The Planned Change Process: Community Perspective

Introduction

In the human services, change occurs with many types of clients, e.g., individuals, families, groups, agencies, and communities. Planned change is more effective if brought about by a well thought out and researched process. It is to be distinguished from change that occurs due to other reasons such as insights (ah-ha experiences) or emotional experiences (religious conversions). It is also to be distinguished from change where the change agents “wing it” or proceed using what they think to be the best way to precede.

This document presents planned change as a nine-stage process. The first part of this document presents the generic nine-stage process found in the human services and explains the stages from a community perspective. The second part of the document works through the stages of planned change where the community is client.

The nine-stage process of planned change can begin at any stage. At what stage you begin depends on the situation, the end results desired, the funds available, time constraints, political realities, available expertise, sanctions you have, etc. However, research demonstrates that the more stages of the process you complete effectively, the more likelihood that change will be successful. Much of the change occurring today does not include all the stages, since going through all of the stages is time consuming and costly.

I. Sensing, engagement, and relationship building

At this stage, you are “getting the lay of the land” by accepting input through all the senses. This is one of the more informal stages and involves processes such as listening, determining people’s self interest from their “stories of who they are,” observing, introducing yourself to others who may be concerned, establishing rapport, creating an atmosphere of mutual trust and respect, brainstorming with people and groups, identification of leaders, discovering politics, clarifying ground rules and roles (confidentiality), understanding past efforts, and thinking about overall strategy formulation. This is the “planning to plan” or developing an action framework stage. This stage identifies the community groups, organizations, and individuals involved, the funds available, political realities, sanctions, time, etc. This stage is useful in exploring needs, capacities, clients, solutions, and those who must play a role in the solution, i.e., stakeholders.

This crucial stage has its roots in the values of the worker and client, in social policy, and in the local situation. During this stage, a practitioner continually envisions the total change process, e.g., considers how the criteria for evaluating success will influence who is involved.

II. Clarifying expectations, visioning, and setting overall direction

This stage specifies the overall framework and intentions of the change process by developing conditions of concern, vision statements, and guiding principles. It defines the environment, parameters, purpose, and values for everything else done. It is useful for motivating and coalescing those involved around common directions. It is an especially important stage when working with conflicting groups, as it helps unite individuals around a common future.
A condition of concern is the situation or phenomena under study. Statements about the condition should concern its nature and severity, the characteristics of the people involved, etc. Conditions become problems when they are judged negative, harmful, or pathological. Some examples might be:

1. X% of the children raised in Texas live in families that have yearly income below the poverty level.
2. The teenage pregnancy rate in Tarrant County is x per 1000 girls age 13-19.

Since we are using a strengths perspective, a condition may be considered an opportunity rather than a problem. For example, a community suffering from recession may become motivated to improve its quality of life to attract needed business.

A vision gives the "big picture" of the changes you desire. It specifies what you expect things to be like after change is implemented. The vision statement is designed for the public and should not contain professional jargon. It incorporates two types of information about desired future states:

1. What the client or targets of your intervention will be like after all possible change is implemented.
2. What the service delivery system will be like and how it must perform to produce the vision.

The vision statement should not specify means or solutions, such as specific agencies, programs, or facilities. It should be based in result or outcome of programs or services. It is good to begin writing your vision statement by completing the sentences:

1. We envision people (who are the target of our change) to be … (add what they will be like after the change is implemented, e.g., mentally healthy)
2. We envision the service delivery system after our change is implemented will… (add what the system will look like, e.g., an integrated system of services).

An example of a vision statement for a community development program might be as follows: We envision a community and families that support infants, children, youth, young adults, middle aged, and the aged in developing their maximum potential emotionally, intellectually, and socially (people statement). We envision a service delivery system that promotes self-help and a mix of human services that intervene if self-help measures, the family, and the community fail (system statement).

An example of a vision statement for a drug prevention program might be as follows

We envision people in our community as drug free and resilient to the risk of drug abuse (people statement). We envision a system of easily available and affordable services that focus on prevention, but if prevention fails, provides a complete range of services such as screening, assessment, treatment, rehabilitation, and follow-up (system statement).

Guiding principles are statements of philosophy, values, beliefs, and assumptions of the practitioner or change sponsor. They can be neither proven nor disproven. Thus, they often begin with the phrase “We believe…” Ideas for guiding principles come from research about the condition of concern, professional ethics, values such as social justice, and the values of the stakeholders in the change effort, e.g., committee members, the community, professions.

Examples of guiding principles are:

- We believe that the family and community are the primary places where citizens develop their maximum potential emotionally, intellectually, and socially. Human services that
support the family and community networks should be preferred over those that optimize the individual independent of or at the expense of the family and community.

- We believe that human service agencies should only intervene if self-help, family, and community networks fail.
- We believe that mental health promotion and mental illness prevention is preferable to treatment.

III. Assessing to discover capacities, needs, and barriers

Assessments use techniques and structured processes to gather information. For each area assessed, you must determine the data to collect, the source of the data, the methods of data collection, the meaning of the data, and how that meaning is translated into needs and capacities. An assessment also provides historical and baseline data from which to measure results. Consequently, evaluation must be considered at this stage to insure the compatibility of assessment data with evaluation data. One way to determine what to assess is to examine the vision statement and guiding principles.

The community assessment stage involves two steps:

A. The gathering of data and evidence (usually of five types)

1. **Demographic information** = Demographics describe the community in terms of populations, e.g., ethnicity, gender, and socio-economic status.

2. **Existing services** = Services currently available to address the need. Service descriptions usually include how many clients have been seen over the last several years and the number on any waiting lists. Sometimes a comprehensive list of services for a problem has been identified in the literature and can be used to identify service gaps.

3. **Needs** = Statements that identify the population at risk (number, type, distribution, etc.) and the problems or challenges they experience. Since you have limited resources, needs help focus your intervention. Needs can be felt, expressed, perceived, relative, normative, or documented. Felt need might be obtained through a citizen answers to a household survey. Expressed need might be obtained from those attending a public forum. Relative need might be obtained from comparative data from similar communities. Normative need can be obtained by comparing local need to regional or national norms, e.g., poverty rates. Need may also be based in theory or from comparing inventories of existing services to components of a comprehensive array of services. Social indicators are often used to document need, for example, school dropout rates.

4. **Capacities** = Capacities are people, institutions, accomplishments, resources, values, or events that provide assets and opportunities for change. Strengths, assets, and capacities are different terms for the same phenomena. However, this document will use the term capacities. While needs influence priorities, or what you do, capacities influence programs or how you do it. Capacities help focus your solution to insure that it has the highest chance for success.

5. **Barriers** = Barriers block the use of existing resources or future solutions, e.g., language, transportation, culture, political climate, etc. Sometimes a perceived absence of felt need may be due to a barrier. For example, we may perceive a “tight knit” community does not have a need for a service, when in reality the current services provided are not culturally relevant.
B. **A determination of needs and capacities.** Comparing the needs and barriers to the overall vision and principles should reveal gaps. Gaps are the same as problems. They help you focus where to target your intervention. Similarly, comparing capacities with your vision and principles helps identify existing building blocks on which to base a solution.

The result of this stage is a list of need statements and capacities statements. Need statements should include what is needed and who (individuals, families, groups) has this need. Need statements should be precise and contain only one need per statement. Need statements do not contain how the need should be met. For example, rather than state: "Social service programs are needed in our neighborhood to prevent drug abuse among teens," state "Drug abuse among teens needs to be prevented." Whether a social service program or another strategy is used should be decided at the intervention planning stage. Capacity statements should identify the individual, organizational, and associations on which to build a solution.

IV. **Prioritizing needs**

Rarely are the resources available to address all the identified needs. Once need statements are developed, a prioritizing process is often used to determine which need or combination of needs should be addressed and in what order. Capacities can also be prioritized. A very rational and mechanical process for prioritizing needs/capacities is in the attached example. Other processes that better take into account the politics of implementation exist, such as committee deliberations. No matter what process is used, it should be conscious and documented.

This stage can be a very simple process or involve a lot of political maneuvering. Stakeholders often disagree over whose problems get the most resources and which agency will be the focus of change. The result of this stage should be a prioritized list of need/capacity statements.

V. **Intervention planning (setting goals and objectives)**

This stage involves developing goals and objectives to specify the solution, the implementation process, and the expected consequences.

**Goals** are statements of the expected future outcomes, e.g., lower the domestic violence rates in Dallas County. They are not measurable but provide programmatic direction. They focus on ends (lower domestic violence rates) not means (build more shelter beds).

**Objectives** are clear, realistic, measurable, and time limited statements of actions which when completed will move towards goal achievement. Objectives state how to build on the capacities and reduce the need. Note that an objective can be to implement a program or to study the need further. In cases where many objectives are developed, it may be necessary to use a prioritizing process to limit future workload.

Objectives are of two types, outcome and process. Outcome objectives address the ends to be attained while process objectives specify the means to achieve the ends (also see the course pack handout on writing goals and objectives).

1. **Outcome objectives** focus on need reduction to increase the conditions of well being in the target population. They present measures of what is different in the "client" after the objective is met. They usually begin with words like to reduce, to lower, or to improve. For example:
Outcome Objective 1.1 = To lower the number of school age adolescents becoming pregnant by 10 percent for each of the next three calendar years as measured by health department data December 2006.

2. **Process objectives** specify what will be done to achieve the outcome objectives. They usually begin with words such as to provide, to serve, to assess, or to train. For example:

   Process Objective 1.11 = To provide 2 hours of peer counseling to 25 high-risk male and female school age adolescents by December 2004 as measured by peer counselor records.

**VI. Developing immediate activities and recommendations**

Several alternate strategies to achieve the goals and objectives should be compared based on capacities, feasibility, cost-benefit, political realities, time constraints, and other considerations. A recommended action strategy may then be selected. Often this stage ends with a list of recommendations that begin with “We recommend.” This stage may also contain a workplan that lists activities to be done, due dates, parties responsible, and indicators of successful completion.

**VII. Implementing**

This stage carries out the goals and objectives using recommended action strategies. Implementation may be done by the person designing the change or contracted out to others.

**VIII. Feedback, monitoring, and evaluating**

Feedback, monitoring and evaluation are required to insure implementation progresses as intended and has the anticipated results.

- **Feedback** is a process of periodically manually or automatically monitoring and reporting progress back to those who need it to change directions. Feedback systems in organizations are often referred to as quality assurance or improvement programs.
- **Monitoring** is a continuous process to determine whether the process objectives are being carried out as intended.
- **Evaluation** is a periodic process to determine whether the outcomes stated in the “as measured by...” part of the outcome objectives are being achieved and whether the outcomes relate to goal achievement.

Evaluation and monitoring measures are usually stated in the objectives. Evaluation and monitoring usually compare progress data on your objectives with the baseline data in the assessment to determine any change. Feedback might suggest that you to need to make changes in your program as well as in your original goals and objectives. You can also assess the impact of your program. Impact concerns whether improvements in your outcome objectives achieve your goals and moves towards your vision.

Internal agency personnel typically conduct feedback and monitoring. Evaluation is sometimes contracted to consultants outside the agency. The results of the feedback, evaluation, and monitoring process are used in refining and revising future planned change.

**IX. Disengaging, termination, aftercare, and follow-up**
In this step, you determine if the goals are met, if the client is stable enough and has the support systems to continue without intervention, and if a referral to another service is needed. At some point in time, you re-contact the client to see if the results achieved were lasting or if the intervention cycle needs to be repeated.