

Importance of Adding Objective Data to Stakeholder Data in Needs Assessments

Abstract

When completing a needs assessment, Extension professionals should include both objective county data and stakeholder input data. Specifically, Extension professionals should identify potential areas of need, source available objective data, source data from relevant county stakeholders, and analyze similarities and differences in objective and stakeholder data. Needs assessments should be conducted in this manner to confirm the needs of a county; address risk of data skewed by subjective stakeholder opinion, particularly in small counties; and identify areas of greatest need. This method has been shown to be effective through implementation in a target rural county.

Keywords: [needs assessment](#), [stakeholders](#), [rural needs assessment](#), [objective data](#)

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Introduction

Existing recommendations for conducting Extension needs assessments center on sourcing the needed data from relevant county stakeholders, such as health-care providers, community leaders, and social services workers (Angima, Etuk, & King, 2014; Comito, Houb, & Licht, 2018; Malmshemer & Germain, 2002). However, adding available objective data to such stakeholder data can bring about further context, providing a more complete picture of community needs (Zimmerman & Kahl, 2018). We performed a needs assessment in one rural county to demonstrate a replicable process for using objective data in conjunction with stakeholder data to thoroughly assess county needs.

Four-Step Method

Step 1: Identify Potential Need Areas

Extension professionals should identify potential areas of need in the community that align with their training, expertise, and interests to ensure that they can competently address identified gaps (Caravella, 2006; Hill & Seger, 2018). Applying this concept, our team identified six potential subjects constituting areas of need in one Utah county: divorce, parenting, mental health, suicide, pornography use, and

caregiver and chronic illness support.

Step 2: Source Available Objective Data and Published Literature

Extension professionals should conduct a thorough search of publicly available health, government, nonprofit, and county periodical objective data. Many web-based data sources are available from organizations such as the U.S. Census Bureau and state health departments (Zimmerman & Kahl, 2018). Relevant published literature may also provide support for available or missing objective data. We found that objective data were available for all six key potential areas of need we had identified and that relevant published literature was available to supplement the data.

Step 3: Source Data From Relevant County Stakeholders

Extension professionals should conduct a search of relevant data from county stakeholders. We found that primary care providers, mental health professionals, and religious leaders are the de facto resources (stakeholders) used in rural communities for the six key potential areas of need we identified (Bannister, Park, Taylor, & Bauerle, 2012; Hartley, Korsen, Bird, & Agger, 1998; Lambert, Agger, & Hartley, 1999; Robinson et al., 2012; Smalley & Rainer, 2012; Swinton, Robinson, & Bischoff, 2009). Because the county had an estimated rural population of only 21,539 (Ratcliffe, Burd, Holder, & Fields, 2016; U.S. Census Bureau, 2018) and few stakeholders, we invited all stakeholders in the county to complete a survey. Stakeholders were asked whether they felt that the six key areas were areas of need in the county (e.g., "Suicide is a problem in the county").

Step 4: Analyze Similarities and Differences in Objective and Stakeholder Data

After gathering data from both objective sources and stakeholders, Extension professionals should perform an analysis of differences and similarities in the data.

Sample Data and Analysis

Results

Related to the six areas of potential need we identified, we obtained data from seven objective/published literature sources and from the participating stakeholders ($N = 21$). In this section, we report both types of data for each area of need.

Divorce

The divorce rate in the county was 65.3% (Utah Department of Health, 2010), 23.4% higher than the national average and 50.1% higher than the state average (Centers for Disease Control and Prevention, 2017). Stakeholder responses are illustrated in Table 1.

Table 1.
Levels of Agreement That Divorce Rate in County Is Too High

Stakeholder category	Min	Max	<i>M^a</i>	<i>SD</i>	Variance	Count
Primary care provider	3	6	4.67	0.94	0.89	6
Mental health provider	4	6	4.88	0.78	0.61	8
Religious leader	1	6	3.86	2.23	4.98	7
Combined	1	6	4.48	1.53	2.34	21

^aMeans are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Parenting

The birth rate in the county is 2.5% higher than the Utah average and 36.4% higher than the national average (Utah Department of Health, 2019). In addition, rural families need more parenting education programs (Owens, Richerson, Murphy, Jagelewski, & Rossi, 2007). Stakeholder responses are illustrated in Table 2.

Table 2.
Levels of Agreement That Parents in County Struggle With Knowing How to Best Parent Their Children

Stakeholder category	Min	Max	<i>M^a</i>	<i>SD</i>	Variance	Count
Primary care provider	4	6	4.67	0.75	0.56	6
Mental health provider	1	6	4.75	1.56	2.44	8
Religious leader	3	6	4.71	0.88	0.78	7
Combined	1	6	4.71	1.16	1.35	21

^aMeans are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Mental Health

Data from the Utah Department of Health (2019) indicate that of the residents of the county over 18 years of age, 15.5% indicate having struggled with a mental health disorder for at least 7 of the preceding 30 days and 20.4% have a depressive-disorder diagnosis. Stakeholder responses are illustrated in Table 3.

Table 3.

Levels of Agreement That Mental Health Struggles (Such as Depression and Anxiety) Are a Problem in County

Stakeholder category	Min	Max	M^a	SD	Variance	Count
Primary care provider	5	6	5.67	0.47	0.22	6
Mental health provider	1	6	5.25	1.64	2.69	8
Religious leader	5	6	5.86	0.35	0.12	7
Combined	1	6	5.57	1.09	1.20	21

^aMeans are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Suicide

Statistics on suicide deaths in the county indicate that suicide is the fifth leading cause of death and that there are 92% more deaths by suicide than the national average (Utah Department of Health, 2019). Stakeholder responses are illustrated in Table 4.

Table 4.

Levels of Agreement That Suicide Is a Problem in County

Stakeholder category	Min	Max	M^a	SD	Variance	Count
Primary care provider	6	6	6	0	0	6
Mental health provider	1	6	5.38	1.65	2.73	8
Religious leader	5	6	5.71	0.45	0.20	7
Combined	1	6	5.67	1.08	1.17	21

^aMeans are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Pornography Use

Utah has the highest online subscription rates of pornographic material in the United States, and the county we studied is one of Utah's four highest in use (Edelman, 2009). Stakeholder responses are illustrated in Table 5.

Table 5.
Levels of Agreement That Pornography Use Is a Problem
in County

Stakeholder category	Min	Max	<i>M^a</i>	<i>SD</i>	Variance	Count
Primary care provider	3	6	5	1.15	1.33	6
Mental health provider	1	6	4.75	1.64	2.69	8
Religious leader	5	6	5.71	0.45	0.20	7
Combined	1	6	5.14	1.28	1.65	21

*a*Means are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Caregiver and Chronic Illness Support

The number of people over the age of 65 in the county is 48.1% higher than the national average (U.S. Census Bureau, 2018; Utah Department of Health, 2019). Additionally, those with chronic illnesses and their caregivers experience significant emotional and mental health ramifications (McDaniel, Hepworth, & Doherty, 1992). Stakeholder responses are illustrated in Table 6.

Table 6.
Levels of Agreement That Those With Chronic Illnesses
and Their Caregivers in County Lack Adequate Emotional
Support

Stakeholder category	Min	Max	<i>M^a</i>	<i>SD</i>	Variance	Count
Primary care provider	4	6	4.83	0.69	0.47	6
Mental health provider	1	5	4.38	1.32	1.73	8
Religious leader	4	6	4.86	0.64	0.41	7
Combined	1	6	4.67	0.99	0.98	21

*a*Means are based on 6-point Likert-style scale ranging from *strongly disagree* (1) to *strongly agree* (6).

Analysis

Potential Limitations of Stakeholder Data

In some circumstances, the opinions of the stakeholders were congruent with the objective data (a cutoff score of 4 was used to suggest congruence). For example, the objective data and stakeholder data mutually suggested that suicide was an area of need for the county. Using both objective and stakeholder data confirms support regarding needs.

In contrast, some participants held different perspectives. For example, on the issue of divorce, religious leaders showed differences in their perspectives. Differences also existed among mental health providers on the issues of parenting, mental health, suicide, and pornography use. The perspectives of stakeholders may not always align with what objective data show. In our study, this could be due to the small sample size or differing perspectives on issues among the few stakeholders available. However, small sample size is unavoidable in a small county, thus potentially challenging the reliability of stakeholder-only needs assessments.

Potential Limitations of Objective Data

If one were to rely solely on objective data when completing a needs assessment, it would be difficult to rank issues of greater or lesser need. Adding the perspectives of stakeholders may be helpful for identifying the areas in greatest need of programming. According to the perspectives of the stakeholders we surveyed, the issues of suicide, mental health, and pornography use were of greatest concern, whereas the issues of divorce, caregiver and chronic illness support, and parenting were of less concern.

Some of the available objective information was old, threatening its current applicability and limiting inferences made from its use. Support or contrasting perspectives provided by the stakeholder data addressed this potential limitation.

Conclusion

On the basis of the combined data we obtained in our needs assessment, we conclude that (a) using both objective and stakeholder data can give confirming support of needs; (b) using only stakeholder data has the potential to skew conclusions, particularly in smaller counties where fewer stakeholders are available; and (c) adding stakeholder perspectives to objective data can help identify the areas of greatest concern and clarify aging objective data. Hence, we recommended that needs assessments involving the four-step process illustrated herein be used to obtain a more reliable picture of needs in a county.

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