CHAPTER 1

Comprehensive Program Development in the Mental Health Professions

Comprehensive Program Development
- Today's Mental Health Professionals and Program Development
- Current Climate in the Mental Health Professions
- Comprehensive Program Development Defined

Comprehensive Program Development Model
- Step I: Establish the Need for Programming
- Step II: Establish a Research Basis for Program Design
- Step IIa: Address Cultural Identity Issues in Program Design
- Step III: Design the Clinical Program
- Step IV: Develop the Staffing Infrastructure
- Step V: Identify and Engage Community Resources
- Step VI: Identify and Evaluate Potential Funding Sources
- Step VII: Develop the Financial Management Plan
- Step VIII: Develop the Proposal
- Step IX: Implement the Program
- Step X: Evaluate the Program
- Step XI: Build and Preserve Community Resources
- Step XII: Develop an Advocacy Plan
- Step XIII: Develop an Information-Sharing Plan
- Step XIV: Attain Program and Organizational Accreditation

About the Text
- Terminology
- Layout of the Text
- Intended Users

Summary

Reflection and Discussion Questions

References

Learning Objectives

1. Define comprehensive program development
2. Increase understanding of the current climate in human services and mental health programming
3. Increase understanding of the role of today's mental health professional and how it has changed over the past 20 years
4. Identify the steps involved in comprehensive program development

COMPREHENSIVE PROGRAM DEVELOPMENT: YESTERDAY VERSUS TODAY

1993	2010
Just having completed my master's degree in counseling and rather quickly been promoted into a program director position, I found myself suddenly responsible for the lives of 24 teenage girls—all of them survivors of physical and/or sexual abuse. I had spent 6 years working in juvenile justice, and I had indeed written my thesis on child sexual abuse—antecedents, protective factors, and treatment interventions—so, of course, I was fully prepared to direct a residential treatment program for young girls struggling to make sense of their world and understand why they were being punished for something that had happened to them. ***Wrong!*** I was ill prepared for such responsibility. Whereas I had already begun to develop a background in supervision and management, I had not yet developed clinical program development skills—essential to my new role. However, little was asked of me in this area from my contractors/funders. In fact, as long as my program provided weekly individual therapy and biweekly group therapy, we were in compliance with our contract. The specific focus of the therapy (e.g., development, peer relations, abuse) was completely up to the therapist—who was under my supervision—to determine. My funders never asked if or how I knew the program was successful in treating abuse and helping these young ladies through their developmental years, but rather, they continued to send a constant stream of new clients as soon as we had a vacancy. Success, in the eyes of our funders, was measured by reuniting these girls with their	I just completed a proposal for a residential substance abuse treatment program contract. If awarded, this will allow an existing program to accept clients from a new funding source. In developing this proposal, we were required to identify specific cultural identity characteristics (e.g., age) of our target population and explain precisely how treatment interventions would accommodate these unique needs. In addition, a large part of the proposal required that we articulate the models of addiction that the program was based on and the practice theories that would guide the clinical interventions. Specific evidence-based interventions also had to be identified. And the research supporting each of these had to be included. In order to demonstrate capability in operating such a program, we were required to include the results of a recent outcomes

families or placing them in a foster home once they had completed the treatment program. ***Successfully completing the program*** of course meant that the girls participated in therapy, attended school regularly, and generally abided by the house rules (easy expectations for 14- and 15-year-olds recently removed from their homes!). We—the treatment team—determined if and when success was achieved. We did not review the research to help us understand what expectations should exist for this particular population, nor did we use any formalized assessment to evaluate the degree and/or type of change that might have occurred, and we certainly did not engage in any type of outcomes evaluation. When the contract came up for rebid, we developed a new proposal articulating our notion of ***treatment*** (e.g., home schedule, school, recreation, therapy) with no accompanying research support, and we continued to be funded.*	evaluation that had been conducted on the program. And the design of the outcomes evaluation for the proposed program also had to be provided in addition to specific evidence of staff competency to effectively implement the program. Finally, eligibility to apply for the funding was based on the organization having attained relevant national accreditation, and thus, evidence of such accreditation also had to be provided.

*Fortunately, and largely because of the incredible group of women with whom I worked and our need to provide the best treatment to our clients, we struggled, learned, and grew quickly.

Comprehensive Program Development

Today's Mental Health Professionals and Program Development

Although not that long ago—1993—times have changed dramatically in clinical program development. This is particularly evident in the expectations and emphasis placed on clinical program design and the use of evaluation methods—driven by rigorous and well-supported clinical design, accountability, and outcomes evaluation. In fact, I would never be allowed today to get away with what I did in 1993, specifically because today the

stakes have been raised considerably (and necessarily), and as they have been raised, funding sources have continued to play an increasingly active role in ensuring that sufficient rigor and accountability exists. This is illustrated clearly in the requirements of my most recent program development project (i.e., 2010).

In addition to the changes that have taken place specifically in program development, the role of the mental health professional has become increasingly more expansive and the practice of counseling (i.e., therapy) has become increasingly more scientific. As such, mental health professionals are currently employed as clinicians, program managers, and administrators across a variety of settings (e.g., outpatient mental health clinics, juvenile justice facilities). And they must demonstrate both evidence-based practices and the ability to administer efficient operations. Additionally, as society continues to evolve, mental health professionals continue to find themselves treating an increasing number of specialized clinical issues (e.g., gambling addiction, self-mutilation, suicide). As a result of these significant changes, professional counselors and other mental health professionals must possess both scientific and business knowledge in order to develop efficient and effective specialized treatment programs that are not only viable but sustainable. With increasing emphasis on the use of evidence-based practices and efficient clinical program operations, mental health professionals must be competent in comprehensive clinical program development.

To further highlight the dramatic changes that have taken place over the past several years, I conducted an interview with Roger Swaninger, president and chief executive officer of Spectrum Human Services, Inc. and Affiliated Companies. Roger has been with Spectrum for 32 years. He was hired shortly after the company was founded, and as a result, he provides a necessary historic perspective on the mental health and human service industry. In addition, he leads a multifaceted nonprofit organization that has grown from an annual operating budget of approximately $2 million to approximately $56 million today, currently consisting of six companies specializing in adult mental health services and treatment, child welfare, juvenile justice, substance abuse prevention and treatment, vocational development, and an outpatient mental health clinic. Roger has witnessed the dramatic changes that have taken place over the past few decades and has been able to not only successfully navigate the changes but grow and develop exponentially despite myriad challenges. In fact, with so many mental health and human service organizations today finding it increasingly difficult to remain in business, the sustainability that Spectrum has demonstrated may offer significant lessons for today's mental health professionals.

INTERVIEW WITH ROGER I. SWANINGER, PRESIDENT & CEO

Spectrum Human Services, Inc. and Affiliated Companies (May 2010)

What are the greatest challenges or threats to human services today?

The most obvious challenge today is funding—today there are both shrinking dollars and more competition, which make this business tougher than ever before. The other great challenge today has to do with the talent factor—finding and keeping the most talented staff.

What are the most significant differences that you see today versus 30 years ago in human services?

Before, I could just go up to the state capitol and pitch my idea for a new program, and often they would go for it. Today, we have to demonstrate that a need exists, provide the research support for the program design, and demonstrate that we can achieve successful outcomes in order to gain and maintain funding.

How do you go about making decisions about new program development?

First we ask, is the idea related to programming that we currently do and/or will it enhance what we currently do? If it is an area that we are already in and it will allow us to expand in that particular area, it already has a natural lead-in. But there are also a number of due diligence activities that we have to consider that include both fully examining the finances of the program and the costs and benefits related to the new program, as well as considering if we have the appropriate infrastructure to support the new program. You have to always estimate risk-reward—you have to ask, how much can I afford to lose and what do I have to gain? You must do due diligence and carefully assess every aspect. All of these factors and more must be considered in every new venture.

To what do you attribute Spectrum's staying power—how has Spectrum managed to succeed despite the challenges that plague human services today?

Diversity of funding, talented staff, and the relationships our staff has built with contractors and others in the field.

We have an existing pool of talented staff that form the core of the organization—staff that have been with the agency for a number of years and that form the agency's executive leadership team. We have also taken calculated risk in expanding our business. I should add that we are very aggressive in going after new business. We have lost our share of contracts over the years, but it hasn't devastated us because we have built up a large continuum so that we have some degree of protection when we do lose specific funding. I think being aggressive has always been part of Spectrum's philosophy. Beginning with the founder, Jim Minder, who was

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very aggressive in going after new business, we had had a tremendous growth spurt in the late 70s, early 80s, and then another in the late 90s.

The premise of this book is that today's mental health professionals must be extremely well rounded, having concrete knowledge and skills in comprehensive program development, including finance and human resource management. What do you believe today's mental health professionals need to be equipped with?

The best of both worlds is needed—you need to have both a clinical and a business background today. You must have business savvy and understand your budget as well as understand the relationship between the services you provide and the finances related to the services. You have to understand the politics of the business and develop effective relationships with funding sources and other key groups.

What types of characteristics do you look for when hiring someone today?

First and foremost, you have to have strong interpersonal skills—you have to be able to develop effective relationships with clients, colleagues, funders, et cetera. You also have to believe in our mission—in what we are trying to accomplish—understanding that serving individuals in need is the most important thing that we do.

I also look for someone who wants my job, someone who is hungry and really wants to do this work and gets excited about it.

Why should mental health professionals want to pursue this work today?

They have an opportunity to have a long-term impact on individuals—to provide input to program design, learn how to achieve effective outcomes, and understand the difference that they can make in the lives of others.

Note: Interview used with permission.

Current Climate in the Mental Health Professions

Much of the significant change that the mental health professions have experienced over the past 2 decades has been largely driven by the managed care movement and the more recent emphasis on the use of evidence-based practices (EBPs). Originally articulated by Sackett, Strauss, Richardson, Rosenberg, and Haynes (2000), and adopted by the Institute of Medicine in 2001, "evidence-based practice is the integration of best research evidence with clinical expertise and patient values" (p. 147). Applied to mental health professions, EBPs involve placing the client first, adopting a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching effectively and efficiently for the current best evidence relative to each question, and taking appropriate action guided by evidence (Gibbs, 2003).

The adoption of EBPs has been far-reaching and has had a considerable effect on mental health practices. In fact, Sexton, Gilman, and Johnson (as cited in Marotta & Watts, 2007) asserted that "the impact of EBPs is dramatic in that they are fundamentally changing the way practitioners work, the criteria from which communities choose programs to help families and youth, the methods of clinical training, the accountability of program developers and interventions, and the outcomes that can be expected from such programs" (p. 492). Also referred to as *empirically based practices*, EBPs are predicated on the use of scientific methods to evaluate clinical interventions. As a result, there is greater pressure on mental health professionals to either utilize clinical interventions that have established efficacy or engage in rigorous evaluation of unevaluated new practices.

Addressing this movement toward greater intentionality and accountability in the counseling profession, A. Scott McGowan, editor of the *Journal of Counseling and Development,* announced a "Best Practices" section to highlight evidence-based practices. Since then, a growing body of *best practice* literature has emerged addressing assessment of violence risk (Haggard-Grann, 2007), treatment of obsessive-compulsive disorder (Hill & Beamish, 2007), and treatment of depression (Puterbaugh, 2006). In addition, comprehensive clinical interventions for specialized populations of juvenile sex offenders (Calley, 2007) and adult male survivors of trauma (Mejia, 2005) have been articulated.

Within the broader mental health literature, specific types of research-based clinical interventions have been proposed, such as Wilderness therapy (Hill, 2007), rape survivor treatment (Hensley, 2002), and outreach strategies for female immigrants and refugees (Khamphakdy-Brown, Jones, & Nilsson, 2006). Finally, clinical interventions for such complex issues as dealing with developmental transitions of young women with attention deficit/hyperactivity (Kelley, English, Schwallie-Giddis, & Jones, 2007) have been proposed. Best practice literature typically summarizes research findings and, as a result, identifies etiological factors and proposes specific interventions for use in clinical treatment. In this manner, much attention is given to disseminating research findings for use in future clinical program development, ensuring that current research is fully utilized to inform practice.

Moving beyond best practice literature and its role in the development of clinical interventions, a very small body of work has begun to emerge exploring other factors related to clinical program development. Cost analyses of program development and implementation have been included (Chatterji, Caffray, & Crowe, 2004; Wilderman, 2005), thus promoting a practical understanding related to the financial implications in program development. In addition, the role of interagency collaboration in comprehensive program development has been examined (Donahue, Lanzara, Felton,

Essock, & Carpinello, 2006). Exploration of both these areas provides another layer of comprehensive program development that is not only complementary to clinically focused research but necessary to forwarding our understanding of *comprehensive program development*.

Whereas literature related to program development in the mental health professions has significantly increased over the past 5 years, limitations to utilizing this literature in practice continue to exist. The growing body of best practice literature provides necessary direction and guidance to treating various clinical issues; however, without a sound, comprehensive clinical program framework, these interventions may not be effectively implemented and evaluated on a broad scale. This causes a dilemma not only because it severely limits the use of such research but also because it creates challenges to perpetuating EBPs, the very issue it is seeking to address. In addition, literature examining factors such as cost and the role of collaboration in clinical program development enhance our understanding of program development but again fail to provide a more complete understanding of program development. To address each of these issues, mental health professionals need to be well versed in comprehensive program development. Moreover, by gaining competence in program development, mental health professionals will be able to effectively utilize existing knowledge to ensure that the most effective clinical interventions are provided to individuals in need.

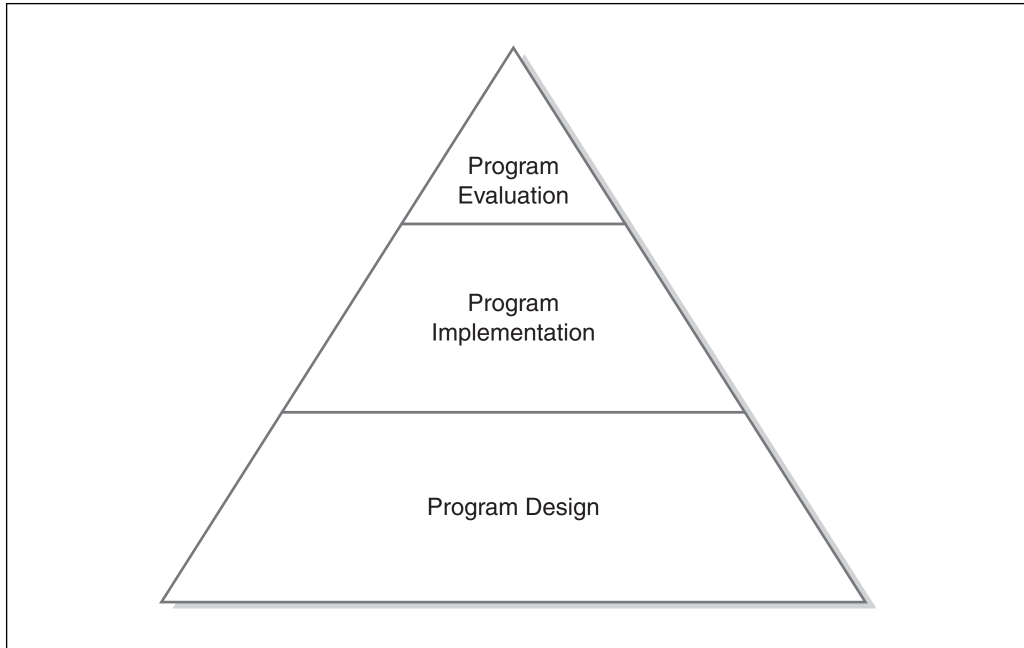
Comprehensive Program Development Defined

Comprehensive clinical program development includes three major phases—program design, program implementation, and program evaluation—and reflects the entire developmental process from start to finish (see Figure 1.1).

Moreover, clinical program development refers to a systematic process that requires various stages of preplanning, planning, implementing, and sustaining effective mental health programming. A wide variety of highly focused and semisequential tasks compose comprehensive program development, including

- developing a program rationale,
- conducting a thorough review of the research for use in program design,
- addressing multicultural considerations in program design,
- designing the clinical program,
- developing the organizational structure,
- identifying relevant community resources,

Figure 1.1 Major Phases of Comprehensive Program Development



- identifying potential funding sources,
- developing a proposal,
- developing the initial budget,
- implementing the program,
- conducting the program evaluation,
- engaging community resources,
- developing a professional advocacy plan,
- identifying methods of data reporting, and
- developing plans to pursue accreditation.

Clinical program development occurs in many venues, including human/social service organizations; public systems specializing in mental health, criminal justice, or child welfare; and outpatient clinics. Clinical program development can be accomplished by mental health professionals with medium to large-sized staffs as well as those in small nonprofit clinics with very few staff members and other resources.

Fundamentally, program development in the mental health professions refers to comprehensive business planning. As such, several key business

principles are used to guide the clinical program development process. These include such principles as

- identifying a need for services,
- identifying a gap in the existing market,
- utilizing research to guide product/service development,
- developing the most effective product/service,
- developing an effective and efficient infrastructure,
- effectively managing finances,
- continuously identifying customers,
- developing key relationships to support and sustain your business,
- employing a development specialist and a lobbyist to continue to promote your business interests,
- ensuring that you have the best product/service to offer,
- regularly sharing your success with *stakeholders*, and
- garnering national recognition.

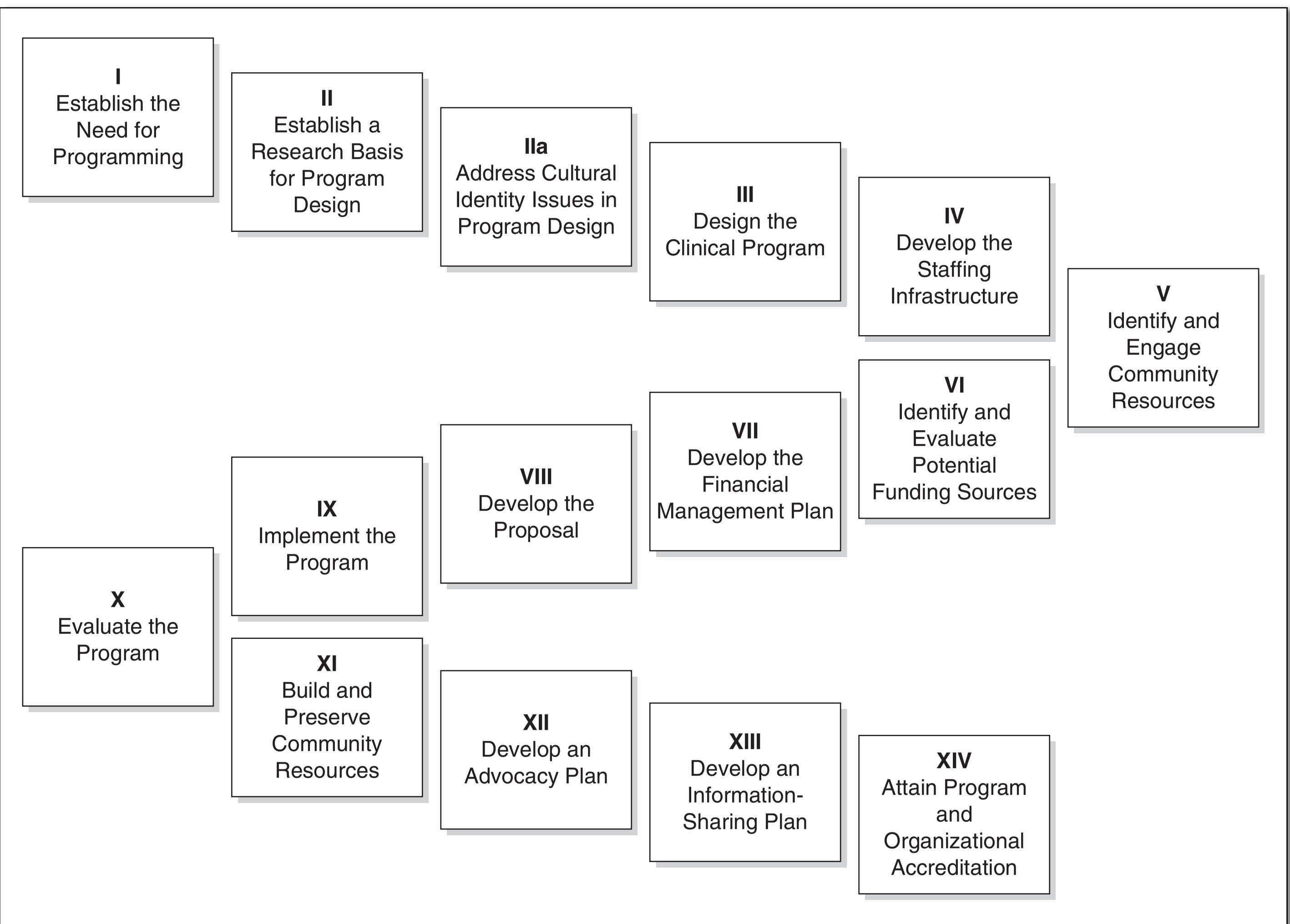
Appreciating the inherent relationship or intersection of these key business concepts with clinical program development is critical to understanding precisely what clinical program development is in the 21st century.

Historically, a very small group of mental health professionals has been resistant to the notion that the mental health industry is indeed a business, often citing in their defense that the concept of business and that of helping individuals are diametrically opposed (Hansen, 2007). Mental health professionals cannot afford to think this way, particularly since our ability to continue to help individuals is significantly dependent on our business skills. If we bear in mind that a failure to effectively operate our business (i.e., mental health practice) may inevitably result in our inability to continue to help individuals, the compatibility of concepts related to both business and mental health practice should become quite clear.

Comprehensive Program Development Model

In order to guide mental health professionals through gaining competence in comprehensive program development, the *Comprehensive Program Development Model* was developed (see Figure 1.2). As you can see, the first eight steps comprise the components necessary for initial program development and implementation, whereas the final six steps illustrate the components necessary for implementation and ensuring long-term program success and sustainability. It is important to note here that the model is semisequential, insofar as some of the steps are purposely ordered. For

Figure 1.2 Comprehensive Program Development Model: Design, Implementation, and Evaluation



instance, establishing a *need* for programming must precede establishing a *research basis* in program design, since without sufficient justification of need, developing a program is futile. However, you may develop a program proposal and initial budget before identifying a potential funding source or vice versa, largely depending on proposal type and available funding opportunities. This is because there are both prescribed funding opportunities (opportunities in which the type of program needed is identified as well as the amount of funding available) and self-initiated or open funding opportunities (opportunities in which you propose the program and requested budget amount). In addition, some of the steps may occur simultaneously. A brief overview of each of the steps is provided below to begin familiarizing you with the model.

Step I: Establish the Need for Programming

The first step in program development is the identification of a broad region in which the program will be implemented. Once determined, the preplanning activities can begin. The results of this first phase result in identifying a *target population*, articulating a statement of the problem/primary needs of the population, and establishing the philosophical/ideological foundation for the program (e.g., juvenile justice is rehabilitation-focused).

Establishing the need for comprehensive programming in mental health counseling involves completing several planning activities that include conducting the following: a needs assessment, an *asset map*, a *community demography assessment*, and a *market analysis*. A needs assessment is used to identify and prioritize the clinical needs of a population. Conversely, an asset map identifies existing strengths (e.g., community organizing and cohesion) and resources in the *target region* (e.g., community organizing practices, human service organizations). A comparison of the results of the needs assessment to the results of the asset map can be used to address identified needs through existing resources. Complementing the needs assessment and asset map, the community demography assessment identifies the various population parameters and characteristics, including cultural identity aspects of community members (e.g., age parameters, prominent spiritual and/or religious faiths), and provides necessary preplanning data to ensure that program design takes into account any unique features of the target population.

Once the primary needs of the region are defined, a market analysis is conducted in the broader region in order to thoroughly examine providers that are already involved in working to address the identified problem(s). A market analysis should involve collecting detailed information about

other providers that includes the following: scope and type of services provided, including treatment modalities, theoretical base, and use of best practices, and other relevant business information, including program history, capacity, staff credentialing, accreditation status, any limitations to service delivery, and any other relevant demographic information about the program and/or organization (e.g., other programs operated by organization). When conducting a market analysis, it is important to not only identify those providers that are engaged in direct interventions for the identified problem(s) (e.g., counseling services to battered women) but also those that may be involved indirectly (e.g., transitional housing for battered women), as these providers may be essential *community resources*. Taken together, these four activities provide comprehensive information about the target region and allow the program developer to systematically identify the problem(s) while becoming more informed about other relevant aspects of the region that will be critical in the program design. As such, a well-researched rationale is developed to provide evidence for the need for program development.

Step II: Establish a Research Basis for Program Design

Once effective justification for the program has been established, work can begin in developing the research basis for the program. This critical step is necessary to establish an empirical basis for the program and requires the completion of an extensive review of the literature. The literature review should minimally include three primary areas: scholarly research; best practice literature developed by professional associations, governmental bodies (e.g., Bureau of Justice), or other such bodies with relevant knowledge of the problem; and practice standards and other literature compiled by relevant accrediting bodies (e.g., Council on Accreditation).

In conducting a review of the scholarly literature for the purpose of new program development, the review should be comprehensive and include the exploration of several key areas. These include various types of data analyses regarding the identified problem (e.g., demographic issues related to sexual offending behaviors among adolescent males), empirically based studies related to the problem, research related to specific clinical interventions to address the problem, results of relevant program evaluations, literature reviews of research related to the problem, meta-analyses related to the problem, and position papers and other scholarship dedicated to examining and addressing the problem.

To complement the review of scholarly literature, best practice standards, white papers, and other literature developed by individuals, organizations

(e.g., national task forces), and professional associations relevant to the problem should be examined. Whereas this type of literature is not typically published through traditional scholarly outlets, it is often the result of research findings and emphasizes practice and application. Conducting an exhaustive review of the current literature related to the problem that includes both scholarly research and other literature can be used to establish the empirical foundation for program design.

Step IIa: Address Cultural Identity Issues in Program Design

A significant subcomponent of the literature review involves specifically focusing on multicultural aspects. Addressing multicultural considerations in the program design does not constitute an independent step because it is simply part of the literature review; however, because of its significance and scope, it is specifically identified as a subset of Step II and a complete chapter is devoted to it.

Data gleaned from initial assessment activities (i.e., community demography assessment, community needs and assets assessment) are reviewed to ensure that the literature review addresses all unique aspects of the community population, thereby promoting culturally competent program design. For instance, if much of the research on the treatment of eating disorders focuses on white female adolescents and teens and your target population in need of treatment of eating disorders is Latino and white young adult males, specific attention must be given to program modifications that can effectively address the differential needs of your population.

Additionally, attention must constantly be given to exploring issues related to the target population's cultural identity throughout program implementation to ensure that program modifications are continuously made to support the dynamic nature of multiculturalism. For instance, whereas just 10 years ago it was more common to be married than single in adulthood, today it is more common to be single than married. In addition, whereas much research and literature has been devoted to African American studies in the past, the significant number of biracial and biethnic relationships producing bi- and multiracial and multiethnic children is again changing how race and ethnicity are perceived. Likewise, the increasingly global nature of our world is impacting the role that geography plays in cultural identity, while at the same time, the growing disparities between the upper and lower socioeconomic structures and diminishing middle class are creating new perceptions and meaning of class in the United States. These constantly changing patterns reflect what I mean by the dynamic nature of multiculturalism—there are always new and different cultural identity

aspects that need to be considered and existing identity aspects that need to be reconsidered in order to understand precisely what meaning they have at any given time and to any given individual.

Because effective programs must be specifically designed for the individuals being served, multiculturalism and, more important, cultural competence (i.e., the use of specific knowledge and skills that effectively address the unique identity of the individual being served) are an inherent part of initial program design. In addition, cultural competence is a primary factor related to subsequent program modifications.

Step III: Design the Clinical Program

The program design consists of a comprehensive description of the program and utilizes specific design tools to illustrate the primary clinical components of the program. Articulated in the program design are the program vision and mission, clinical interventions, short- and long-term outcomes, and outcome measures.

The initial steps in program design involve revisiting both the philosophical/ideological foundations on which the program is built and the primary needs to be addressed by the program in order to articulate the program's vision and mission. These activities provide particular meaning to program design by allowing program developers to tie the primary needs and the ideological basis to the long-term vision of the program and broadly describe how and what the program attempts to achieve (i.e., mission). These initial design activities promote cohesion and provide direction for the more concrete steps of program design that follow.

Once the mission and vision of the program have been articulated, the core program design components consisting of clinical interventions, short- and long-term outcomes, and outcomes measures must be identified. The results of the literature review (Step II) provide the basis for program design and ensure that the identified clinical interventions have an empirical basis.

To assist in designing the clinical components of the program, a program planning tool such as a logic model (Alter & Egan, 1997) may be particularly helpful. A logic model is used to organize the design structure of the program and graphically should reflect a straightforward flow in program design. The logic model evolves forward from the identified need to the specific interventions to the intended outcomes of the interventions and the methods by which those outcomes will be measured. Using such a tool allows the program designer to effectively evaluate the coherence of the program design.

Step IV: Develop the Staffing Infrastructure

Once the program design has been determined, attention must be given to developing the appropriate *staffing infrastructure* necessary to implement the program. Considerations in this stage include identifying the *governance structure* (e.g., board of directors) if the program is being implemented as part of a new organization, administrative support positions (e.g., human resources, finance), program administrators (e.g., executive director, program director), management and supervisory staff, and direct service staff (e.g., counselors, case managers).

Several issues relative to the development of a staffing infrastructure that have particular significance to the program's effectiveness, efficiency, and sustainability should be considered. First, the results of the market analysis and logic model should be reexamined to determine the positions needed to implement each of the program's direct interventions. Second, the results of the market analysis should be reexamined to determine how similar program operations are structured. Finally, all key activities needed to fully operate the program must be identified (e.g., advocacy, oversight, finance). Each of these activities provides sound direction to decision making regarding each of the positions needed based on job duties.

The organizational chart provides a graph of the staffing infrastructure detailing reporting relationships, number of staff members employed, and specific duties of staff, thus making the various service components operational by identifying the responsibilities of the workforce. As a result, the use of an organizational chart is recommended to identify the necessary staffing infrastructure. Organizational structure provides the initial framework for organizational functioning and organizational behavior, and determining the appropriate structure requires consideration of organizational theory. Because this text cannot provide the level of detail needed for a full discussion of organizational theory, interested readers should pursue literature specifically on organizational theory to acquire deeper knowledge of this important topic. For the purpose of developing the organizational staffing structure in new program design, four issues should guide decision making: job duties of all positions, degree of need for supervisory and administrative support and oversight, organizational communication, and organizational decision making. Briefly, multiple layers of supervisory and management staff may prohibit efficient decision making and impact effective flow of communication throughout the program. Again, by allowing perceived effectiveness and efficiency in program operations to guide decision making

regarding staffing infrastructure, the developmental process related to the staffing infrastructure should proceed smoothly.

Step V: Identify and Engage Community Resources

Initial community resource development involves the identification of various community resources consisting of like programs, organizations, or professionals and the identification of the methods by which such community resources will be utilized in program implementation. Some community resources may augment program service components as primary referral sources, whereas others may become part of a collective advocacy group.

The initial work in community resource development occurs as part of the asset map and market analysis that are conducted in the initial program planning step (i.e., establishing a need). At this point, precisely how the community resources will be utilized in program implementation (e.g., Marijuana Anonymous) or program sustainability (e.g., local juvenile courts) must be determined. Finally, relationships with community resources must be formalized. Formalizing relationships between the program and the various community resources involves finalizing all details of the relationship, minimally including the role of each party, responsibilities, and lines of communication. Ideally, community resource development should be guided by three key factors: utilization of current community resources to augment service array, coalition building with competitors and other invested stakeholders to increase advocacy strength, and development of strategic partners and supporters for long-term program sustainability.

Step VI: Identify and Evaluate Potential Funding Sources

Identifying potential funding sources requires extensive research that includes exploring all potential types of funding sources related to the specific type of mental health counseling program developed, including governmental sources at the local (e.g., county health department), state (e.g., state department of mental health), and national levels (e.g., National Institutes of Health) and nongovernmental sources (e.g., Annie E. Casey Foundation). During this phase, it is again necessary to revisit the market analysis to examine the funding sources related to all current providers and gain more specific information related to the parameters of funding (e.g., term, limitations) as well as any other pertinent information

(e.g., success/lack of success with particular funders, lessons learned, relationships with funders).

In completing this phase, it is necessary to gather extensive information about each potential funding source. This information should minimally include the following: (1) primary focus of funding source (e.g., children's mental health), (2) amount of available funding, (3) length of funding (e.g., 1 year, unlimited), (4) terms and restrictions related to funding, (5) history of funding source, and (6) other pertinent information. Additionally, distinctions should be made between contractual funders and grant funders as two discrete, often noncompeting funding sources that may be used concurrently. Finally, all potential donors and types of potential donations should be identified.

Step VII: Develop the Financial Management Plan

Developing a financial management plan requires projections on both expenditures and revenues and comprehensive planning. The program budget details total annual expenditures that include both personnel (e.g., salaries, fringe benefits) and nonpersonnel costs (e.g., rent, insurance, professional development, evaluation instruments). Line-item budgets should be used to provide detailed information on all expenditures. Particular care must be taken to ensure a thorough examination of all real costs and potential related costs. Conversely, the revenue report should identify all actual and potential funding sources, amounts of funding and any terms or restrictions related to funding (e.g., term-limited, restricted to nonpersonnel costs), including monetary and nonmonetary donations (e.g., building space). It is recommended that great caution be given when identifying donations in the financial report, particularly because this type of funding may lack certainty and is often limited to one-time events. As a result, donations should be considered as extraneous to other forms of funding.

It is recommended that the financial management plan is developed for 3 to 5 years to reflect long-term planning and to promote increased understanding of the financial implications involved in program development. The financial management plan is intricately tied to other aspects of program implementation and program sustainability, directly reflecting expenditures related to organizational infrastructure and real and potential funding sources. Whereas funding sources are initially identified as specific to financial implications, the following step is dedicated to a broader exploration of potential funding sources.

Step VIII: Develop the Proposal

Developing a proposal for a clinical program requires pulling together what has been learned through the *comprehensive needs assessment* process and articulating the program design, staffing structure, and budget information. It is in the proposal development step that you are able to utilize the sum of work completed in program planning and craft the most effective argument for funding the program.

Because specific proposal development is extremely varied and based on the type of funding opportunity being pursued, the chapter on this step deals with essential considerations of proposal development. These include the use of a grant writer versus program developer, the use of internal reviewers, organizing the work of proposal development, and skills needed for proposal development.

Step IX: Implement the Program

Program implementation deals specifically with putting the program into place and the various tasks associated with initial implementation. Initially, this requires a thorough review of the contract/award and establishing an effective working relationship with the funding source/contract manager. On an ongoing basis, program implementation includes ensuring that the necessary structure exists to monitor and support the program throughout implementation. These activities include, but are not limited to, providing sufficient administrative and leadership support, acquiring and utilizing effective information systems, engaging in quality assurance activities, and ensuring contract compliance.

Step X: Evaluate the Program

Designing the evaluation program actually begins in the initial design of the clinical program phase with the identification and/or development of the clinical design, development of program outcomes, and the identification of measurement tools. At this later step dedicated to finalizing the program evaluation, three specific types of evaluation should be considered: fidelity assessment, process evaluation, and outcomes evaluation. Whereas both fidelity assessment and process evaluation deal with program implementation, outcomes evaluation focuses on the program's success or lack thereof. The relationship between interventions and goals is reexamined, and both short- and long-term outcome goals are finalized

with identified time frames for attainment. Additionally, outcomes measures are reexamined to determine their appropriateness in assessing the established outcomes.

Selection of assessment tools should focus on the relevance of the tool to specific issues (e.g., depression inventory to screen for depression) and the efficacy of the assessment tools (i.e., reliability and validity of the measure). More than one method of assessment for each outcome is recommended to increase the reliability of the evaluation results. For instance, published standardized assessment tools (e.g., substance abuse assessment) in conjunction with observable or other concrete forms of assessment (e.g., urine screen) may be used concurrently to increase the strength of the evaluation results. Finally, data collection methods (e.g., initial intake interview), responsibility for data collection and analysis, and time frames (e.g., 6 months post-discharge) are determined in the evaluation design phase.

The evaluation plan promotes accountability, directly tying interventions to outcomes and identifying a process and time frames for outcomes to be evaluated. Moreover, evaluation planning allows clinicians to modify the original program design as a result of the evaluation. As such, evaluation planning and program design are dynamic activities that are often modified over time, contributing to the promotion of evidence-based practices.

Step XI: Build and Preserve Community Resources

Because community resource development is predicated on relationships between two entities (program and community resource), it is necessary to view community resource development as consisting of two essential components: identifying and engaging community resources (Step V) and building and preserving these relationships. By viewing community resource development in this manner, the significance of these relationships is reflected.

Whereas community resources were identified and the relationships were formalized in an earlier step, Step XI focuses specifically on continuous efforts to build and preserve these relationships. Establishing regular and frequent times for communication and instituting regular venues for information sharing are two examples of methods by which to continuously attend to relationships with community resources.

This type of community resource relationship building may yield concrete benefits of ensuring continued business *partnerships* when services are being provided by the community resource; however, there are also potential indirect benefits to such relationship building that cannot be

overlooked. By promoting strong relationships with community resources, programs often may create new factions of support systems for use in community advocacy efforts, program promotion, and securing new and continued funding. As such, community resources play a pivotal role in developing, implementing, and sustaining successful clinical programs and, therefore, must be given focused attention throughout a program's life cycle.

Step XII: Develop an Advocacy Plan

Advocacy planning is critical to program sustainability, and continuous advocacy planning ensures that the program is responsive to environmental changes, as well as that the public remains aware of specific treatment needs being met through programming (e.g., child sexual abuse survivors). Advocacy planning includes the identification of all governmental and nongovernmental entities with whom the program will engage in advocacy efforts (e.g., increase funding for adolescent mental health), identification of community partners with whom advocacy coalitions might be formed—drawing directly from previous community resource efforts—and the articulation of multiple concrete methods of advocacy to be completed annually by the program (e.g., participation in public hearings, engaging a lobbyist). Depending on the type of program designed, advocacy efforts may be varied and include such activities as participating in public hearings, engaging a lobbyist, and facilitating regular forums to discuss advocacy issues with community partners. Ideally, multiple factions of advocates should be engaged and varied methods should be utilized to promote broad-based advocacy and to ensure that client needs continue to be promoted through public venues. Additionally, it is necessary to engage in advocacy efforts at the local, state, national, and international levels. Whereas initial advocacy begins in the program development phase, particularly in establishing the need for the program, program sustainability is often largely predicated on public awareness of specific treatment needs. As a result, advocacy efforts should be embedded throughout program operations in order to be systematically and continuously promoted.

Step XIII: Develop an Information-Sharing Plan

Once the evaluation program has been designed, it is necessary to develop plans for data reporting. Whereas outcomes data generated from the evaluation program are an integral part of a program data set, output data (e.g., number of clients served) and other relevant program data (e.g., staff

credentials, operating costs) are also critical components that together provide a comprehensive picture of the program. It is therefore essential that this data is regularly shared with stakeholders. To accomplish this, a comprehensive data-reporting plan should be developed.

The data-reporting plan should minimally include types of data to be reported (e.g., outcomes evaluation, outputs), reporting time frames (e.g., quarterly, annually), individuals and entities to whom data will be reported (e.g., funding sources, community members, staff), and methods of data reporting (e.g., written report, meeting). Whereas all relevant program data and information should also be captured in the program's annual report, attention must be given to determining shorter and more frequent time frames for reporting data to promote increased accountability in program design. In fact, doing so may promote a culture of transparency and continuous evaluation, both of which are integral to the program's long-term sustainability.

Step XIV: Attain Program and Organizational Accreditation

The final step in comprehensive clinical program development involves accreditation planning. Whereas accreditation is a voluntary process and may be less relevant for certain types of programs than others, attainment of accreditation reflects the program's commitment to best practices and continuous evaluation. Accreditation standards are typically established as a result of current research and best practices. As such, accreditation can be used to guide ongoing program development as well as reinforce the integrity of the program.

Initial accreditation planning involves identifying an appropriate accrediting body(ies) and establishing a time frame by which to pursue accreditation. National accrediting bodies specific to clinical programs include but are not limited to the Council on Accreditation (COA) and the Joint Council on Accreditation of Health Organizations (JCAHO). Pursuit of accreditation is a lengthy process and, as such, requires long-term planning. Additionally, accreditation creates an ongoing expense incurred by the program and organization. As a result, thoughtful consideration must be given to determine when to pursue accreditation. Ideally, accreditation expenses should be reflected in the initial annual budget to prepare the program's stakeholders for the ongoing expenditures as well as to reflect the program's commitment to pursuing accreditation. Activities related to accreditation and reaccreditation impact all stages of program development and often strengthen the program by emphasizing the use of best practices in design, promoting a culture of evaluation and program accountability. Therefore, it is recommended that attention be given to accreditation planning throughout a program's life cycle.

Recall that at the beginning of the chapter, I raised the notion that comprehensive program development in the mental health professions is akin to business planning. I hope that this has become clearer from your reading so far. And to further clarify the relationship between basic business principles and comprehensive program development, take a moment to compare the basic business principles that were presented earlier with the comprehensive program development model in Figure 1.2. Table 1.1 illustrates this relationship.

Table 1.1 Comparison of Basic Business Principles and Comprehensive Program Development Model Steps

Basic Business Principles	Comprehensive Program Development Model Steps
Identifying a need for services	Establishing the need for programming
Utilizing research to guide product/service development	Establishing a research basis
Utilizing research to guide product/service development	Addressing cultural identity issues in program design
Developing the most effective product/service	Designing the clinical program
Developing an effective and efficient infrastructure	Developing the staffing infrastructure
Effectively managing finances	Developing the financial management plan
Continuously identifying customers	Identifying and evaluating funding sources
Developing key relationships to support and sustain your business	Building and preserving relationships
Employing a lobbyist	Developing an advocacy plan
Ensuring that you have the best product/service to offer	Evaluating the program
Regularly sharing your success with stakeholders	Developing an information-sharing plan
Garnering national recognition	Attaining program and organizational accreditation

As you can see, comprehensive program development and traditional business planning are not at all conflicting but, rather, are completely synonymous. It is in this way that I hope you may develop—if you have not already done so—a keen appreciation for the *business* that is the mental health profession.

About the Text

Terminology

What is meant by the term *mental health professionals*? Mental health professionals include master's- and doctoral-level practitioners in counseling, psychology (clinical and counseling psychology only), and social work. The primary objectives of each of these disciplines are to help individuals and groups through the use of various types of clinical interventions. Whereas the disciplines differ in specific areas, they share more commonalities than differences, and therefore, the inclusive term *mental health profession/professional* is commonly used today. This is the term most often used throughout this text. Marriage and family therapists are also included under the umbrella of mental health professionals, as are psychiatrists that engage in counseling.

The terms *program developer, program administrator,* and *mental health professional* are used throughout the text, primarily to denote the various roles that mental health professionals fulfill. *Mental health professional* refers to the primary identity of the professional, whereas it is indeed mental health professionals that serve in the roles of program developer, program administrator, program manager or supervisor, program evaluator, and chief executive officer in mental health and human services today.

The terms *human services* and *mental health programs* are also used interchangeably throughout the text. These refer to programs that are designed to address human, social, emotional, and behavioral needs. These programs are typically funded through governmental, foundation, or other philanthropic support and may exist as single-program organizations, part of multifaceted organizations, or within primary, secondary, and postsecondary educational institutions. Whereas the primary focus of this text is on nonprofit human service and mental health organizations, with the exception of funding and financial management, the material in the text is just as applicable to for-profit organizations.

Finally, the terms *counseling* and *therapy* are used interchangeably throughout the text. Both terms refer to the therapeutic practice in which master's- and doctoral-level mental health professionals (e.g., counselors, clinical/counseling psychologists, clinical social workers) engage.

Layout of the Text

The text centers on the *Comprehensive Program Development Model,* with a full chapter dedicated to each of the 14 steps (with a separate chapter devoted to multicultural considerations, which is actually a part of Step II of the model). Each of the chapters provides specific background information to increase understanding of each major task (i.e., step) involved in program development, and unique tools are provided to guide program development activities. Case vignettes are used at the beginning of each chapter to illustrate the importance of the specific step presented in the chapter, and case illustrations are used at the end of each chapter to highlight the material presented in the chapter. A summary chapter is provided as a brief review of the text and to offer significant issues for consideration in future program development efforts. A list of key words is provided in the back of the book, composed of key concepts presented throughout the text. A list of web-based resources is provided in the Appendix at the end of the book, composed of websites and specific resources discussed throughout the text.

Intended Users

The text is designed for master's- and doctoral-level practitioners and students in any of the major mental health professions (counseling, clinical and counseling psychology, and social work) as well as practicing mental health professionals and managers and leaders of mental health and human service organizations. The purpose of the text is to provide effective guidance and tools to current or future mental health professionals engaged in program development efforts. Such efforts might take place in a nonprofit human service organization, outpatient clinic, school, university, or governmental organization dedicated to serving individuals in need (e.g., state child welfare system, prison). Because of the nature of the framework provided in the text, the text has specific utility to the practical application of comprehensive program development.

Summary

Mental health treatment has changed dramatically, particularly in the past 2 decades. With the advent of managed care and the continued development of knowledge related to mental health treatment, the mental health industry has increasingly become more scientific and rigorous than ever before. As a result, the use of evidence-based practices is a standard requirement for counselors and other mental health professionals. At the same time, mental health professionals are increasingly responsible for the development of comprehensive mental health programs—programs that must be research-based. Therefore, mental health professionals must both understand and appreciate evidence-based practices but also the manner in which evidence-based practices are used in the development of comprehensive mental health and human service programs.

Comprehensive program development in the mental health professions involves design, implementation, and evaluation and, as a result, requires broad-based planning and a tremendous amount of work. Additionally, program development requires scientific, business, and clinical knowledge and skills. Because mental health professionals are often responsible for program design and program administration, it is essential that they are fully competent in comprehensive clinical program development. Clinical program design provides an essential component of program development; however, without completing due diligence to determine the viability of a clinical program (i.e., established need, funding) and possessing basic budget and management skills, it is almost impossible to implement a program. Moreover, without advocacy and leadership skills and program evaluation abilities, sustaining comprehensive mental health programs can be incredibly challenging.

The text provides a framework to guide mental health professionals in comprehensive program development. By using the text, it is hoped that mental health professionals will be better prepared to engage in clinical program development and gain increased appreciation for the complexities inherent in comprehensive program development. Furthermore, it is hoped that the use of such a framework will support mental health professionals in continuing to make even greater strides in the 21st century by responding effectively to a climate influenced by evidence-based practices that is wholly complemented by well-rounded business acumen.

REFLECTION AND DISCUSSION QUESTIONS

Please take a few minutes to reflect on the following questions before moving on to the next chapter:

1. What barriers might exist for you in developing a mental health/human service program?
2. Which of the steps involved in the comprehensive program development model do you believe might be the most challenging? Why?
3. What information provided in this chapter would be beneficial to you in developing a program? Why?
4. What are your thoughts and reactions about the *business* of the mental health professions and the notion that business skills are an essential requirement for today's mental health professionals?

References

Alter, C., & Egan, M. (1997). Logic modeling: A tool for teaching critical thinking in social work practice. *Journal of Social Work Education*, *33,* 85–102.

Calley, N. G. (2007). Integrating theory and research: The development of a research-based treatment program for juvenile sex offenders. *Journal of Counseling and Development, 85,* 131–142.

Chatterji, P., Caffray, C. M., & Crowe, M. (2004). Cost assessment of a school-based mental health screening and treatment program in New York City. *Mental Health Services Research, 6,* 155–166.

Donahue, S. A., Lanzara, C. B., Felton, C. J., Essock, S. M., & Carpinello, S. (2006). Project Liberty: New York's crisis counseling program created in the aftermath of September 11, 2001. *Psychiatric Services, 57*, 1253–1258.

Gibbs, L. (2003). *Evidence-based practice for the helping professions: A practical guide*. Pacific Grove, CA: Brooks/Cole.

Haggard-Grann, U. (2007). Assessing violence risk: A review and clinical recommendations. *Journal of Counseling and Development, 85*, 294–302.

Hansen, J. T. (2007). Should counseling be considered a health care profession? Critical thoughts on the transition to a health care ideology. *Journal of Counseling and Development, 85*, 286–293.

Hensley, L. G. (2002). Treatment for survivors of rape: Issues and interventions. *Journal of Mental Health Counseling, 24*, 330–347.

Hill, N. R. (2007). Wilderness therapy as a treatment modality for at-risk youth: A primer for mental health counselors. *Journal of Mental Health Counseling, 29*, 338–349.

Hill, N. R., & Beamish, P. M. (2007). Treatment outcomes for obsessive-compulsive disorder: A critical review. *Journal of Counseling and Development, 85*, 504–510.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Kelley, S. D. M., English, W., Schwallie-Giddis, P., & Jones, L. M. (2007). Exemplary counseling strategies for developmental transitions of young women with attention-deficit/hyperactivity disorder. *Journal of Counseling and Development, 85*, 173–181.

Khamphakdy-Brown, S., Jones, L. N., & Nilsson, J. E. (2006). The empowerment program: An application of an outreach program for refugee and immigrant women. *Journal of Mental Health Counseling, 28,* 38–47.

Marotta, S. A., & Watts, R. E. (2007). An introduction to the best practices section. *Journal of Counseling and Development, 85*, 491–503.

Mejia, X. (2005). Gender matters: Working with adult male survivors of trauma. *Journal of Counseling and Development, 83,* 29–40.

Puterbaugh, D. T. (2006). Communication counseling as part of a treatment plan for depression. *Journal of Counseling and Development, 84*, 373–381.

Sackett, D. L., Strauss, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach* (2nd ed.). London: Churchill Livingstone.

Wilderman, R. (2005). A practical and inexpensive model for outpatient mental health evaluation. *Dissertation Abstracts International, 65,* 3734(B).