrella of mental health. The human potential movement of the 1960's and early 1970's made it "O.K." to seek help if you didn't feel "O.K." - regardless of the reason. In many regions substance abuse moved under the auspices of mental health. A recent National Institute of Mental Health study (Myers et al, 1984) reports alcohol abuse as the most frequent presenting problem of males within CMHC's. This widening definition of what was a legitimate concern of mental health, combined with a growing population has taken the potential mental health consumer far beyond what any need assessment strategy of the 1960's could have envisioned. It is now virtually impossible to offer a definitive definition of mental illness. The amelioration of mental illness and the enhancement of normal functioning have become a joint concern, often indistinguishable from one another.

Associated with this widening of the concept of mental illness has come the proliferation in the "helping professionals" and the increasing power of psychiatry. This relationship was not one way - the conceptual expansion of mental illness was in part a result of psychiatric medicalization, while at the same time, the growing demand resulted in increasing numbers of professionals. Whereas the mentally ill in institutions were cared for by physicians, nurses and aides, most often trained within the
same facilities, the move to the community encouraged the
development of other mental health professionals - clinical
psychologists and social workers, later followed by a
variety of quasi-professionals - art therapists, music
therapists, recreation therapists, case workers, health care
aides etc. The visibility of the mentally ill in the
community contributed to this development, as did the new
emphasis on the "relationship therapies" in part made
possible by the development of psychotropic medications.
This growth in service providers has resulted in what Magaro
et al. (1978) has termed the "mental health industry". The
relative economic abundance of the 1960's and 1970's
supported this industry's development, with need
increasingly seeming to be a bottomless pit. Despite the
tremendous growth in services and service providers, demand
for service appears to continually outpace supply.

D. The End to Development and Dollars

The end to the developmental phase of service
development in 1980's has come about as a result of the
interaction of two major factors: the combined effects of
the results of service expansion in the last two decades,
discussed above, and the worldwide economic decline which
has seen dwindling resources allocated to health and social
service sectors by the right wing governments in Great
Britain, the United States and Canada. Crichton (1983) has
suggested that Canadian politics has emphasized a utilitarian liberalism, challenged by an ideology of collectivist humanitarianism. The economic downswing of the 1980's had led to an emphasis on the right wing of this liberal democratic framework, emphasizing entrepreneurialism, small government and a shift in focus from the consumption ministries to the production ministries (Cambell et al., 1981). This change in focus has been particularly evident in British Columbia, where a populist oriented government held by Social Credit Party has taken drastic steps to curb health care expenditures. From 1971 to 1981 annual government health expenditures in British Columbia grew from 337 million to two billion dollars - an increase of almost six hundred percent. British Columbia, particularly affected by the worldwide economic downswing due to its reliance on natural resource revenues, has faced major cuts in service in health, social service and education sectors throughout the early 1980's. At the same time there has been a significant shift in the type and locus of planning. The incremental and developmental planning led primarily by health care professions during the past two decades has been replaced by an emphasis on "rational" decision making through a highly centralized and politically influenced process.

A growing population, an expanding definition of mental illness and a reduction of available dollars has led to the
current crisis in health care funding. It can result in only two possible actions: a narrowing of service boundaries or an overall dilution of service. Either of these goals can be obtained through several different options. Boyd (1979) outlines two of the possibilities:

1. Voluntary restraint, mainly through assuming more responsibility for one's own health.

2. Rationing, based on demographic, social, clinical or geographic criteria, or the ability to pay.

It is this second option that needs assessments technologies have a role to play. In their ability to identify and quantify need—be it a reflection of what a community wants, a projection from a set of social indicators, or a set of data relying on a sophisticated diagnostic classification system, need assessment techniques can produce data on which resource allocation decisions can be based, satisfying the current pressures for rational decision making. Rational planning has been described as "the application of scientific method—however crude—to policy making" (Faludi, 1973). Need assessment technologies can provide the scientific basis to satisfy this requirement. However, herein lies the crux of the argument of this paper. Such techniques are not value free. The model used will greatly influence the answers generated. Thus, to use need assessment technologies to provide data on which resource allocations can be based necessitates an
understanding of the values and concepts implicit in each model. It has become generally accepted that science is not value free. To search for a 'best' model of need assessment (Royse and Drude, 1982) is to ignore this fact. Resource allocation and service planning have become an increasingly political process. The tool used to generate data for these decisions must be understood as well as the context in which it is used.
Chapter II: Mental Illness

A. Problems with Definitions

Before examining need assessments the question of what mental illness is needs to be addressed. In the Middle Ages deviant behavior was thought to be due to the supernatural, giving the Church the role of diagnostician, labeler and therapist. Later, sin and low morals replaced the supernatural and the Church continued its role. The scientific advances of the nineteenth century transferred this power largely to the medical profession where it remains.

The late nineteenth century and early part of the twentieth century supported the "asylum industry", previously referred to. Mental illness was clearly any condition that resulted in one’s incarceration in an asylum. The emergence of a medical model in the nineteenth century served to take deviant behavior out of the realm of the supernatural but did very little to identify and definitive biological etiology or cure. Mental disorders became viewed as biologically based mainly as an obvious extension of the germ theory of disease. Despite the distinct lack of success in producing any direct evidence to sustain this medical model of mental illness, the status of the physician appears to have been bolstered by achievements in the physical diseases of the body.

The development of the psychoactive drugs in the 1950’s
again served to bolster the medical model of mental illness, though later criticisms have pointed out that maintenance does not necessarily mean etiology. Despite this the medical model continued to hold dominance despite the beginnings of sociological investigations into deviant behavior. This growth turned the academic focus in mental health to a social causation theory (eg. Marxian theory; Durkheim, 1951; Merton, 1957; Brenner, 1973). Terms such as behavior disorder, maladjustment and non adaptive behavior - all suggesting a social or environmental etiology - have become interchangeable with medical terms such as mental illness, mental sickness, mental disorder.

European psychiatry developed quite independently of North American psychiatry during the early part of the twentieth century, focussing on differential diagnosis and classification systems. The North American tradition was fuelled by the early epidemiological work (eg. Faris and Dunham, 1939; Hollingshead and Redlich, 1958) which ignored such classification systems, focussing instead on problem lists and global measurements. Thus, in North America mental illness - mental health was seen as a continuum. Mental illness was viewed as the "downside" of mental health. Mental health became viewed as a state of balance between an individual and his surroundings, between oneself and others (eg. Sartorius, 1984).

This expansive view of mental illness was further
advanced by the Human Potential Movement. The growth of the non-medically based mental health professions assisted in the development and advancement of the relationship-based therapies. The medical profession itself embraced problems of living as legitimate medical territory through the process of medicalization (eg. Conrad, 1980).

The result is that a definition of mental illness is virtually impossible. Mental illness is not the homogeneous concept the term suggests. It potentially includes all forms of "deviant" behavior, from psychosis to hyperactivity. The impact on the development of service is clear - as long as the definition expands demand for service will outpace supply.

The two major models of mental illness - medical and social - have been largely integrated in North America and this relationship is important when examining need assessment in mental health.

B. The Inter-relationship of Medical and Social Models of Mental Illness

Within western society the disease model, or medical model, of illness is nearly universally accepted as explanation for physical ailments. Indeed, the term "physical" implies not only the location of the problem but also the cause. This has also largely been the case for mental disorders within the organized and professional
health care system, despite the academic contributions of sociologists throughout this century.

Some writers have argued that this has largely come about for political and power reasons (eg. Conrad, 1980; Mishler, 1981). Medicine has been long viewed as a powerful agent of social control and the medicalization of behaviors seemingly socially caused has served to transfer the responsibility from society to the individual. It has been argued that medical psychiatry's main task in the nineteenth century was that of confining civilization's misfits in a place where they could not disturb society. The successful medicalization or 'psychiatrization' of those who exhibit unacceptable behavior has made institutionalization unnecessary. Medical ideology can define a patient's condition as lying outside the realm of 'normal' behavior and maintain the individual's responsibility for it.

The medical profession has been long criticized as an agent of power, an elitist group that benefit from the status quo. They have gained and retained their powerful position in society largely due to superstition - man's fear of death and the witchdoctors' presumed ability to control it - and partly from the status associated with its reliance on scientific methods. Psychiatry in turn capitalized on these two seemingly contradictory forces - superstition and science - by identifying with medicine.

Given the power of the medical profession and its
desire to retain the status quo, it has been argued that psychiatry has vested interests in the continuation of the medical model of illness. This is not only from a financial viewpoint – though this is important as can be seen by organized psychiatry’s reluctance to allow the newer mental health professions – social workers and psychologists – on to their territory, and their compromise of a multi-disciplinary team – with physician at head of team, of course. This territorial imperative is also backed by legislation disallowing other professions from diagnosis and treatment of what are designated as medical conditions.

Some writers (e.g. Ingleby, 1980) have suggested that psychiatry’s interest in maintaining the medical model – the view of the individual as responsible for the amelioration of his problem (albeit socially caused) is a result of the larger political context. To acknowledge that mental disorder has a social causation – that society is responsible for the deviant behavior of its members – would suggest that society, not individuals, should be changed. It has been argued that the elitists – in this case the psychiatrists – have a vested interest in not changing society.

The result is that academically we have two distinct theories of mental illness – a medical and a social. In practice we have one – the medical. This is an important point for needs assessment in health care planning. In
western society, mental illness is by definition an illness to be dealt with within the medical establishment. This medical establishment has co-opted the newer professions into this model. Health care services are developed with change of the individual as their focus. Their target is the individual, the case. The medicalization of mental disorders or abnormal behavior has also co-opted many of the recently developed social causation models and legitimized them as medical territory. The medical establishment is itself seemingly schizophrenic, admitting to socially caused disorders but maintaining the efficacy of medically based cures.

This is not a rational position – in the sense of logic of causality. It reflects the control the medical establishment has in persuading society of their curative powers. Medicine, assisted by the technological development, starting in the fifties with the debut of the antipsychotic medications, has geared society for the "quick fix". It has made promises of treatment and cures which, particularly in the mental health sector, it has largely failed to provide. It has pointed to its use of medications and treatment such as E.C.T. as indicators that much of mental disorder is in fact biological in order. Such arguments have been shown to be based on faulty logic as successful management of a patient does not necessarily imply either cause nor cure.
The result in mental health has been an interesting division in care services. As a rule private psychiatry, the most highly 'sophisticated' mental health workers, have turned away from the seriously and chronically mentally ill, relegating this group to the least trained to "manage", while retaining their power through their right to medicate and certify. This is precisely the group for which physicians have argued an organic basis (though not yet identified) for mental illness - the schizophrenics and bipolar disorders. The bulk of psychiatry in North America is private practice and the bulk of this private practice is made up of those who have been described as the dissatisfied and distressed. No organically based etiology has been identified for this group. In fact, psychiatrists themselves are quick to accept a social causation theory, including 'adjustment' disorders within medical classification systems.

In another ironic turn of events the mentally retarded, with a doubtless biological or organic basis in nearly every instance(1) have, in many areas, been relegated to the responsibility of social service agencies rather than the medical sector. The argument is that etiology is unimportant, while functioning is. Functioning is seen, in

(1) the exception being severe cases of environmental deprivation
the case of the mentally retarded, as social in nature. So, by virtue of their behavior they are not seen to be the territory of the medical establishment - the polar opposite of the mentally ill who are considered medical problems because of their behavior, not necessarily its etiology.

C. **Positivist vs Interpretive Paradigms**

Ingleby (1980) has differentiated between positivist and interpretive views about mental illness and this distinction is very relevant to the current health care system. Ingleby has argued that these two approaches reflect different, mutually exclusive, paradigms. He suggests that they differ in their view as to what is valid and credible data on which to build a theory. Ingleby includes the medical as well as most social models of mental illness within his positivist framework. He argues that these models share the same (to him, faulty) premise that observation can be made objectively and value free, that measures can be defined operationally and applied in a precise, replicable fashion and that theories can be constructed on the same causal, deterministic basis as in the natural sciences. He further argues that the positivist view assumes that there are no features distinguishing human beings from the rest of nature which might necessitate the adoption of a different paradigm.

In favor of the interpretive model Ingleby emphasizes
the uniquely human nature of man, the importance of subjective interpretations and context to the meaning of any behavior (analogous to the ethnomethodologists such as Garfinkel, 1934, and radical psychiatrists such as Laing, 1967). The interpretive view argues for grounds and reasons while the positivist view examines the same factors as causes. Where the positivist sees abnormal behavior as abnormal within the broad spectrum of society, the interpretive view makes sense of that same behavior as a coping behavior, adaptive to the situation.

This distinction is essential for need assessment. As we have discussed, the emphasis in health care delivery has developed in response to the medical model, albeit with lip service to social theories. It can be argued that this has been done unconsciously by both physicians and government planners, allowing a system to evolve based on one concept of mental disorder. Much of this can be attributed not only to the insidious power of the medical profession but also the incremental planning methods used in developing these systems. The relationship of needs and planning are more thoroughly discussed below. However, it is important to clarify at this point that given the new emphasis on rational planning as opposed to the historical incremental approach, planners and governments now may have an opportunity to justify moving away from this medically dominated model. As will be discussed, it is an expensive
one, with little thought to efficiency. It is a superstitious one, with the 'witchdoctor' aura still intact but, as a result of the consumerism of the sixties and seventies, certainly slipping. It will be argued that given this new era, an era where rational methods are being stressed, a comprehensive understanding of how medical and social models of mental illness have been inextricably welded together may prevent future planners from being necessarily confined to the existing models of care. Governments may, for their own reasons, be reluctant to change course. The important issue is, however, there needs to be an appreciation of how strongly the medical model - or positivist model - has influenced not only our view of mental illness and mental health care, but also the instruments used to assess need. Need assessment models are not value free. Intelligent use of them requires understanding of the models about mental disorder inherent within them.
Chapter III: A Conceptual Analysis of Need Assessment

A. A Definition of Need Assessment

Having established the importance of a potentially elastic concept of mental illness and the relative contribution of both medical and social causation models to the mental health care industry, attention can now be turned to need assessment itself.

Various definitions exist for needs assessment but surprisingly they are much in agreement. This is surprising as analysis of either concept of need or of assessment brings about hot debate. Of course this reflects the basic problem - people are quick to agree that needs must be assessed, yet have little understanding of the assumptions underlying the concepts.

Bell, Warheit and Schwab (1977) suggest that a need assessment program can be most simply defined as an attempt to enumerate the health needs of a population living in a community. They further describe it as a research and planning activity designed to determine the health needs and utilization patterns of those living in a community. Kami's (1979) suggests that need assessment is any activity which provides a description and/or measures of either the relative, or absolute needs of people living in a defined area. Royse and Drude (1982), in recent support of the technology, refer to it as a process of identifying target populations and directing programming. I.Q. has been
defined as that which I.Q. assessment measures. Perhaps this is the case with need assessment - need assessment is that which need assessments measure.

B. Problems with the Concept

The objective of need assessment seems to be clear - to identify some type of data to facilitate some type of planning in some community. The problem lies in the definitions of need and the methodologies by which it is measured. Critics of the process (e.g. Kimmel, 1977; Cochran, 1979) have warned that conceptually need assessment is too loose, with imprecise and unreliable methodologies and no standards. Such critiques have been refuted by others, such as Kamis (1979) and Royse and Drude (1982), who have acknowledged shortcomings but encouraged progress in the field. The essence, however, of both critiques and rebuttals appears to focus on the need for a more 'scientific' or 'hard' approach. Royse and Drude (1982) in particular centre on the limitations of the methodologies, calling on national professional organizations to facilitate the development of new instruments and the standardization of old. The focus of the critiques appears to remain at this methodological level, with little attention being paid to the more fundamental level of values.

Blum (1974) and Siegel, Attkisson and Carson (1978) are amongst the few who seem to be prepared to at best touch
upon some of the thornier issues, acknowledging the major role of values in the process. Siegel, Attkisson and Carson (1978) differentiate between 'need identification' and 'need assessment'. They suggest that need 'identification' is the process by which health and social service requirements in a certain area are described, while need 'assessment' involves the process of estimating the relative importance of those needs. They cite Blum (1974) in describing the process of need identification and assessment as involving two distinct steps: (a) the application of a measuring tool to a defined area and, (b) the application of judgement to assess the significance of the information in order to determine priorities for program planning and service development.

The implication of the above two-stage process is that values come into play in the second stage only, the measurement tool implied to be a value-free device. Siegel et al. state that the various known assessment techniques produce information that describe or define social conditions or situations and that these conditions are not necessarily predetermined to be positive or negative. They suggest that the interpretation of the situation depends upon the values and expectations of those doing the interpreting. They go on to quote Blum (1974), "The identical situation may be seen as good by those whose value expectations are met, and as bad by those whose values are not, those whose values are unrelated, or who do not connect
the condition to values may not perceive the condition of all, or view it as a natural state of affairs".

It is the premise of this paper that values come into play before the interpretation of data. Values are implied by the question asked, the data collected and the methodology used. As Ingelby (1980) has suggested in discussion of positivist vs interpretative paradigms of mental illness, the different models imply whole systems of prejudice about what constitutes useful and respectable data. The decision as to which model, or what type of data to collect, is not a value-free one. It is not an arbitrary one. The decision reflects a specific model of mental illness, its causes, its potential for care - maintenance, treatment, cure or prevention - and the appropriateness of types of care. It reflects the values and goals not only of the culture in which the assessment (as opposed to the community in question) occurs but also of the political forces at work. To negate the importance of either force - model of illness or political/social context - is to ignore crucial factors which contribute to the direction of development of the mental health industry. To explore only the term 'assessment' as is suggested in the focus on methodologies by writers such as Royse and Drude (1982) is to neglect the more fundamental question of what is need, how it is defined and by whom.

This brings us back to the question of need, and the
need to examine the assumptions of want, need and demand. How these three inter-related concepts are defined and used has a large impact on the type of model of assessment a planner will use.

C. **Want, Demand and Need**

The terms want, demand and need are frequently used interchangeably though they actually refer to quite different states. Need assessment may actually be want assessment, demand assessment or need assessment depending upon the model of assessment being used. An understanding of the different implications of each of these three terms is essential to appreciate the merits of the technologies.

1. **Want/Demand**

Want is the most basic of the states, reflecting an individual's assessment of his health state compared with his own internal norm. This is a highly relative state, unique to each individual and potentially variable within the same individual. A want is not sufficient to activate access to care. A want must be translated into a demand for service. The factors which determine whether an individual will activate a self-assessment of want (for better health) into demand are complex.

Cooper (1975) has discussed some of the factors which influence how an individual makes the decision to translate
want into demand. He cites Kessel and Shepherd (1965) who have reported little obvious difference between patients who, over a ten year period, never saw their doctor and those with the average number of attendances. Cooper reports that such factors as job satisfaction, personality and stability of family background have been found to alter rates of demand. Other factors, such as economic deterrents, proximity of available care, plus sheer availability of manpower resources, have also been shown to dramatically affect demand. Cooper suggests that in the long run, demand will tend to gravitate towards whatever level of care happens to be available. This may be also affected by the availability of social agencies, for without such agencies people tend to translate their social needs into health needs.

Demand, although voiced by the individual, is articulated by the professional. The individual may, as a result of various factors, decide to voice his demand for care, but once having done this, it is the professional who either validates this into need or not and who then dictates what sort of need exists. The individual chooses to voice demand but does not in most cases have the power to determine what kind of care or how much care he requires. It is the professional - usually physician - who decides what type of service he will render, how often, and where. He also dictates what sort and what quantity of other health
services will be used - such as medication, hospitalization, laboratory services, etc. This is part of the 'bargain' between demand and need, between layman and expert. The obligation inherent in having one's wants and demands authenticated into need is the acknowledgement of the sick role and the giving up of control to the professional (Parsons, 1958). This itself is an increasingly strong factor in the translation of demand into need. With the advent of consumerism and emphasis on human rights which grew in the late 1960's and 1970's, there has been a growing awareness of this implicit 'bargain' in the demand for health care and large numbers of lay people have questioned these implied obligations. This is particularly true of the mental health field, spurred by radical psychiatrists such as Laing (1960, 1971) and Szasz (1961) and writers such as Goffman (1961, 1965).

2. Need

Need is generally expressed as the professional's view of what the client requires; demand suggesting a lay appraisal. Boulding (1966) suggests that the concept of need is often criticized as being too mechanical, denying autonomy and individuality of the human person. User demand, on the other hand, implies autonomy, individual choice and the tailoring of inputs to individual preferences. There are further problems, however. If need
is viewed as the professional choice, one must question which professional is making the choice. In the case of demand, autonomy implies that the chooser is aware of the choices - the sovereign consumer - which is clearly not the case in health.

The factors affecting need are complex. The fact that the concept of need has been criticized as being too mechanical implies that it is a result of some scientific fact. However, as Boulding (1967) has pointed out, even science is not a passive servant of existing values. This is clearly the case of need, illustrated by the wide variety of professional values, opinions and practice, both within and between cultures. Blum and Stein (1981) suggest that need is a 'health deficiency', a gap between an existing and a desired state of health. Under this definition, need is thought of as true, real or biological. Donabedian (1973) offers a similarly medically oriented definition, describing need as a disturbance in health or well-being that requires medical or professional care. He maintains that need be concretely declared by the physician.

Recent work in the field of health economics offers evidence to refute this belief in a static, doctor-identified level of need. Cooper (1975) points out that, faced with a patient declaring demand, it is difficult for a physician to decide to do nothing. Goldberg and Huxley (1980) facetiously comment "if only psychiatrists were in
the habit of saying to their patients, 'You don't have a psychiatric illness, go away'". Need is a medical opinion, not a medical fact, as can be gathered from considerable research on various patterns of practice under similar circumstances. Considerable publicity has been given to 'unnecessary' surgery in recent years - particularly gynaecological and obstetrical. Cooper refers to data indicating that hospital surgeons in the United States manage to find twice as many patients per capita in need of surgery as do their British counterparts and points out that this difference is made more surprising when allowance is made for the existence of a large medically deprived population in the United States due to the price barrier. He further suggests that need tends to grow in line with provision, as doctors react to any increase in supply by realigning their conception of need further along the possible continuum. He quotes Feldstein (1977) indicating that both admissions and length of stay increased with bed availability. Cooper suggests that, like an iceberg, the more resources devoted to meeting it, the more need seems to float to the surface.

Other authors have indicated similar findings. In the Canadian context, health economists such as Evans (1978), Stoddart and Barer (1981) and Roos, Gaumont and Horne (1976) have detailed similar examples of this phenomenon. They suggest that the traditional relationship of supply and
demand cannot be applied to health care because of the physician's ability to generate demand through the professional identification of need and cite examples of increased supply being related to further increase need, as dictated by the physician.

Current concerns within the Canadian medicare system are viewed by the Canadian Medical Association (C.M.A.) as 'underfunding' as the principle problem. Critics of this approach fear that given a free reign, a lid would never be put on funding, the 'need' growing in line with the funding. While the C.M.A. sees underfunding as a principle problem, other studies, such as a recently provincially-commissioned study into medical manpower and training needs, indicate too many doctors already exist in Canada. Plain (1984) reported about 5 percent too many doctors of all types and 30% too many family doctors within the three western provinces. Plain estimated each general practitioner represents a cost of $450,000 to the province each year for hospital beds used by their patients and general operating costs. He indicates that too many doctors result in each creating his own demand for service and points out that few people can determine themselves if a recommended procedure is actually necessary. A similar Canadian study done in 1983 by by Le Riche and Halliday (Globe and Mail, 1984) reported an association between surgeon supply and more appendectomies, tonsillectomies, gall bladder operations, hysterectomies and
Caesarean sections being performed.

Demand, though advocated by consumers and those who feel strongly about personal liberties vs. professional domination, can result in a very unequal division as a result of the several factors which have been discussed as affecting demand. Economics may be the most relevant here. In both physical and mental health arenas, it has been shown that socio-economic class has a large effect on demand, with the higher end of the scale demanding and receiving more care (e.g. Hollingshead and Redlich, 1958). This may be a good thing or a bad thing in the end, of course. More is not necessarily better in health care. However, regardless of the valuation, in the end the wealthy do get 'more' if allocation is left up to demand.

A rather interesting example of this is the current British Columbia government's policy to de-institutionalize the mentally retarded. In effect, this means that the government will no longer be dictating level of care in that 'specialized services' will no longer be offered. The retarded will, by and large, be expected to 'stand in queue' for basic health care services such as doctor's appointments, surgery, dentistry and so on. The British Columbia Association for Mentally Handicapped Persons (B.C.M.H.P.) has embraced the idea of normalization - which is in effect standing in queue. However, without specialized programs, will the severely and profoundly
retarded ever get to the head of the queue? Lack of expertise or willingness to deal with this group - and care of the severely retarded can be argued to be a specialty - may result in less care as their demand is not acknowledged. Lack of available appropriate care may cause decreased demand over a period of time. Will the B.C.M.H.P. be so pleased with normalization at that point? This may turn out to be an example of where allowing consumer demand rather than professional need dictate service levels results in lowered standards of care.

D. The Linkage of Want, Demand and Need

The factors which link these three concepts are complex and not well understood. However, they are crucial to any examination of the models of need assessment. Each implies a vastly different conceptual understanding of the variables involved in assessment and thus will affect its outcome. Figure 1 illustrates the possible chains of events that may link these concepts.
Thus access to service may originate with either the individual or the professional. What should be measured in need assessment - the individual's want, the individual's demand or the professional's defined need? Each offers potentially quite different information.

E. Want, Demand and Need in Mental Health

Mental health perhaps even more than physical health is value-laden. An example of this is the 1973 decision by the American Psychiatric Association to no longer include homosexuality as a psychiatric disease. Despite the fact that there had never been a substantial organic cause for
this 'disease' and despite there not being any known cure, homosexuality had been seen as a need for psychiatric care. At the same time, there is increasing interest within the medical profession and, in particular, psychiatry in other 'diseases' such as behavioral problems, hyperactivity, drug use, and learning problems. The process by which these behaviors are becoming increasingly medicalized has been discussed and it is important to understand this has contributed to the elasticity of medically defined need in mental health. According to cultural values and norms, need can expand or contract, exhibiting how value-laden and relative the concept is.

Related to this is psychiatry's traditional focus on specific treatment - originally purges, bromides, bleedings and later E.C.T., insulin shock therapy, psychotropic medications - that has influenced the belief that there is a cure, even for ills which even the psychiatrists themselves admit to being socially or environmentally based, the idea of professionally dictated need is more firmly entrenched. The idea of need implies a potential cure, and psychiatry has promoted the idea that medicine has that potential cure, thus legitimizing the medicalization of need. As Warner (1978) has noted, people now have come to expect and demand the "technical fix" that medical science has promised.

Closely linked with the analysis of need and demand is the diagnostic process. As previously mentioned, how a want
becomes a demand and how that demand is or is not validated, is a complex process and particularly so within the field of mental health. Because of this, the diagnostic process deserves separate attention.

F. The Diagnostic Process

The diagnostic process is important because regardless of model of illness the diagnostic process is a prerequisite for accessing the traditional care system which continues to be largely medically dominated.

The first stage of the diagnostic process involves the patient making a subjective complaint of ill-health, some change in what he has come to perceive as his normal state of well-being. There is a growing literature examining the extraordinary variability between what various individuals acknowledge as the norm of either physical or mental health. This is reflected in the difficulty in formulating clear and concise definitions of health. People differ from individual to individual, area to area and culture to culture in their conception of well-being and in their willingness to tolerate discomfort as part of life's cycle as opposed to viewing it as evidence of sickness or disease.

Mechanic (1972) points out that how a person perceives his discomfort or disability can affect the way in which it manifests itself and develops. This is of particular importance with mental illness due to the strong social
values embodied within a definition of mental health.

The increasing "medicalization of normality" has resulted in problems such as marital unhappiness, drug dependence, social difficulties, learning difficulties, as being the legitimate territory of mental health. Thus, the fact that a person views his discomfort as "mental health" related may affect its development (Scheff, 1966). Rather than seeing it as part of the life cycle and transitory, the perception of the problem as mental health related and therefore treatable may well sway the individual to validate it as a disorder by diagnosing it and presenting it for treatment. It has been suggested that many mental health clients are so mildly disturbed that they would in all probability recover without treatment. Cummings and Cummings (1965) have reported that most psychoneuroses appear to be self-limiting conditions with duration of about two years, with or without treatment. In turn, Mechanic (1972) cites evidence that, in 1968 in America, more than two-fifths of all visits to office-based psychiatrists were for conditions diagnosed as neuroses. Cummings and Cummings (1965) further suggest that personality or character disorders are similarly self-limiting, as well as being resistent to treatment, yet Mechanic also reports for the same year that 14 percent of visits were for such disorders. This would suggest that at least half of all visits to office-based psychiatrists were for conditions not requiring
treatment.

Despite this, writers such as Mechanic and Dohrenwend (1980) cite evidence that only one out of four persons actually experiencing mental illness does seek treatment within the normal therapeutic network and that even large numbers of the most seriously ill (the schizophrenics and psychotics) do not receive treatment.

How then does one become a 'case'? This is at the crux of the issue of needs assessment. If needs assessment has the aim of providing data on which to base program planning, the essence is to ascertain not true prevalence but potential demand under given circumstances. Prevalence does not necessarily equal need. True prevalence will overestimate need, identifying individuals who would not use services even if provided. As we have discussed, need implies the professional's assessment of a need, not necessarily the individual's. This is important as several need assessment models rely on this professionally generated data. Need assessments relying on epidemiological indices based on diagnostic classifications and utilization figures based on diagnostic data rely on the diagnostic process. To deal with the issue of how one is diagnosed, how one becomes a case, requires attention to the question: what is disease?
G. Disease

Clare (1980) cites Peter Sedgwick who questions whether all diseases, physical as well as mental, might not be described as ‘social constructions’. He argues that the notion of disease is a human notion and that man applies the disease concept on basis of personal and social values that can and do change: disease depends on the social values and personal mores of a particular society or culture. Clare points out that this is equally true of physical disease as mental, and cites considerable work done on scales and techniques in an attempt to measure physical health and disease, all quite controversial.

Clare further suggests, along with others in the area, that disease is best conceptualized as a ‘deviation from clearly defined norm’. However, given the social nature of mental illness, this definition hardly answers the question.

Attempts have been made to further distinguish between illness and disease. An acceptable definition that differentiates these two constructs depends upon the eye of the beholder. A positivist conception of illness is the presence of disease in an organism that inhibits its functioning of the physiological organs. This is a limiting definition but implicit in it is the assumption of some norm of functioning, against which non-functioning can be measured. Of course, in the case of all but a very few of the organically related mental disorders, this definition
does not apply at all.

Others argue that disease and illness are separate entities. Disease is thus viewed as a physiological state, while illness is a social state caused presumably by the disease (eg. Kleinman, 1980). The pathologist sees disease while the physician infers disease from witnessing the symptoms of illness. This allows for diseases without illness and illness without disease.

The cultural relativist takes a different position, viewing a condition as a disease or illness only if recognized and defined as one by the culture. Such a stance has been criticized for minimizing the organic-physiological nature of illness and disease. However, its usefulness in the culture-bound realm of mental health is obvious.

Conrad (1980) furthers this discussion by questioning how something becomes defined as an illness. Taking a sociological perspective, he suggests that illness and disease are human constructions, not existing without someone recognizing and defining them. He points out that there are processes that we term diseases, but does not make them diseases without that labeling. Illnesses are described as being human judgements on conditions that exist in the natural world, essentially social constructions. Inter-related reliability of judgement merely reflects the social consensus.

In earlier work Mechanic (1966) indicated that the term
illness has always been used in two ways in medicine. On one hand it has referred to a limited scientific concept and, on the other, to any condition which might cause an individual to seek medical help. He suggests that "illness behavior" is any behavior that is relevant to the second, social concept of illness. Geil (1980) suggests that the response behavior of any individual reporting symptoms when questioned in an epidemiological survey may reflect this "illness behavior" rather than medical illness in a true medical sense.

Illness behavior can be argued to be the product of social and cultural conditioning - not medical certainty. Thus it is the socio-cultural environment which defines a condition as an illness and then determines how the individual should respond to the illness. The implications for mental disorder of this dichotomy between "true" illness and "illness behavior" are profound as diagnosis of mental disorder is based on patient report, not by objective and demonstrable evidence produced by examination of tissue or blood as are most physical disorders. Such a dichotomy also has profound implications for any need assessment method relying on self report.

As Mechanic (1972) has suggested, how a person perceives his discomfort or disability can also affect the way in which it manifests itself. The negative connotation of the social judgement of illness has implications for the
future of that discomfort. In the realm of mental disorders no physiological disease process is necessary, subjective report illness being sufficient to be defined and treated as if diseased. Few functional mental disorders have any substantiated organic basis.

Given that diagnosis as if diseased is thought to have profound implications, both for the patient himself and for how others treat him, the impact of diagnosis cannot be understated. The emphasis on diagnosis has come about largely through the medicalization of various behaviors and has resulted in enormous potential for medicine as an instrument of social control (eg. Scheff, 1967). Avoidance of responsibility for one’s actions, both those which may have resulted in the diagnosis and those while in this sick role, as well as exemption of personal responsibilities are two benefits of those attributed with this role. However, in exchange two obligations are enforced by the ‘therapeutic agents’ in order for the sick role to be maintained: the person must recognize and admit that being ill is an undesirable state and wish to recover, and, most importantly, the person must cooperate with a competent therapist, usually a physician (Parsons, 1958). A trade-off therefore exists - lack of responsibility for lack of control. Thus, implicit in this role is the medical establishment as an institution of social control. How the medical establishment, with physicians as their agents, have
reflected and imparted social and political values has already been touched upon. The important issue is the recognition that to be diagnosed is not only a lengthy and involved process, but also implies an acceptance of that society's values. With this comes the understanding that need assessment techniques which rely on professionally identified criteria - either epidemiological indices or utilization data - carry with them the values of the medical model of mental illness.
A. **Introduction**

Given the previous analysis of the underlying assumptions of need and demand, we can now review the major models of need assessment with an appreciation of the implications of each. Different strategies entail different assumptions not only regarding need and demand, but also about mental illness. As has been previously discussed, each model is a conceptual system. The models cannot be used interchangeably. Royse and Drude (1982) have proposed improving standards in the needs assessment field by systematic research to evaluate a number of approaches simultaneously in the same area. They suggest that it could be then empirically demonstrated which of the approaches lead the investigators to the same conclusions about the extent of needs in that area. They further suggest that an ‘expert committee’ analyzing the data from such research would be led to disallow certain current need assessment approaches as valid methodologies.

It is precisely this approach this paper attempts to refute. Such an approach assumes the ‘medically indicated’ approach to need suggested by writers such as Donabedian (1973). This attempt to differentiate amongst the various models does not aim to prioritize models in terms of their goodness or badness, usefulness or non-usefulness; nor does it attempt to identify all methodological weaknesses within
each model. Rather, it is an attempt to avoid the common assumption, which obviously Royse and Drude share, that the only important factor in assessment is assessment.

In general, four major models of need assessment have been advocated:

1. epidemiological surveys
2. utilization rates
3. social indicators
4. community group forums

Although only the first two approaches utilize what can be considered as medically oriented data, only the community group approaches clearly fall out of the bounds of the broad medical model. As will be seen in the following discussion, epidemiological indices and utilization rates both focus at the individual level, the case being the focus for care and treatment. The first two models identify cases – epidemiological indices identifying 'true' prevalence while utilization figures identify 'case' prevalence. The social indicator models develop a statistical overview of a specific population, community or society and by doing this can identify 'at risk' areas for further case identification. As has been earlier discussed, this model, though assuming a social causation model, has been co-opted by the medical establishment as a means of identifying areas for professional care. Thus social indicators measuring social problems are often seen to indicate medical need.
Finally, the community group forum approach focuses not on the case but on the needs perceived by the community in question. Its approach is generally non-professional and 'bottom-up', though, as will be discussed, such procedures may be gaining in sophistication.

B. Epidemiological Surveys

Community epidemiological surveys are generally considered the most rational and scientific of the need assessment methods, producing the most acceptable and 'hard' data to those insisting upon scientific rigor. Such surveys involve case-finding assessments within community populations generating 'true' prevalence figures. The process is generally referred to as 'psychiatric epidemiology', which clearly indicates its assumptions.

There have been three distinct periods in the development of epidemiological surveys of mental disorders. The first attempt to investigate the true prevalence of mental disorders in a community in the United States was undertaken in 1855 (Weissman and Klerman, 1978). Key community leaders, and hospital and other official records were utilized to determine the frequency of idiocy and insanity, as mental disorder was called. This type of indirect measurement using key informants and medical records were the primary means of estimating need until World War II.
Faris and Dunham (1939) provided the basis for determining need for psychiatric services in the Chicago metropolitan area in the 1930's with an ecologic study which examined the ecological distribution of first admissions. They found that diagnosis was related to the area of residence of the patients, the highest rates of hospitalization occurring for residents from the areas of highest social disorganization. This was the first step towards demonstrating the importance of social variables in mental health.

Dunham (1983) has recently critiqued this earlier study. He suggests that this approach produced unreliable results because they did not take into account the cases that never came to the attention of the agency (the main concern of current assessment methods relying on utilization rates). He observes that in 1930 he did not foresee this as an issue, assuming that the undetected cases would eventually be committed or be admitted to a mental hospital. This time between symptom onset and care he terms 'the gap' and he notes that it varies with socioeconomic level.

Secondly, he voices concern that the 1930 diagnoses were unreliable due to lack of knowledge about differential diagnosis. Finally he suggests that the rates pattern reported were misleading because they represented the residential mobility of the mentally ill rather than their community of origin.
The second period of epidemiological development in mental health developed post WWII. The war effected major changes in how mental disorder was viewed. Firstly, large numbers of men were rejected for service on psychiatric grounds. Despite that the scientific grounds for these rejections were questioned it brought attention to mental health problems in general. The results of this screening process became of increased interest as large numbers of service men developed psychiatric difficulties presumably as a result of the conditions of war - situational stresses such as combat and deprivation of concentration camps. The fact that these disorders developed in individuals already screened for psychiatric illness led to a focus on precipitant stress as opposed to predisposition. This expertise and knowledge developed during WWII contributed to growing interest in prevalence and in social conditions in the general population and led to large community surveys.

The Midtown Manhattan survey (1962) interviewed 1,000 adult residents selected by probability sampling in midtown Manhattan. Leighton (1959) assessed the impact of social and economic change on the mental health of a stable community in Stirling County. Hollingshead and Redlich's (1958) study of treated prevalence established social class as an important determinant of treated mental illness. The studies of this era reported generally high rates of mental impairment. For example, the Manhattan study reported 23%
of their subjects substantially impaired.

Many of the studies of this period used measures of overall mental impairment and problem lists. Psychiatric classification was in the developmental stages and its low reliability was acknowledged. In addition, such scales and lists made large surveys feasible, reducing the need for psychiatric input, making them easier and more economical. Social factors of mental illness were the focus.

Concurrent European studies tended to reflect the earlier developing European psychiatric tradition. Essen-Moller’s survey of Lund, Sweden, used trained psychiatrists to interview 2,550 inhabitants in a specific geographical area, defining not only psychiatric disorder but also major personality deviations, normal personality variants and subjective complaints (Goldberg and Huxley, 1980). This use of traditional psychiatric diagnostic categories made the assumption that each illness had a different underlying etiology, syndrome, course, and treatment, and that biology rather than environment was the major contributing factor. This was contrary to this American emphasis on social causation which contributed to a more unitary concept of illness, mental health and mental illness being viewed as opposite points on a continuum.

Weissman and Klerman (1978) suggest that this period of epidemiological development made important contributions to health research. They suggest that these surveys introduced
rigor to epidemiology by the development of sampling techniques, standardized questionnaires and sophisticated statistical analysis. Furthermore, they enlarged the domain of independent variables in epidemiology to include psychosocial and economic factors and sensitized researchers to the influence of such variables in medical conditions.

However, the value of such global measures of mental illness is controversial, as is their appropriate use. At the methodological level, it has been suggested that the scales suffer from various response biases. Mechanic (1972) cites Bruce Dohrenwend's work, indicating correlations between test and retest a year later were higher among psychiatric inpatients than community samples, suggesting that such scales may measure some transient stress. On a more cynical note, such results may suggest that the potentially transient nature of mental disorder may become permanent when subjected to at least inpatient treatment, and perhaps any treatment at all! The possibility that definition of oneself as 'in care' may serve to perpetuate the identification of the problem also exists (Scheff, 1966). From the psychiatric epidemiological viewpoint, the global impairment scales used are independent of diagnosis can not be translated into diagnostic categories to generate rates of treated/untreated disorders.

The validity of global impairment scales is also open to question: what do the scales actually measure? The
Dohrenwends suggest that they particularly seem to tap anxiety, sadness, psychophysiological symptoms, lack of energy and a perception of poor health. Such symptoms are, however, more indicative of the neurosis than the psychosis, most hospitalizations (at least those in psychiatric facilities prior to advent of the community mental health movement) reflecting the psychotic symptoms of the seriously ill. Whether these two groups can be compared is questionable. In addition, Cummings and Cummings (1965) have commented on findings that most neurotic disorders are self-limiting, with or without treatment.

The third period of epidemiological study in mental health began in the late sixties as developments in medical sciences stressed evidence of biological factors in mental health. Growing interest in classification led to advances in validity and reliability in diagnosis. 'Psychiatric epidemiology' developed, shifting the emphasis from the epidemiology of mental health to an epidemiology of mental disorders.

A basic premise underlying epidemiologic studies is that a specific disease is not randomly distributed throughout a population but that subgroups of a population, defined by age, sex, ethnic or racial, or other relevant characteristics will differ in the frequency of individual disease. Knowledge of this uneven distribution can suggest causal factors which can then be further established by
other research techniques. The increasing acceptance of a multifactorial mode of explanation for psychiatric disorders has emphasized the research for multiple risk factors.

The major epidemiological survey currently being undertaken in the United States is N.I.M.H.'s Epidemiological Catchment Area program (Reiger, Myers, Kramer, Robins, Blazer, Hough, Eaton, Loche, 1984). This survey has a sample size of roughly 20,000 subjects drawn from five sites. The basic goals are to estimate rates of prevalence and incidence of specific mental disorders, to estimate rates of health and mental health services use, to study factors influencing the development and continuance of disorders, and to study factors influencing use of services (Eaton, Holzer, Von Korff, Anthony, Helzer, George, Burnham, Boyd, Kessler and Loche, 1984). The focus is on the Diagnostic Interview Schedules - defined DSM III mental disorders. Freedman (1984) describes this program's future outcome as a kind of topographic map, a background charting relative peaks and valleys and their specific contents.

Currently, existing estimates of psychiatric illness from recent epidemiological surveys range from 1 percent to 50 percent, depending upon the nature of the measurement technique. Gould, Wunsch-Hitzig and Dohrenwend (1980) report in their recent summary of the literature, that the true prevalence of clinical maladaptation among school children in a representative sample of U.S. communities is
unlikely to average less than 12 percent. Neugebauer, Dohrenwend and Dohrenwend (1980) report that the true prevalence of adult psychiatric disorders, with no known organic basis, at an overall rate for the aggregated functional disorders of between 16 and 25 percent. Dohrenwend (1980) in his summary chapter breaks this down to: between .6 and 3.0 percent for schizophrenia, about 3.0 percent for affective psychosis, between 8.0 and 15.0 percent for neurosis and about 7.0 percent for personality disorder. In addition to these cases of psychiatric disorder, he hypothesizes that about 13.0 percent of the population in a representative sample of U.S. communities would show severe psychological and somatic distress that was not accompanied by clinical psychiatric disorder. Together, these results estimate that about 25 percent of the population at any given time is experiencing some degree of psychological disorder. Most importantly for this discussion is the fact that Dohrenwend hypothesizes that only about one-quarter of those with clinically significant functional disorders ever received treatment and that even for the most severe disorders large minorities have never received treatment. He estimates that perhaps 20 percent of schizophrenics and 40 percent of psychotics do not receive treatment. (The assumption is, of course, that treatment refers to traditional therapeutic services as opposed to the non-professional network of care).
Related to this is the failure of epidemiological indices to offer information regarding the differences between those who present themselves for treatment and those who do not identify themselves as requiring care. Thus, the results of such surveys may offer rates of 'true prevalence' in the experts' eyes, but do not reflect demand in the eyes of the patient. In terms of assessing need for service delivery epidemiological indices are unable to offer information as to what proportion of the 'true prevalence' figure will actually present itself for care.

Thus, a major shortcoming of such indices for needs assessment is not only do they focus on the traditional medical model of diagnosis and thus are plagued by related methodological problems, they are also over inclusive, not able to make the crucial difference between those whom the experts perceive as having mental health disability and those who represent potential demand. Becoming a patient, as we have discussed, is the end result of a complex chain of events. Epidemiological indices, in their ability to estimate the professional's view of need, will likely over-estimate demand in any service planning endeavor.

C. Utilization Rates

The aim of the social survey, or service utilization model, is to review the various providers' (both individual and agency) past and current services rendered patterns and
requests for service by citizens in an attempt to understand the number and types of services demanded in a particular community. These data may be secured through structured interviews and extrapolations from past and current records and management information.

The use of under-treatment rates as an indicator of need poses major methodological problems. In counting admissions, what is to be considered a case? Institutions differ in their practices regarding what type of contact for service qualifies as an admission and what does not. Admission rates may be misleading because of duplicated counts resulting from a single individual having multiple admissions during a given period to a single institution. What constitutes a mental health facility may be defined differently from one geographical area to another. At the same time different government sectors may provide services by a different name to the same population.

Diagnosis is problematic; reliability is poor. Supporters of this approach defend diagnostic reliability but published figures vary widely. One of the most critical of reports is that of Rosenhan (1973) which revealed that in one case hospital doctors diagnosed schizophrenia on the single symptom of hearing voices in perfectly normal pseudo-patients. Once having made this diagnosis and admitting to hospital, they did not reverse their diagnosis at any time during the patients' stays, which ranged from 7 to 52 days,
despite the fact that the pseudo subjects did not complain
further of any symptoms. The impression is that the
diagnostic skills of American psychiatrists are of
questionable value.

Another objection to the utilization of treated rates
is that the act of hospitalization for psychiatric care (or
community-based care for that matter) may be less an
indication of psychopathology on the part of the patient
that it is an indication of society's reaction to what it
labels deviant behavior. The expansion of the realm of
mental health to include behaviors previously thought of as
merely bad or sinful is undertaken elsewhere in this paper.
On the other hand it may reflect "illness behavior"
(Mechanic, 1962) rather than illness itself. Users of
mental health services are not always those who need it
most.

Of equal importance is the fact that needers are not
always utilizers: the problem of unmet need. This is in
part because, as discussed earlier, being a patient (being
in treatment), is a final step in a long chain of events.
Such factors as accessibility of care and socioeconomic
status, influence this eventuality. Needs assessment based
on this type of strategy can only make predictions about
this group, not about all people with mental disorders.
Supporters of the utilization approach suggest that the
broader epidemiological approaches identify too large a
group for program planning, arguing that the group not identified by utilization figures and waiting list data would likely not use services and are therefore not relevant to planning. This seems a narrow and inflexible view of the concept of planning – planning can include means of reducing stigma or other barriers to care.

Most utilization data relies on diagnostic data, and thus this model’s credibility. This reflects the medical model theory of mental illness. Diagnostic data are not without problems for planning purposes. In British Columbia, Hospital Programs, which administer inpatient and daycare facilities for the mentally ill, use a different classification system that those facilities operated by Mental Health Services, the Mental Health Centres and large inpatient facility. Thus, neither comparison or cumulative totals are possible.

In short, to define and identify need solely on the basis of demand for services is to take a narrow conceptual approach. Relying on the medical model, it provides data with questionable reliability about a discrete group of health care users. It may serve the purposes of justification and resource allocation well on an individual program basis but offers little to the broad spectrum approach of planning. Seemingly generating ‘rational’ data it has its political purpose in generating data with which a government can assure its public that they are providing
service. It provides a base by which incremental additions to services can be made when constrained by financial limits.

Finally, utilization figures provide information about the use of services already provided. Need assessment implies an attempt to specifically address the needs heretofore unrecognized and unmet. This reflects the developmental nature of planning. Utilization at best provides a basis for incremental planning, at worst provides a basis for justification planning.

D. Social Indicator Approaches

The indicator approaches have recently been considered very popular, appealing to the social and environmental advocates of mental health. These approaches consist of compiling and making inferences of need from descriptive statistics found in public records or reports, thus no new data are generated. The essence is the analysis and integration of existing information.

The term social indicator is attributed to R. Bauer who edited a book on social indicators in 1966, marking the beginning of interest in this area. The approach is based on earlier work by researchers such as Hollingshead and Redlich (1958), Leighton (1959), Myers and Roberts (1959) and Srole, Langer and Michael (1963), who focussed attention on the social factors associated with mental illness. The
assumption on which such technique is built is that certain population characteristics predict high risk in terms of incidence of mental health illness and the concomitant need for mental health and other social and health services.

The social indicator is thus a measure of social problems. On the aggregate they are often assumed to be an indication of the quality of life and are often used as a global means of evaluating interventions in a community.

The social indicator movement is an effort to develop an assessment procedure parallel and complimentary to the highly successful economic index (Bloom 1983). However, unlike economic theory, no theory of community exists by which to define relevant variables. Thus social indicators have been chosen inductively rather than deductively.

Three specific indices have been most often cited as being related to increased incidence of mental illness: poverty, social pathology, and subgroups with special needs.

1) Poverty

Customary indices of poverty are low per capita income, chronic unemployment, substandard housing and low levels of education. How poverty actually relates to mental illness is unclear, though at least three different theories have been put forth. Hollingshead and Redlich reported in their 1958 New Haven study that low socio-economic status within a community is found to be associated with relatively high rates of
disorder. Dohrenwend and Dohrenwend (1969) furthered this research, suggesting that it was not socio-economic status alone but rather the associated stress of that social position that was the crucial factor in the associated high rate of disorder. Leighton (1959) in his Stirling County Study, suggested that a community’s degree of integration or disintegration was related to the mental health of its inhabitants. He, along with his co-workers, defined indices of sociocultural disintegration, including such factors as: a high frequency of broken homes, extensive poverty, extensive migration, weak and fragmented networks of communication and rapid and widespread social change. At the same time, Myers and Roberts (1959), in their continuation of Hollingshead and Redlich’s earlier work, suggested that inter-familial stress - disorganized home, heavy responsibility of the mother, absence of father, lack of parental guidance and control - was also associated with high rates of psychological disorder.

On the later Midtown Manhattan Study, Srole, Langer and Michael (1962) examined social class in terms of stress-strain model, in which mental illness was seen as a reaction to noxious environmental forces, such as childhood economic deprivation, broken homes and socio-economic worries. The investigators found
that the sheer number of identified stress factors reported was the most efficient method of predicting mental health risk. No one stress factor itself was particularly significant but a hypothetical person reporting three factors had greater risk that a person reporting one or two factors. The number of stress factors was more important than the particular combination of factors.

Such evidence supports the notion of poverty as one causal factor in mental health. Although such indices as broken homes and absence of father are not purely the domain of the poor, they are over-represented in this group. This view of poverty as a causal factor in mental illness and the associated ‘stress’ model of disease adheres most closely to the socialization/environmental theory of mental illness. Within the positivist’s framework, it suggests that the stress of certain factors result in identifiable mental illness. Although also in partial support of the interpretive theory, it is mainly reductionist, suggesting illness is a direct result of certain specific factors, in a straightforward causal relationship: poverty → stress → mental illness. Although the theory suggests under which condition mental illness will occur, it fails to offer explanation for individual variability given the same
degree of stress.

The second theory regarding the poverty-mental illness relationship is that poverty prevents one from seeking help from mental disorders because of such poverty-related factors as inability to pay, cultural barriers to care, transportation and other access-related problems. Such factors are known to prevent access to care. This model would suggest that the rate of illness in a poor population would be that of any other population if service (i.e. treatment and cure) was sought or could be accessed. This takes poverty itself out of the causal role and places it as only a barrier to care. Such an explanation for high rates of illness in poor areas supports the medical model of mental illness in that it implies that the illness is individualistic rather than socially caused, that there exists a disease entity within the individual, and that with individual treatment, it can be cured, regardless of the social situation.

The third explanation of the relationship between poverty and mental illness has been termed the 'social drift' hypothesis (Myerson, 1941). It also supports a medical model of illness for it suggests that the higher rates of illness found in the lower socio-economic class is a result of mentally-ill individuals 'drifting' down from other socio-economic
levels as a result of their illness. It clearly supports the individualistic view of illness and implies incurability – that even with the services available in the higher socio-economic levels, those who are mentally ill are resistant to treatment (intentionally or unintentionally) and drift to the lower levels of society. This is actually in direct opposition to the 'stress' theory of poverty, suggesting that the mentally ill drift down to a less complicated and stressful existence.

2) **Social pathology**

Indices of social pathology are closely linked with those of poverty and there is an obvious correlation between the two. Alcoholism, drug addiction, crime and delinquency are the most often mentioned indices of social pathology. Such factors have been examined in studies such as the aforementioned, and particularly by Leighton (1959) who defined high frequency of crime and delinquency as one of his indices of socio-cultural disintegration. The use of social pathology as an indicator has also come about as the definition of mental illness has expanded. Behavior which was previously considered sinful, bad or just deviant – such as alcoholism and crime – has become included within the mandate of mental health.
To include deviancy in this manner supports the process of medicalization - the expansion of the domain of medicine over behaviors which have no known organic or physiological cause. Whereas previously such behaviors were seen to be willful and the responsibility of the individual, they are now increasingly viewed as the result of mental illness, and therefore treatable in an individual by a mental health professional. However, this approach also supports a notion of social or environmental causation - high stress, faulty learning and similar factors causing the individual to behave in an 'abnormal' (rather than deviant which implies badness and willfulness) manner.

3) **Population subgroups with special needs**

   The four groups most mentioned are children, the aged, the mentally retarded and the physically disabled. The inclusion of children and the aged appears to be based on the assumption of high risk. Epidemiological estimates of mental illness in children vary widely but is generally thought to be around 10%, likely varying with age, social class, ethnic group and geographic region. It is likely not purely due to estimates of illness within these two groups though that they are included in most indicator lists. The existence of both children and the elderly also places
an additional burden of stress on adults in the community - socio-economic as well as relationship oriented. Thus, it may be assumed that large numbers of either children or elderly, while bringing within themselves higher rates of illness, also contribute to higher rates of illness in their caretakers. In addition, the poverty factors previously discussed are particularly relevant to the elderly in North America, living too often in marginal poverty and isolation. Recent figures for Alzheimer's disease, a specific syndrome of geriatric senility which involves gross behavioral disturbance as a result of memory loss and other mental as well as physical deterioration, suggest that 40% of those over 80, 15% of those over 70 and 7.5% of those over 55 are victims.

The U.S. Community Mental Health Centre movement has included the care of the mentally retarded, contrary to most of Canada where retardation is considered a social rather than health problem. The inclusion of physical handicapped is assumed to be based on the assumption that such individuals are at greater risk for the development of mental and emotional disorders than the general population. This inclusion could also be argued for on the basis of the concomitant poverty of those both retarded and physically disabled, and, also, on the basis of the
increased stress on their caregivers. Both explanations support a social/environmental model of mental illness, though once again, open to the same criticisms discussed regarding the poverty and social pathology indices.

Several major problems exist with social indicators. As previously mentioned their choice is inductive rather than deductive and therefore it is difficult to know if an adequate set of indicators has been chosen. Secondly, interpretation of change over time relies on values judgement - how much change is significant? Finally, there is little evidence for the validity of these measures. Writers such as Weiss and Bucuvalas (1980) and Goldsmith (1972) have reported that, in Carol Weiss' terms, there is an 'oversell' of social indicators. Goldsmith suggests that their purpose needs to be clarified and that those in current use are inadequate. Weiss argues that this movement can contribute to (1) improved descriptive reporting; (2) analysis of social change, and (3) to the prediction of future social events and social life. At the same time she criticizes their use in the setting of goals and priorities, suggesting that the very process of developing indicators is value-laden; their very definition
reflects sociopolitical values. Weiss suggests that by dignifying a statistic by referring to it as an indicator does not provide the conceptual framework by which to understand it. They can not by themselves make decisions for planning, yet given this lack of conceptual framework, can be used in any manner the user wishes. How much is enough, and how much is too much are questions not answered, but are left to the judgement of the user.

E. Community Group Approaches

Of the four models, it is the community group approaches which focus in on the lay people in a community, and, for that reason, have been very popular with the consumer advocates of the last decade. Such approaches allow for citizen and community participation in the identification of needs and subsequent establishment of service requirements. Surveys, either anonymous, through-the-mail or direct interview-based methods, and group forum methods provide a citizen perspective on the nature and magnitude of community needs as opposed to the expert perspective which may be mixed with professional vested issues. By asking the people who live in the area one's results are hopefully more sensitive to the particular peculiarities of a region and reflect what the residents would accept as service. This is a particularly important point when dealing with communities, cultures or classes.
foreign to the experts.

An additional asset is that such approaches serve to both familiarize citizens of potential facilities and, through making them part of the planning process, may enhance possibility that such services will eventually be used.

This model deals not with the individual and his needs but rather with perceived group needs, not with diagnosis but with group dissatisfaction. The data are not rigorous, but rather impressions, comments, perceptions of need. While lacking the rigor of specific diagnosis, they may actually present a more accurate picture of total need - not in a quantifiable sense but in a qualitative sense.

Because of these characteristics such models are attractive less to the scientist, statistician, biometrician, and yet more attractive to the sociologist. There is an implication in such studies that cause is not the important factor - thus allowing for a multitude of different factors. The essence is more that need for a service which can be seen by the community as potentially ameliorating the problems they themselves perceive. Depending on the situation this may mean that health care oriented solutions are not offered as panaceas for traditional health care problems. Such an approach may allow a community to target both problem and solution in the way which fits that particular community best.
This model is probably in closest alignment with the interpretive model of mental illness. Its impression oriented approach and its allowance for culture specific responses, implies an understanding of gestalt. Needs are not necessarily seen to be linked to specific causes, nor are they bound by strictly medical format. This is not to say that responses do not take that approach, for the medicalization of culture is pervasive and advertising and education have been shown to affect perception of need, and presumably of what is the appropriate source of care. Despite this, this model at least allows for the possibility of an interpretative response on the part of the consumer. It will not be viewed as credible by those wishing a 'hard data' approach to need assessment.

F. The Relationship Between Need and Planning

The four models of need assessment presented can be shown to consistently fit on a continuum. Figure 2 illustrates the models vis à vis their assumptions regarding model of illness, data requirements and scientific rigor. This will later be shown to also relate in a similar fashion to the characteristics of their users and their context.
Having analyzed these models on an individual basis, comment can be made regarding their relationship as a group to the planning process. The recent emphasis on need assessment reflects the assumption that by providing a 'better' data base, 'better' program planning and health care delivery will be developed. A spin off of need assessment has been the growth of program evaluation work, based on the initial need assessment for the program in question. The assumption that need assessment does facilitate better program planning through increasing rationality of the planning process has itself not been evaluated and only future history will adequately ascertain if the costs associated with such activities have produced a
superior system than the incremental model produced. In the end, that too will be a value judgement.

Regardless of this unanswerable question, the validity of some of the assumptions involved in the need assessment/planning process can be examined.

Firstly it is assumed that the measurement of illness will give us a measure of the need for professional intervention. This is unlikely particularly in the mental health sector. As has been previously discussed, the majority of conditions are mild, often self limiting and even tend to disappear in spite of treatment (Cummings and Cummings, 1965). The frequency of spontaneous recovery is one of the major obstacles to the scientific evaluation of therapeutic efforts. In addition, professional consideration for 'treatment territory' may cloud the evaluation of need for care (e.g. physicians deliver babies in urban areas, nurses in rural areas; psychiatrists deal with young, attractive, articulate mental health patients, nurses and other mental health professionals with old, unattractive, inarticulate chronic mental health patients). Often ignored also is the large and effective network of care-givers not associated with the health professions. Mechanic (1972) reported that the lay network was the most prevalent source of help for personal problems, thirty-three percent of respondents seeking help from a friend and twenty-eight percent seeking help from a relative. He
reported only twenty-eight percent of his respondents choose professional help, and of those only two percent choose psychiatry. Need assessment can be seen to expand the professional’s territory (and perhaps therein lies much of its appeal to the professional). Need assessment data therefore, can not be assumed to readily translate into service needs – either quantity, duration or even type.

A second assumption is that there are efficacious treatments for the conditions identified. As previously discussed there are illnesses for which, at least currently, we can offer no cures. This is true of most of the major psychiatric illnesses. Thus, identification of a need must not be thought of only in terms of cure. For many it means merely the identification of morbidity and, given that prevalence is a function of duration, it serves to increase prevalence. Once identified certain conditions such as the major mental illnesses require (in the humanitarian and sometimes political sense) maintenance care. In some political situations it may be unwise to identify cases which can not be cured but only maintained at a high cost to society. The deinstitutionalization of both the mentally retarded and mentally ill has occurred in political contexts which have stressed cost containment or reduction. Costs of community care may be lower than institutional costs but costs of 'lost' clients are even lower – at least to those who were paying the institutional costs! Often these 'lost'
clients surface on another sector’s caseload - social services’ or attorney general’s. In the situation where there is no cure, only maintenance, active casefinding may be discouraged by those in financial control.

Thirdly, need assessment tends to imply that communities are so different as to require exact and precise measurement of health for adequate planning. Gould et al. (1980) recently summarized the results of 88 epidemiological studies and the current N.I.M.H. Epidemiological Catchment Area program is examining five different areas - a total of over 20,000 individuals. At the same time any seasoned clinician can identify the major service gaps (unmet need) or service inadequacies of his community - generally the poor, the elderly and the non-compliant seriously ill. The Midtown Manhattan study identified only one in twenty disabled in treatment (Srole, Langner, Michael, 1962). Dohrenwend (1980) estimates twenty to forty percent of the seriously ill are not linked to professional care. Given that the costs of care to all potential users is likely well beyond society’s capability an argument could be made to ‘stop identifying and just start treating’. Perhaps the gaps and duplications in the existing system have less to do with lack of a planning base and more from the professional and political powers that have directed the focus of service delivery. It is this context that has affected both need assessment and service planning which is now turned to.
Chapter V: Viewpoints in Need Assessment

A. **Introduction**

In a recent paper on priority setting for Canadian Mental Health Services (Satorius, 1984) it was suggested that to formulate mental health policies decision makers must reach into philosophy, religion, ethics and history. Underlying this is the understanding that the value systems of the society, the value system of the planner, the value system of the scientist, must all be addressed. This is also the crux of this paper - the values of the both the tool and the context must be taken into account when using needs assessment as an allocative tool. The previous discussion has examined the conceptual basis underlying both mental illness and the various need assessment techniques. The values of the socio-political environment are now addressed.

B. **Boundaries in Power in Planning**

Before turning to these issues, the important link of need assessment and planning must be emphasized.

The purpose of need assessment was previously loosely defined as the identification of some type of data to facilitate some type of planning in some community. Need assessment is therefore inextricably linked with planning. Need assessments may not always lead to a plan’s implementation but they are linked to the will to plan.
Without this intention need assessments are for the most part irrelevant (1).

Given this, need assessments are bound by similar constraints as the planning process itself. Boulding (1967) and Lindblom (1959) have described the concept of "bounded rationality" in reference to policy development but it is equally relevant to planning. By this it is suggested that policy makers or planners are limited by time and by ability to put together and act upon all the relevant data in any situation (Crichton, 1981). This can be expanded to include the cognitive boundaries which are a product of the special concerns, vested interests and philosophical and political orientation of the major actors involved.

Planners plan to succeed. Thus, feasibility of a plan is an essential element of a plan's success. This is true also of the need assessment - the data generated must be of such nature as to maximize chances of a plan's acceptance, and thus the relative nature of need assessment.

Feasibility, according to Hall, Land, Parker and Webb (1975) is in its broadest sense determined by the prevailing structure and distribution of theoretical and technical knowledge. They further suggest that feasibility is not

(1) The exception to this is when need assessments are used purely for political purposes when no plan was intended or in the cases where a need assessment is done "after the fact", for either legislative or political reasons.
entirely independent of who does the judging - particular ideologies, interests, prejudices and information will affect the kinds of conclusions drawn about the feasibility of any plan. It is this aspect of feasibility that is dealt with here. There may be competing views about feasibility and the progress of any proposal can be affected by how this competition is resolved. Hall et al. point out that feasibility is rarely immediately apparent. It is in this context in which the need assessment may function to gauge a plan's potential acceptance or success. A feasibility study looks at a target prior to the commitment to plan. This is part of a process of "sounding out" and may be formal (e.g. the size of a target population in question) or informal (e.g. the feeling of the community about a planned program). Even in this limited role, however, matching of the orientation of those in a position to facilitate the success of a plan with the type of needs data which matches their values and interests will enhance a positive outcome.

Planning means change and change is rarely perceived as positive by all that are affected by it. To achieve change requires a power base. With the exception of totalitarian societies, this power base is generally a heterogeneous group consisting of governments (federal, provincial, municipal), trade unions, professions, advocacy groups and other interest groups. Crichton (1981) suggests that the first step in successful planning is to achieve enough
consensus among the negotiating interest groups that they will sit down together to work on problems. She cautions that without that agreement planning will fail.

How such negotiations take place and how consensus is reached is beyond the scope of this paper. However, it is important to note that whatever consensus is reached, the resulting major actors will exert their values and preferences - not only in terms of need assessment and planning but also in terms of their own views of rationality and change.

C. Planning Models

Given the close relationship between need assessment and planning an understanding of the major planning approaches is necessary in order to evaluate the role of need assessment strategies. The following attempts to differentiate between the two major approaches and clarify how each is related to certain need assessment methodologies.

1. **Incremental Model**

Lindblom (1959) has referred to this model as "the art of muddling through". Crichton (1981) has described such planners as problem solvers. The emphasis is on making relatively small improvements, based on a comparison of a limited number of concrete
program alternatives. Lindblom has argued that by taking only small steps, decision makers have the opportunity to evaluate programs and test political acceptance, thereby maximizing success. Crichton has described it as "troubleshooting". She suggests that this method identifies a problem, evaluates it, coordinates the response and endeavors to control the situation. Critics of this model argue that its lack of success in providing for a health care system with containable costs and point to the spiraling costs of a system rampant with both gaps and duplications. Incremental Planning can also be criticized as the "squeaky wheel" approach to planning - those who squeak loudest are allocated funds, with little view to the broad picture, alternative approaches or anticipated impacts of the program itself.

2. The Rational Model

Faludi (1973) defines the Rational Planning model as "the application of scientific method - however crude - to policy making. What this means is that conscious efforts are made to increase the validity of policies in terms of the present and anticipated future of the environment". This implies setting goals, examining alternatives and choosing the 'best' option for the situation at hand. This does not necessarily
imply total control over all variables but rather a logical and systematic approach of comparing the anticipated impacts of several alternatives. Freidman (1967) describes a similar model as a developmental model. Crichton (1981) describes this model as beginning by researching issues, selecting from alternative choices, making and taking decisions, operation-aligning the changes, evaluating and feeding back results. This suggests a dynamic and ongoing process to planning.

The Rational Model has been criticized by writers such as Lindblom (1959) who suggests that it calls for an extreme amount of rationality which is impossible to achieve in the 'open' system in which we operate. Lindblom further suggests that it is impossible to anticipate the total effects of any act and thus to attempt to choose rationally between alternatives is impossible. Advocates of Rational Planning argue that acknowledgement and control over some variables is better than none at all.
Figure 3 presents the relationship between the Planning Models and need assessment methodologies. The incremental approach relies on information from specific sources. It avoids the "big picture". This planning model has emphasized the growth of individual services and thus its emphasis is on utilization figures (to justify growth) and the "squeaky wheel" approach of community forums (to point direction).

The Rational Model emphasizes the "big picture" and thus epidemiological indices presenting true prevalence figures are most important. Such indices are generally diagnostic in nature, as the current use of DSM III in N.I.M.H.'s Epidemiological Catchment area study. Social indicators can also contribute to an estimate of true prevalence when used on a wide scale. Neither epidemiological indices nor social indicators can be directly translated into care needs, for all identified
cases will not access care services. Thus, utilization rates are a necessary component in translating epidemiological indices into health service planning. Social indicators are also of value, though ideally only when there is the possibility of addressing the social causes of the disorders.

This matching of need assessment and planning models is essential. Need assessments are only a tool used to provide the base from which planning can occur. Congruence between the tool and plan not only maximize success of the endeavor, they tend to emerge together as a result of other socio-political factors.

D. Values in Political Ideology

To maximize planning success the values and interests inherent in the ideology of the political force in power must be acknowledged. Different political ideologies hold quite different views on health, and mental health in particular, on the role of the planner, on change and on the role of government in these areas. Different views of rationality and of change will produce different constraints or boundaries to the planner. In turn, the type of data held to be credible and of use will differ according to these views.

Hall (1972) has described politics as being "concerned with the relationship of power or of influence, generally
within the context of government”. Blackburn and Blum (1968) define politics as "the act of promoting or preventing social change" and "the activities of political parties and the activities of organized groups trying to influence government directly and indirectly". They suggest that politics is the most frequently used method of deliberate change.

Neither politics nor planning can alone create change in democratic countries. Politics does provide the power base, however, while planning provides a set of perspectives or techniques that can assist political decision making. The planner’s ability to understand and use the political process to his advantage may be the largest determiner of a plan’s success; the political component can not be ignored when trying to understand the difficulties confronting the planner (Crichton, 1981).

Blackburn and Blum (1968) have dealt with this issue of philosophy and values in political change in respect to social action. In comparing models of social change the authors in effect describe the perspectives of the major political frameworks. Figure 3 presents an abbreviated version of their matrix. It is clear that the role of need assessment and planning will differ according to political ideology. The accompanying figure helps to identify some of the major themes or issues relevant to planning within the health care sector.
### Figure 4: Models of Social Action and Political Change

(adapted from Blackburn and Blum, 1968)

<table>
<thead>
<tr>
<th>Focus on Equilibrium</th>
<th>Focus on New Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservation and Homeostasis</td>
<td>Change</td>
</tr>
<tr>
<td>Incremental/Adaptive Planning</td>
<td>Rational/Development Planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL ORDER AND CONFLICT</th>
<th>SOCIAL GOALS</th>
<th>PRIMARY HEALTH GOALS</th>
<th>HEALTH PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketplace the determiner, society is what we find.</td>
<td>Let nature take its course, man’s instincts guide him well</td>
<td>Survival of the fittest</td>
<td>Health is one element of survival and health programs only increase the proportion of the unfit</td>
</tr>
<tr>
<td>Society greater than its parts, creates order and maintains institutions</td>
<td>Order and consensus are societal goals, man needs socializing (schooling and return to the path)</td>
<td>Treatment and rehabilitation</td>
<td>Health is part of conformance and health programs can restore the sick to the best level of health that can be expected</td>
</tr>
<tr>
<td>Society absorbs its conflicts and changes, and expects that these will result in new deviances which will create new conflicts</td>
<td>Society creates goals, values, and selects means to overcome the undesired and avoid the unexpected</td>
<td>Prevention</td>
<td>Health can be improved by planned avoidance of various causes of ill health. Prevention of what we are sure we don’t want is the highest practical current goal, as we aren’t sure of all the things we do want</td>
</tr>
<tr>
<td>Totalitarian</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Laissez Faire**
- **Disjointed Incrementalism**
- **Goal Oriented Developmental Planning**
- **Man creates new societies as deviants help remake society and then become part of it**

- **Society greater than its parts, creates order and maintains institutions**
- **Order and consensus are societal goals, man needs socializing (schooling and return to the path)**
- **Society absorbs its conflicts and changes, and expects that these will result in new deviances which will create new conflicts**
- **Society creates goals, values, and selects means to overcome the undesired and avoid the unexpected**
- **Health can be defined positively and is a top priority goal**

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| HOW HEALTH SERVICES ARE PROVIDED | Healers appear on demand | Marketplace medicine supplemented with government programs and private charitable programs to assist poor, and groups with special health problems. Provide limited public health services | Market, government and charitable medicine all pushed to provide a greater quantity of co-ordinated services. Any method used which delivers without sacrificing other major values | Government medicine |
| ATTITUDE TOWARD SOCIAL ACTION AND PLANNING | Making market freer and more competitive would eliminate need for government activity | Remedy undesirable situations as they become intolerable, patch up and use ad hoc planning when problems are really bad | Democratically controlled planning helps society correct the unwanted, avoid the unintended, and reach what is desired. Evaluate old and plan for new achievable goals on basis of trials | Make ideal goal our immediate target. Planning on a massive scale can bring society to its new goals |
| SCOPE OF CHANGE | As market dictates | Piecemeal or ad hoc changes | Broad interrelated changes | Total reorganization |
| ATTITUDE TOWARD DEVIANTS | Survival of the fittest plus charity | Retraining and therapy to help deviant become a competitive individual, institutional arrangements to temporarily assist deviants | Retraining and therapy where effective but also institutional arrangements to permanently assist deviants | Either total institutionalization or total rejection |
| WHO IS IN CHARGE? | No one | Those with power from money, election to office or voluntary organization | Whoever has most rational and popular plan | Technologists |
| CENTRALIZATION/DECENTRALIZATION | No intervention from higher levels of government | Assistance from higher levels of government on request, as for new plans | Work jointly on planning at all levels of governments, and focus on enabling shifts in accordance with ability to undertake tasks | Operate and control primarily at national level |

**Figure 4**

Models of Social Action and Political Change
(adapted from Blackburn and Blum, 1968)
Societies which do not believe that social change is possible do not plan. Thus, the existence of planning assures at least a belief that change is possible. It is the different beliefs in how change comes about, who controls or directs change and who change is directed to which results in different types and styles of planning. Each ideology will focus on the variable within society which it feels will most likely bring about or facilitate change. Each view results in plans focussed on different variables. Issues such as to whom change should be directed, who should direct change and how change should take place will be dealt with later in this chapter, as well as the various types of rationality different ideologies hold. For now it is sufficient to identify that such different ideologies do in fact result in different types and styles of planning by virtue of their individual values and beliefs about change.

Blackburn and Blum point out in their description of their models that each expresses an attitude towards community planning and solving social problems. The models are described as "exaggerating" the differences and thus cannot be directly compared to existing political parties but this exaggeration does help to clarify the different perspectives of each.

Laissez-faire describes the model which calls for least government action. Disjointed Incrementalism describes the
usual form of non-planning in western democratic societies, relying mainly on incremental changes to the existing system, based on a pluralist power base. The Goal Oriented Developmental Model can be generalized to the recent emphasis on more rational and global planning. The Totalitarian Approach includes both the planning approach of the Soviet Union as well as the authoritarian planning approach taken by many private corporations and some governments.

1. The Laissez-Faire Model

This model has both an academic and a popular version which tend to differ considerably in any practical situation. The essence of this model is control by the perfectly competitive market rather than any governmental intervention. The government is seen as having no role in change. Thus, the popular model tends to be used in defence of private profits while the academic model, supporting freedom to choose among real alternatives, individual freedom, individual initiative, has argued for less bureaucratic control by giving people money instead of forcing them to accept highly government regulated health and social services. These values of the academic model are held by many who do not support the practical application of the model. As Blackburn and Blum suggest, the desire to change
people at times conflicts with the commitments to the institution of freedom of choice, resulting in the same people who favor the free market ideology also advocating tight controls on government supplied services.

2. **Disjointed Incrementalism**

This model is based on the accepted legitimacy of a pluralist power base which allows input to the planning process from many sources and thus emphasizes the role that society itself plays in both social maintenance and social change. Planning, largely incremental in nature, is for the purpose of reacting to problems occurring as the system develops, as opposed to the global pursuit of actually planning the system itself. There is an acceptance of an 'open' system in which there is no end to the possible consequences, an inability to guage the total effects of any action because of the multitude of values which will be legitimately addressed.

3. **Goal-Oriented Development**

This model stresses the need for accepted goals, as opposed to the previous incremental "fix it" approach. It relies on community participation for direction but at the same time, tries to anticipate the
unintended or undesirable effects which may result from any action. The goal is long term and comprehensive, relying on more rational planning methods, including ongoing evaluation and review. This model reflects a more visible hand of government but one reflective of and sensitive to the community. Such democratically controlled planning is seen as a means of attaining the desired with a minimal of unwanted effects.

These two models can be roughly equated to what Crichton (1983) has described as the right and the left wings of the utilitarian liberalism of the western democratic tradition: the right wing supporting an ideology of entrepreneurialism and equality of opportunity while the left wing supports universal support services, equality of condition and the welfare state.

4. Totalitarian Model

This model emphasizes the technocratic approach to planning, planning "scientifically" without responsiveness to communities or concern with the impact on the lives of its citizens. It is not only associated with the Soviet Union but also with any solely "top down" approach where the values deemed as important are only those of those in power. The total planning model offers almost no room for anyone other
than 'experts', not accepting or tolerating any input into the plans. The focus is on massive change, and such change can not be altered easily. Paradoxically, the practical form of the laissez-faire model, currently being espoused to a large degree in both Great Britain and the United States, as well as in British Columbia, offers similarly little freedom of choice or opportunity for input. It is a curious mix of free market economy supported by government along with massive government intervention, regulation and limitations in the health and social service sector based primarily on "expert" opinions.

Awareness of how the various political ideologies view the elements of social change - and therefore need and planning - is crucial to understanding what type of need assessment will be relevant or meaningful to the political context. The possible scope of change, the focus of change and the potential actors are all a function of this power base. The balance of this chapter will deal with these constraints and how they affect the assessment of need.

E. The Role of the Planner

Integral to this question of values in need assessment
and planning is the role of the planner. Beyond the personal values of the planner are the values of the positions he occupies vis a vis the power base, the government. Data collected naturally will tend to serve the interests of planner’s own role. Their position tends to dictate their view as well as their limitations or boundaries of influence.

Gilbert and Sprecht (1974) outlined three contexts of planning in which the planner potentially holds quite a different role. Each position creates differently bounded rationalities or perspectives.

1. The Technocratic Planner

The technocratic planner exists in two quite different contexts which results in two quite different roles. Gilbert and Sprecht’s view is the academic and scientific planner, accountable primarily to his profession. He is the independent academic who is free to produce the optimal plan based upon his knowledge of economics, epidemiology, demography etc. This is a scientific approach to planning, expoused by the recent stress towards rational planning. One associates a high degree of autonomy with technocratic planning, with respect towards the methodology and direction taken. However, this autonomy is somewhat illusionary. The technocratic or academic planner may have relative
autonomy in relatively luxurious financial climates but considerably less so in periods of restraint when it is more likely that the ends will be dictated to him and the constraints more rigid and visible. Glennerster (1975) has pointed out that technocratic planning is more likely to occur in governments based on pluralist power.

Blackburn and Blum (1968) describe a quite different context and role. They suggest that technocratic planning is associated with the totalitarian 'top down' approach of centralized governments who rely solely on 'experts', insensitive to the attitudes of the community. In this context the technocratic planner is chosen for not only his expertise but more importantly perhaps for his views - those necessarily shared by the government.

2. The Bureaucratic Planner

Bureaucratic planners are those who are primarily accountable to the political and administrative hierarchy. The overlap between political and administrative policy making fluctuates as a function of the role that the political party in power expects politics to play vis a vis the public service. Thus there is an overlap between Blackburn and Blum's view of the technocratic planner and the Gilbert and
Sprecht's view of the bureaucratic planner. The more centralized the power, the more accountable to the political system the planner must be. This results in Gilbert and Sprecht's view of bureaucratic planning. This differs from Blackburn and Blum's view in terms of the actual power of the government. Blackburn and Blum's view assumes total government control, not possible except in totalitarian governments. Gilbert and Sprecht's view accepts a more diluted form of centralized government. In general bureaucratic or political planning faces many constraints. Eckstein (1956) argued that the myriad of constraints faced by the bureaucratic planner - lack of control, lack of data, need to appease various interest groups and professions, other parts of government and the electorate - has often resulted in a constricted role, reducing the planning scope and resulting in the incremental planning synonymous with most democratic governments. Crichton (1981) suggests that this type of balancing of priorities for a bureaucratic planner may be somewhat easier at the higher levels of government but that at the lower level where the public service tends to overlap in operational activities, this balancing will almost always result in incrementalism - the lower ranks concerned primarily with maintenance activities.
It can be seen, then, that technocratic and bureaucratic planning can share a similar role, yet will differ as a result of the degree of control or power the government actually has. The issue is not merely centralization but rather absolute authority. In one context this may result in broad, developmental and rational planning. In the other context it results in planning scope being reduced and the incremental model being adhered to.

3. **The Advocacy Planner**

The advocacy planner is accountable primarily to the consumer group that purchases his services. Such planners tend to espouse the social philosophy held by the employer - the planner tends to be chosen for primarily his views. This type of planning developed along side the early need assessment movement during a time when the focus was on developing services responsive to the needs of particular groups, with little eye to fiscal concerns. Such planning continues to hold importance most in this type of atmosphere, when there appears to be considerable opportunity to influence the system. This may be in terms of available resources or in terms of unsteady political times where greater influence via the media can affect increased change. In general, the more centralized the
government, the less likelihood of effecting change through this means.

Advocacy planning is rarely developmental - interest groups rarely have the broad of scope and necessary power base. Rather it tends, particularly in the more recent times of fiscal concern, to provide some means of influencing incremental change which may, at worse, be a form of tokenism from a centralized government faced with socially or politically unfavourable attention.

4. **Summary of Planning Roles**

The contexts, or roles, of the planner are clearly a major factor in the need assessment approach which will be chosen to provide the data on which planning for change can be based. The technocrat operating in a highly centralized totalitarian government looks at planning in a broad and developmental manner, using rational planning methods. The technocrat operating in the more democratic government systems can approach issues in a similar manner but will be constrained by a more pluralistic power base which ultimately he must be accountable to. Thus, technocratic planning in its pure form is somewhat illusionary in democratic governments. Ideally, however, technocratic planning assumes the use of the most rigorous of the need assessment methods, such as epidemiological methods,
attempting to produce the most quantifiable data base.

Bureaucratic planners emerge in centralized systems of government but the government's own constraints tends to encourage adaptive and incremental planning, using the less rigorous need assessment strategies, such as utilization figures and social surveys.

Finally, the advocacy planner is most viable in a decentralized system but the constraints of his power base and influence will generally restrain him to adaptive and incremental planning though usually by the more consumer acceptable methods of community forums and questionnaires\(^\text{(2)}\).

It is clear that there are many real world constraints which affect the academic models and such models offered by both Gilbert and Sprecht and Blackman and Blum can only offer insights into possible scenarios, both models being readily influenced by the individual circumstances of any context.

\(^{(2)}\) Consumer groups and governments occasionally appear to coincide with their planning, as was the case in British Columbia's deinstitutionalization of the mentally retarded in 1984. Both government and the B.C.A.M.R.P. appeared to agree on the ends of a developmental plan but careful analysis would suggest that this agreement was with vastly different intentions - normalization for B.C.A.M.R.P. and cost containment for the government.
F. **Rationality - Different Viewpoints**

Viewpoints implies that the same problem can be seen from many angles and that the solution to the problem can take on many different forms. The term rational is generally assumed to imply logic but it must be understood that one man's logic is another's idiocy. Rational is a value laden term and is relative to the beholder's view of the world - and in the case of mental health - the individual's beliefs about mental illness, its causes, its course and its prevention. No planner would admit to being irrational but different constraints produce different types of rationality.

In the case of needs assessment the preferred model implies specific views about the concepts of need, demand, want, the model of mental illness and the political context. To paraphrase Boulding (1967), rationality is "bounded", not absolute.

Arnold (1968) suggests that there are different kinds of rationality depending upon the kind of problem that is involved. Relying on Diesling's work she outlines five types of reasons which she suggests are functionally necessary in society. Depending upon the viewpoint one type of rationality may take precedence over another.
1. **Logical Rationality**

Logical rationality concerns the logic of cause and effect. Much of problem solving depends on the knowledge or beliefs (not necessarily substantiated) we have of how problems we wish to solve are caused. This is particularly important in the health sector as most disease control programs, either preventative or therapeutic in nature, are dependent on logical rationality. In mental health this suggests that the model used to explain mental illness will dictate whether or not a planning process is rational. A medical model should necessitate a medically defined need and medically oriented solution in order to be perceived as rational. A social model should necessitate a socially defined need and socially oriented solution.

2. **Economic Rationality**

A second kind of rationality is economic rationality. In this case causal relationships are assumed and the decisions involve efficient allocations of resources. The problem of limited resources, be they people, money or technology, underlies economic rationality. Objectives must be prioritized in order to make economically rational decisions. Through prioritizing one implies the "best" way to allocate
resources to achieve maximum utility. Economic rationality has grown with the move towards professional health administrators but has also brought with it a focus on the ethical problems of prioritizing health objectives. How one orders disease problems — in terms of cost to society or costs to the individual — and how one guages "greater gain" is fraught with problems and presents as one of the most challenging problems in health care today. Who will prioritize need and on what basis they will do it brings into focus many of the current conflicts in health. Who will dominate in these decisions — health professionals or professional administrators? Who will benefit — the group (society) or the individual?

3. **Social/Legal Rationality**

Social rationality involves the maintenance of social interaction and social integration, ensuring at least a minimal base of common values, expectations and norms. Without this rationality, action would occur on an individualized basis — on each individuals perception of what is logically and economically rational, ignoring the need for society to function with some measure of concerted action. Legal rationality defines the parameters of social rationality — what is morally acceptable and what are
the limits of action that might affect other people. These two forms of rationality operate together to dictate the constraints of treatment, and in mental health particularly, the limits to imposing care. Certain individuals perceive it to be most economically rational to impose care on difficult mental health clients but these other kinds of rationality prevent such individualized action.

4. **Political Rationality**

Finally, political rationality articulates a society’s values about authority and responsibility through organized forms for the achievement of all other kinds of rationality. Political rationality resolves the question of who will make what decisions for whom and under what conditions.

Economic ideals and social ideals occupy opposite ends of a continuum. Arnold (1968) suggests that it is the political system that has been identified in democratic countries as the force which must make a choice of position between these two values.

It is clear from this discussion of types of rationality that whoever is in the position of power - whoever makes the decision as to what is rational - is a key
actor in any plan. Logical rationality presupposes a specific model of mental illness - one does not look at social indicators if one believes in a medical or biological cause of illness. Current economic rationality holds that cost benefit for society is the rational approach. Social rationality and legal rationality makes assumptions about the role of society at large, while political rationality articulates a society’s beliefs as to who is in control. Clearly in any democratic society social and legal rationality are the givens in which any planner must work. It is this competition between logical, economic and political rationality that must be recognized and addressed in the planning process. Each has a different goal and will thus view different data as being useful and legitimate.

G. Change - Different Views

Need assessment and planning assume that change will occur. How change is viewed - how it occurs, who it should be directed to and who should steer the process - will influence how need is assessed. Causality is also related to the change. The belief as to how a disorder is caused will naturally determine the focus of both need assessment and service development. As earlier discussed, two parallel theories of causality have developed within mental health and each has potentially different implications for both need assessment and service planning.
1. How Change Occurs and to Whom

The question of how change should occur is related to values about change. Change itself can be perceived negatively by those who believe that society should be a stable and well integrated system. On the other hand those who view society as an ongoing process, rather than an end, will welcome the struggle between views that change tends to bring. An emphasis on social order suggests a different perspective on change than an emphasis on social conflict.

As Blackburn and Blum (1968) have observed, social order implies control, and views man as a product of societal training and habituation, with natural drives well controlled; the conflict perspective tends to view man as possessing certain essential qualities which drive him to mold himself and design his social relations. Given these conflicting views mental disorder can be perceived as either a threat to natural order or a sign that change is required in the existing society. This is related to the views of causality - is deviancy a product of the individual himself or a product of society’s effect on the individual?

The response to mental disorder will be different depending upon the perspective of change held. Those who maintain that change is negative will make efforts to curb such deviancy through instituting controls and emphasizing the individual’s need to adapt to his society. For mental health this means an emphasis on the individual, a medical
model of causation. An emphasis on therapeutic services to "fix" the deviant and a reliance on institutions to "control" him. Planning is then focussed on changing, or at least controlling, the individual. Need assessment is similarly focussed on individual pathology, using epidemiological surveys and utilization data to provide a basis on which to plan.

Conflict theorists view deviancy as the realization of human potential. Change is valued as a positive force, allowing movement towards a better functioning society. Mental disorder is seen as deviant behavior resulting from an individual's reaction to larger societal processes. Deviant behavior is understood to result from the pressure of social conditions on individuals. It is a sign that the society, not the individual, must be changed. In this case, planning is focussed on changing the society. Need assessment is similarly focussed on the impact of society, using social indicator approaches or community forums to assess need. As Blackburn and Blum have stated, planning proposals and programs will vary greatly if they start with a strong bias toward the object of changing people or the object of changing institutions or society.

2. **Who Should Direct Change?**

The question of who should facilitate and direct change is closely related to how change should come about.
Different planning models make different assumptions as to who has this control or power and to what degree. Government has traditionally provided the power base through which changes in the health sector have been directed. Until the 1960's the direction which change took was largely dictated by the health professions. The consumerism of the sixties and seventies led to increased participation by communities and advocacy groups. The eighties' concern for cost containment has resulted in the transfer of power in directions from both health professionals and consumers to government itself. Concerned with declining revenues, large deficits and voters' reluctance to accept tax increases, politicians have put a psychological lid on spending and have looked towards professional managers to curb costs and direct the necessary changes to accomplish this. Governments are thus faced with taking on the onerous job of meeting with voters' approval while juggling the interests of strong lobbies such as the health professionals, trade unions and advocacy groups. The relationship between the "political planners" and "professional" planners has thus increased in importance.

Crichton suggests that in any government there is an overlap between these political and the administrative functions and that the relative emphasis placed on each of these two for us depends largely upon the political party in power. As previously discussed, who does have this role
will affect how need is viewed and what type of planning will be favoured.

H. Discussion

The foregoing merely touches upon some of the many major factors which need to be taken into account when anticipating use of a need assessment tool. It is offered in the endeavour to clarify the misconception that a 'best' model of need assessment exists. The argument of this paper has emphasized the need to examine the values held by each need assessment model and, in turn, the values of the context in which that tool is to be utilized. A 'best fit' must be the ultimate goal, a sensitive analysis of both tool and context. Where the power lies and how it is distributed, what role the planner holds within this system, what views of change and rationality are all contributing factors to this 'best fit'.

A clear and logical linear model can not be developed, the circumstances surrounding each scenario being complex. This paper does not argue for a formula, matrix or cookbook approach. The crux of this thesis is that a "if this, then that" approach can not be taken. Each situation is unique and the planner, when faced with choosing a need assessment tool with which to build a data base for planning, must be sensitive to all of the issues raised. The exact configuration of relative factors will be unique to each situation.
Chapter VI: From Model to Reality

A. The British Columbia Scene

This paper has argued that the decision of which need assessment tool to use, or what type of data to collect and base resource allocation on, is neither a value free nor arbitrary one. Rather, it is a decision that reflects a specific view not only of mental illness, its cause and its potential for cure or care, but also a socio-political view of need, of disease, of planning, of change, and the role that government may want to play in any of these areas.

Academic models abound in all arenas but too often they have little relevance to the real world. This is less likely in the social policy realm since in this area models are often based not on an academic’s view of what should or could be but rather a reflection of what has or does occur. These models are often built as an explanation of what does exist (e.g. Blackburn and Blum, 1968; Marmor, 1970; Gilbert and Sprecht, 1974). Despite this link with the real world no one planning model can adequately describe any specific situation. The emphasis of this paper has been the need to be sensitive to the particular variables of each individual context, avoiding a "cookbook" approach to need assessment. With this sensitivity in mind, it is essential to appreciate that no one model - be it of need assessment, of planning, of change, or of political ideology - can be used to adequately describe or explain the British Columbia, or any
other, mental health scene. Rather, such models offer some guides by which some sense can be made of what is invariably a highly complex process.

1. The Development of the Current System

The current British Columbia community based mental health service delivery system was described in Chapter One of this paper. There is no simple explanation by which the development of this now very comprehensive system can be explained. The system developed slowly over nearly twenty years, weathering political changes, social changes, and bureaucratic changes. The fact that in 1985 nearly every area of British Columbia is served by a multidisciplinary outpatient mental health team which also offers easy access to both residential care and inpatient care is in reality a credit to the much maligned incremental planning method.

The socio-political context during the majority of this development was influenced by several factors: the relative financial prosperity of the 1960’s and early 1970’s which allowed for development of health and social services, the desire of the Premier, then W.A.C. Bennett, to be seen as a paternalistic populist, providing for his people (Morley et al, 1981), the concomittant community mental health development in the United States, and the reliance on health professionals to steer development of services. The currently existing community mental health system in British
Columbia developed in a rather piecemeal or incremental fashion, a result of all of these factors.

Need was "obvious" - the development of community based services to keep in pace with changes in mental health care delivery happening at different paces throughout North America. As discussed in Chapter One, this development was largely steered and fuelled by psychiatrists who argued that psychiatric illness should receive the same consideration and importance as physical illness. The report More for the Mind (1963) did much to legitimize the future development of community based care.

Thus, need was initially very much medically defined. The planning model was generally incremental in nature. The role of planner was held by the health care professional.

Actual political ideology had considerably less to do with the development of health care services in British Columbia during the W.A.C. Bennett years. Morely et al, (1981) suggest that throughout the first twenty years that the Social Credit Party was in power in British Columbia, the party ideology had little to do with the government. Rather, the party provided a convenient electoral framework for a pragmatic and developmental oriented government through the dominance of one man, the Premier, and the centralization of political decision making. W.A.C. Bennett demonstrated that his government was a "government dedicated to growth". The bureaucratic and administrative history of
the British Columbia Ministry of Health and the development of the current Mental Health Services present interesting history in their own but these details are beyond the scope of this paper. The important issue here is that the system as it exists today developed largely as a function of an incremental, professionally dominated planning process, facilitated by a government dedicated to growth in a time of relative financial prosperity.

Much of the current community based mental health system was in place by the time the New Democratic Party came to power in 1972. Their administration was brief, though a lengthy document, The Foulkes Report on Health Security for British Columbians (1973) was prepared during this time as a comprehensive plan for the province. Crichton (1981) points out that Foulkes' paper was less of a plan and more a statement of social philosophy. The Foulkes Report was an innovative approach to providing health care services, a developmental plan pointing new directions for nearly every aspect of health care. Crichton points out that this report was really an example of advocacy planning, not the adaptive and bureaucratic planning required by a new government faced with a public service and health care system firmly entrenched by the twenty year history of the previous administration.

The New Democratic Party’s era of power was short lived and in 1975 the Social Credit Party was returned to power,
Bill Bennett now Premier. As previously discussed the late 1970’s also witnessed the end to the developmental phase in health and social services. Many factors contributed to this: declining revenues (particularly in the British Columbian resource based economy), the combined effects of drastic service expansion of the past two decades, the growth in population, the increase in cost of health care technology are amongst many. Cambell et al, (1981) have discussed the resulting shift in focus from the consumption ministries which had enjoyed development dollars, to the production ministries, which would hopefully produce dollars. This change in focus has been clearly evident in British Columbia where major efforts have been made to curb development and health care expenditures.

2. The New Direction

As development of health care services came to an end a new process of justification of services has developed. A B.C. Ministry report, Regionalization of Health Care in BC (1981) commented on the process of resource allocation. It specified that resources be distributed rationally and equitably within the overall objectives of improved efficiency and effectiveness of the health care system. The emphasis has thus moved to a process of accountability and justification for programs and services. As fewer dollars became available to such consumption ministries as Health,
the need to either narrow service boundaries, or dilute service became apparent. As we have discussed, Boyd (1979) has outlined how these options can be achieved. The rationing of services has become necessary and it is here where need assessment has developed a renewed role.

The planning process has changed dramatically from the professionally directed incremental approach of the earlier era. As discussed in Chapter One, the Ministry of Health has experienced a major shift from the direction of health care professionals to the direction of professional managers. As Cambell et al, (1981) have indicated, the majority of decision makers in the senior levels of the Ministry are no longer physicians but are managers chosen for their administrative expertise. Thus, the focus has moved from program content and professional excellence to administrative accountability.

In Mental Health Services this has been evidenced by no senior positions being held by psychiatrists (one consulting psychiatrist still exists). At the same time a new organizational structure has provided for Regional Managers, directly responsible to the Director of Mental Health Services. The focus of these managers - a title that was recently changed from Regional Coordinator - appears to be primarily administrative, providing the facts and figures of caseloads for accountability required for continued existence of programs. Program Directors exist at
Headquarters but the current organizational chart does not provide any formal connection between the Directors ostensibly responsible for Programs and the managers responsible for regional administration.

The policies of the Mental Health Centres are beginning to reflect this structure. Service boundaries are being narrowed, the focus being increasingly placed on only the seriously mentally ill. The regional structure serves to encourage standardization of service, quite opposite to the original direction of the community based movement which stressed resource development on the basis of the unique needs of each community. The introduction of a management information system, relying on the DSM III diagnostic classification scheme, in late 1985, will serve to further delineate boundaries and standardize service.

Planning in this context, the Ministry level, has thus become a highly bureaucratic process, argued to be rational and using mainly utilization rates as a data base for resource allocation. However, the broader context presents a contradiction of this. The current government, based on a populist ideology, has emphasized a traditionally laissez-faire approach, de-emphasizing government involvement in either planning or services. Despite this, at the Ministry level, control of service delivery appears to be becoming of paramount importance as the goals of accountability and efficiency compete with the ideology of small government.
As discussed in Chapter Five, the academic model of laissez-faire and its popular version often become confused in any practical situation. Thus, we currently have the interesting scenario of a government whose political ideology favors free market ideology, while its practical application results in tighter controls and increased government intervention in the provision of health and social services.

Where does need assessment stand in this complex situation? Those adhering to free market ideology will argue that need assessment is largely irrelevant, as the government should have little role in planning. The attitude held towards the mentally ill and other such deviants is one of minimal care, a focus on the survival of the fittest, equality of opportunity, and charity to those who are unable to compete in the free market.

On the other hand, in the practical application of such ideology, there is a focus on what Blackburn and Blum (1968) have identified as technocratic planning. In this context the planner is chosen more likely for his views than his expertise, the ends being already dictated by a 'top down' management approach. In this scenario, the laissez-faire ideology is contrasted with a very totalitarian approach to planning.

In this case, when also compounded by the fiscal restraint of the 1980's, need assessment becomes the tool of
resource allocation, which is more often used to justify existing programs than to serve as a source of direction for new ones. Utilization rates are the most common tool, serving not only to provide accountability data but also to emphasize that services are in fact being provided, taking the focus away from existing gaps or inadequacies. Thus, change is not favored, development not sought. This approach tends to, at best, maintain the status quo, while at worst, reduce service levels.
Chapter VII: Summary and Conclusions

This paper has focussed on the relationship of need assessment to the planning process. Need assessment is a necessary tool of the planning process and is thus inextricably linked to the same influences as the planning process itself. Need assessment can thus not be examined as a stand-alone technology in the way statistical methods are viewed. There cannot be a 'best' method, but rather a 'best-fit', given the values of the model and the values of the context.

This view of need assessment as beyond a technology has resulted largely from its changing role. Developing originally as a method of directing developing services to the unique needs of specific communities, its role has changed with the changing economic climate which has witnessed a major shift within government from service development to service containment and justification. With this shift need assessment has developed an allocative function, used as much, if not more, to curtail or justify services as to develop services.

This paper has argued that to use need assessment technologies to provide a basis for allocative decisions necessitates an understanding of the values and concepts, both implicit within the model and within the planning context. Need assessments are not done without some intent to plan and achievement of that plan will necessitate
understanding the socio-political context. The power base by which a plan is achieved is invariably political, though the extent this is true will vary with the political ideology.

Intelligence has been facetiously defined as what intelligence tests measure. Need has often been viewed in the past in the same manner - that which need assessments measure. This paper has endeavoured to portray need as a far more complex and elastic concept, its assessment dependent upon its definition. Need has been viewed as synonymous with want or demand but as need assessment has taken on an allocative function a clearer analysis and definition is required, the values implicit in the definition of need dictating the assessment tool along with the values of the user or context.

Mental illness is itself an illusionary concept, a precise universally accepted definition does not exist. Unlike physical illness, neither etiology nor treatment is clear, relying instead on various theoretical models - usually the medical and social models. Despite these two different models, or understandings, of mental illness, the traditional service delivery model has relied on the medical model and development has been dictated largely by the medical professional.

As population has increased while dollars available to health care have been capped, it has become recognized that
need is potentially infinite and this fact has contributed to a curtailing of the traditional role of the professional in dictating service requirements. This acceptance of an infinite level of need, yet with declining resources available, has led to a new emphasis on rationing. The problem of balancing ever expanding needs and scarce resources must be resolved and methods of rationing have been developed to address this problem. Thus, the emphasis on professionally dictated need has been reduced in favour of a more administratively dictated level of demand - demand being potentially finite and theoretically measurable.

It is with these changes that the role of need assessment is now developing into an allocative rather than developmental tool. With this change comes an increasing need to fit need assessment technology into the planning process itself, with an appreciation of the difficulties confronting planners in the implementation of their plans. Thus a clearer understanding of the role of the planner, his methods and the sociopolitical context in which he must operate is essential to ensure appropriate and maximum use of the need assessment technologies.

This paper was not intended to prioritize need assessment technologies, nor provide a framework for their use. Rather, its intent has been to elucidate the values and concepts implicit in the need assessment technologies and stress the importance of linking these with the values of
both the user and his context. Need assessment can not be viewed simply as a technology. Its new role as an allocative tool has given it new status in the potentially political realm of rationing scarce service resources and use of any of the various need assessment technologies must appreciate this.
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