CRUCIAL TIMES

Community Resource Unit Inc.
Suite 5B/19 Lang Parade
AUCHENFLOWER QLD 4066

MARCH 2006 ISSUE 35
Ph: 07 3870 1022 Fax: 07 3371 3842
Email: cru@cru.org.au Website: www.cru.org.au

Editorial

Exploring The Rightful Place Of Quality Assurance In Human Services

Jane Sherwin

The word 'quality' is a word and a concept that we in human services must understand consciously, critically and carefully. Notions of 'quality', 'quality control' and 'quality assurance' originated in the engineering and manufacturing industries, and are now used by the broader business and commercial sectors. Their original intent was to standardise products, and increase efficiency and effectiveness through the reduction of undesirable or faulty elements in the products themselves or in the manufacturing processes. Quality systems in this commercial sense are exercises of regulation and standardisation; they reduce complex matters to simple elements. Therefore it follows that standardisation cannot meet the absolute individual requirements of all customers. Such a standardised, inflexible response is the antithesis of what would be required in quality assurance for human services which should endeavour to meet the individual requirements of the people who receive the service.

Quality is more likely to be achieved when a human service is designed to be coherent with the needs of the people it serves. When designing a high quality service, we must start with the people and their needs, not with a building that needs to be filled, nor with the size of the grant that is available. Such considerations happen after it is clear what the needs of the people served are and what the ideal service response should be. It is only then that compromises about what is possible can happen.

CRU believes strongly that unless human services are designed and delivered in ways that are coherent with the real needs of the people being served, and in the context of supporting people to live as citizens and in the regular community, then it is very difficult to claim to have achieved quality. If, for example, someone needs a home, but all they get is to live in a residence

Contents

CRU's MISSION STATEMENT

- To challenge ideas and practices which limit the lives of people with disabilities.
- To inspire and encourage individuals and organisations to pursue better lives for people with disabilities.

with people they have neither chosen to live with nor even knew previously, then we cannot pretend that their needs are truly being met – a home is much more than just a form of shelter. If someone needs a reason to get out of bed in the morning, but all they get is a series of visits to shops and coffee drinking rather than work, recreation or leisure, then there is a mismatch between what that person needs and what they actually get.

We must also be conscious that merely providing a service does not mean that the needs of the people who receive the service are necessarily being met. A service meets a range of other needs including the needs of its workforce to have secure employment and the needs of society which typically chooses to avoid, ignore and even dump those people who are perceived to have low or no valued status.

When a service truly understands the identity of each person it serves and delivers a service which is highly relevant to those needs, does not waste people's time and actually leaves the person better off as a result of being involved with the service, then we could say that the service is more likely to be offering something of good quality to that person.

Quality is also more likely when both what is achieved and the ways that are used are both consistent with what is valued in ordinary community life. For example, the use of demeaning and time wasting activities is less likely to constitute quality than the use of activities that contribute to the person developing to their fullest potential.

The pursuit of quality is also the pursuit of ethical behaviour. We are in danger of losing sight of the real intention of human services if we equate notions and ideals of quality with activities about efficiencies, effectiveness, policy documents, audits and indicators, rather than with heart, commitment and consciousness.

An ideal service design will be underpinned and complimented by a set of ethics that include being highly committed to:

- re-visiting the assumptions that are made about people with disabilities in terms of what is possible in someone's life, how capable they are, and the extent to which they belong in ordinary life rather than service life;
- continually evolving the service to better meet the needs of people;
- employing people with values and attitudes that foster community belonging, and that help services evolve to more progressive forms;
- re-inventing the power relationship between paid people and people who are reliant on a service;
- standing in the shoes of the person with a disability when making any decisions about the service that are likely to affect the people receiving a service; and
- seeing disability issues as a civic issue and working towards the liberation of people with disabilities from societal stigma, marginalisation in society and dependence on service.

Measurements of quality can be either a paper exercise or a vehicle that is useful in the pursuit of quality. Quality systems can be a bit like the application of a coat of house paint. They can make something look good, but it might only be superficial unless the preparation is done well and the foundations are in solid condition.

Having compliance with standards neither guarantees that quality exists nor that quality will endure over the long term. At worst, it could result in a flurry of policy-writing and record-keeping and, at best, will simply embed minimum standards of service. However, the pursuit of quality can be assisted by complying with standards and accomplishing accreditation, if these systems are seen as vehicles towards quality and not as ends in themselves.

Quality is more likely to be achieved when a human service is designed to be coherent with the needs of the people it serves.

It is vital that we recognise that quality is a voyage, not the destination. Questions of quality must be visited again and again. Quality is not a fixed point. The end point, like a horizon, will never be reached. Indeed, if one approaches quality with humility and questioning, we would always be seeking to offer something better to the people who rely on human services.

It is yet to be seen whether quality in human services will survive in these days when community agencies are expected more and more to act like corporate bodies or arms of government and to treat people as human commodities. The pursuit of quality asks us to look at what life is really like for people, without the blinkers that reinforce the 'different-ness' of people. If we always try to do our best as a commitment to vulnerable people and to the community living movement, we might begin to understand the true meaning of quality.

From the President

Mike Duggan

We recognise quality in any service by apprehending its degree of excellence. We seek the path to quality and endeavour to achieve it as an intrinsic value. Sometimes we know what quality is until we are asked to explain it. Explaining it is not so easy.

At times the pathway towards quality in human services has led into a dead-end, and for some the search for a solution seems to be through rules, regulations and legislation. To take this route however, may only hinder the search for quality and we may find ourselves at risk of being choked with red tape. Bureaucracy is probably no solution and may even become an end in itself, diverting our gaze and energy from 'the main game' – assisting and supporting people with disabilities to live full and meaningful lives as part of a community. Real quality cannot be assured in human services simply by legislation, polices, procedures and the like; real quality in human services is nurtured in many ways.

Organisations, as well as individual workers in organisations, must have a commitment to quality. Often the best and most effective ways to tap into, and nurture this commitment is through multiple approaches, including informal approaches. People need to be given recognition and praise, as well as the chance to develop and contribute ideas and practices.

Power belongs in the hands of people, not the system. Thus, we must organise and support consumer, parent, and citizen representative groups, and of course act on their findings. By doing this, the impetus will more likely be at the grassroots, where it belongs. People with disabilities and their families must have the authority to decide who they will live with, who will support them and what those supports look like. Where people have more direct say over their lives they are less likely to be abused and neglected.

Advocacy, in all forms, is an important element of any quality assurance system in human services. Advocacy provides an independent avenue for ensuring the best interests of people with disabilities and their families are met. Advocacy is particularly important for those people who have few family or friendship connections. We have to lobby governments to continue to support all forms of advocacy, particularly citizen advocacy programs.

Creative funding initiatives enable people with disabilities to develop individual, tailored housing options, which can lead to greater independence and autonomy. Similarly, when people with disabilities and families are able to purchase their services directly, they can have greater control over the type and quality of those services and are able to tailor those services to meet their particular individual needs.

I believe the essence of flexible, person-centred human services is found when individual and organisational dedication to striving to achieve the best outcome for the people we support is based on mutual values and a shared vision for the future. This is the road map that directs our efforts to recognise, nurture and reinforce quality in the lives of people with disabilities. With this road map to guide us, we can be more hopeful that we can find our way out of the dead-end and back on the main pathway towards improving the quality of human services to people with disabilities.

PEACE!
Mike Duggan

Learning The Lessons Of History In The Pursuit Of Quality

Dr Lorna Hallahan *is a manager at Anglicare in South Australia and a lecturer in social work at Flinders University. She has been involved in the disability movement for many years and believes that it is possible for people of integrity and energy to contribute to communities that welcome and honour people with impairments and those who stand with them.*

The history of quality as an idea and a pursuit extends from the earliest times of philosophy and religious thought. As a starting point Aristotle on ethics makes interesting reading, but let's start this brief history of the pursuit of quality by looking at human services in England in1849.

In 1849 a scandal broke out when Mr Peter Drouet, the operator of 'Mr. Drouet's Pauper Asylum for Children' on his family farm estate at Tooting was found guilty by a medical coroner of contributing to the deaths by cholera of over 200 of the 1400 children in his charge. (Later the Central Criminal Court acquitted him of manslaughter charges.) Various reports of the day, including articles by Charles Dickens, questioned how such an appalling loss of life could happen. Some attributed it to the greed and carelessness of Drouet although most agreed that he was, in the jargon of the day, 'farming' his children within the law. Others decried the Reformed Poor Laws of 1834 and the setting up of pauper's farms, poor houses, lunatic asylums, and other asylums as iniquitous. (We can also assume that a percentage of the parents of these children were transported to Australia where a fresh wave of gathering vulnerable populations into prisons and asylums was well underway.) All the commentators concluded that the Parish Guardians, who were responsible for admitting the children to the farm, appeared to be unaware of how their children were faring at Mr. Drouet's asylum, saying: 'content with regular cursory inspections of the establishment, the Guardians failed to investigate the children's true mental and physical state'.

Since the 1850s many hospitals, asylums, reform schools, rehabilitation centres, and nursing homes in Britain, Canada, The United States, New Zealand and Australia have been reviewed and their practices condemned as inhumane. Throughout this period, as a remedy, the responsible governments have enacted legislation and developed public policies to professionalise service workers and to solve abuse and neglect in services by 'proper management'.

Alongside these civic developments there were other movements. For example, in the United States, Frederic Taylor's principles of scientific management in manufacturing emerged as influential in organisational design in the interwar period. Over the next thirty years the philosophy and practice of classical management and Taylorism, as it became known, were adopted and adapted by different types of organisations all pursuing machine-like efficiency requiring careful design and fine tuning. The new scientific management found its way into welfare and human services organisations by the 1970s with some interesting impacts, including the industrialisation of social care work and a focus on performance measurement, program evaluation, outcome standards, and so on. Some welfare historians argue that this phase of the management revolution created the formal human service system of the 1980s, even though to many of us it seems to have been around much longer.

So, with a seemingly endless supply of examples of negligence in human services to analyse, the debate about quality continues in various forms to our day.

Some individuals, governments and services see the introduction of such quality measures into human services over the past 25 years as a significant measure to prevent abuse and neglect of those who are services-reliant. Recommendations about quality are still to be found in the reports of most enquiries into the problems with services. For example, the 2001 Australian parliamentary committee enquiry into immigration detention services refers to contractual arrangements that enshrine an obligation to conform to Immigration Detention Standards, daily performance monitoring, and quarterly formal evaluations. (The committee concluded that many of these obligations were not being met, resulting in poor conditions and human rights abuses.) In Australia, any organisation tendering for grants to operate a human service is required to provide detailed information to government funding authorities about their quality production, assessment and improvement plans and processes. Many large

organisations are accredited through large, generic quality standards systems, which can apply equally to things as diverse as the production of ice cream or the provision of acute health care services. Many employ staff whose sole or major duty is to develop policy on service excellence.

Even though its application seems almost universal, this approach has not been without its critics. Throughout this period, many writers have critiqued managerialism in human services, with its language of quality consumer outcomes, as a form of people processing, linked more to liability, risk management or financial accountability than to finding ways to help people live decent lives. Some advocate a return to ostensibly simpler or barefoot ways of developing and delivering services, favouring higher levels of volunteer participation, family rather than organisational governance or intentional community living. Still others argue that even though quality makes its way into the burgeoning human services industry via industry and managerialism, describing its co-option to public administration rather than social care does not do away with the necessity to pursue excellence in all that human services strive to do.

These writers argue that people reliant on services to change the circumstances of their lives need service providers and workers with heightened moral sensibility and imagination in order to make the complex value judgements required in deciding what excellence might look like. They need the courage to pursue the best for and with all people in their care. In the disability sector this has translated into increasing attention to and sophistication in ethical deliberation, principled vision-setting and rigorous evaluation.

So, despite the sorry history of welfare over the last 160 years, albeit punctuated by some glorious moments when justice and love seemed possible, many of us still look forward with hope. However, we know that the idea and pursuit of quality will not bear rich fruit in the lives of people reliant on human services when it is held captive by unjust social policies or slick, risk-aversive people processing. Until quality is freed from these traps and allowed to operate as a guide to excellence, we, like the Parish Guardians in Tooting, could find ourselves completing wonderful paper work while failing to investigate the 'true mental and physical state' of those with whom we work – and thus, failing to learn the lessons of history.

Quality: A Fine Drop Of Red Versus Entry And Exit Procedures

***Karin Swift** has been interested in disability issues for most of her life. She has been involved in various Brisbane networks for over twelve years and has a keen sense of social justice. Currently, Karin is employed as the Coordinator of Queensland Disability Housing Coalition Inc. Karin lives with her husband, David, in a lovely house on Brisbane's south side and in her 'spare' time, she is a member of management committees of advocacy organisations for people with disability in Brisbane.*

This era seems to be obsessed with 'Quality', 'Best Practice' and 'Healthy-Heart Ticks'. This obsession has led to endless amounts of bureaucratic paper-shuffling so that service systems can pat themselves on the back, and families and people with disabilities might be able to have some, albeit, limited assurance that their service at least adheres to some standards. In this climate, it seems timely to ask: what does quality actually mean?

It is probably fair to assume that there will be many answers to this question, as the people being asked will all have their own individual perspective. The nature of quality is complex and in our efforts to define what quality is, we may find that it defies any simple explanation.

If I may be so bold, I would like to offer my own personal perspective on what quality means to me. I would also like to encourage others to think about what quality means to them; it is only when we examine the places where quality may be located that we can begin to make sense of proposed quality systems, soon to be implemented by Disability Services Queensland (DSQ), and gain a perspective on how, or even if, they can be used to improve the quality of life of the people who need to use human services.

When I think of quality, the following random thoughts come to mind: doing something well

and with purpose, a fine box of chocolates, a nice bottle of wine, good times spent with friends, family and loved ones, time to myself, reading a good book, relaxing on holidays, having meaningful relationships with people whom I love and people who love me, having a home filled with nice, though not necessarily expensive things.

It could be argued that none of these things have anything to do with human services or meeting the current minimum standards and that a person's life should be about much more than the services they receive. However, many of us might agree that a 'good quality' human service may play a role in assisting a person to achieve or maintain some of these things.

There seems to be a distinction between the quality of my life, or the things that I think define quality, and Quality Assurance (QA) as defined by DSQ. The DSQ definition of QA requires human services to meet ten *minimum* standards based on the Disability Services Act, and not necessarily the standard of quality I would like to achieve in my life. Herein lies the dilemma.

For me a good quality human service is one that knows what their service business is and what is clearly my business or my family's. The service is able to offer support when needed in the least obtrusive way. The menu of support is not limited to, or defined by, the needs of twenty other people living in the same geographical area or by occupational health and safety regulations or by other industrial relations regulations.

For me, the people who work in a good quality human service might not be my personal friends but they would at least have enough personal interest in me to want good things for my life and want me to achieve my best. The people working in my home would value me enough to respect and care for me and my property. They would support me with personal care in a manner that is respectful, gives me dignity and is a reflection of how they themselves would like to be treated, and especially not as a diseased organism. They would be respectful of relationships I had with members of my family, my partner and my friends. They would realise they are in a paid role to support me in my lifestyle and would not expect me to make continual adjustments based on their needs. They would realise they are working in my home, and not in a human service facility.

Surprisingly, few of these qualities are mentioned in the ten DSQ minimum service standards. This could be for a number of reasons: perhaps these qualities speak about the essence of our humanity, or the quality of our human interactions, and are simply too complex to 'tick and flick' or to write into policy. Perhaps when these standards were created no-one thought to ask people with disabilities and families what should be included. Perhaps quality assurance processes are more suited to manufacturing factories than to *human* services.

Furthermore, can quality be achieved by services meeting an arbitrary set of minimum standards that have more to do with filling in paperwork than to the quality of people's lives? Or should quality be about going for broke, reaching for the stars, striving for Utopia, doing what no-one has yet been bold enough to try?

… a good quality human service is one that knows what their service business is and what is clearly my business or my family's.

Something to ponder when I open my next bottle of 'quality' wine…

Does A Quality System Keep People Safe?

Greg Wagner *is the Coordinator of Queenslanders with Disability Network (QDN) a state-wide network of over 1000 people and organisations throughout Queensland who share a common vision for people with disability which includes the belief that people with disability have a right, a place and a contribution to make to the community as empowered, free citizens. Prior to commencing his employment with QDN, Greg worked in the social advocacy movement for ten years.*

The question of whether a quality system will keep people safe is a somewhat loaded question as we can make a number of assumptions about what we mean by the terms 'safe' and 'quality'. While driving home I was thinking about this question and saw a delivery van for a fruit juice company which bore a large 'Quality System' logo, stating 'A Quality Endorsed Company', with lots of those proficient-looking, red ticks down the side. I thought: Yes, that's what I want from my fruit juice – all those nice ticks. Clean wholesome oranges – tick! Friendly, environmentally-conscious fruit pickers – tick! Double-locking, safety lid – tick, tick!

Can such a mechanism for assessing quality be applied to the human service system and will a quality system really keep people who rely on services safe from neglect, abuse or exploitation? This is not an easy question to answer when we start to look more closely at this issue, and in particular, at what a quality system is and how it is administered. These are essential questions if we are to understand whether a quality system is really a safeguard or just bureaucratic smoke and mirrors.

In Queensland we are currently in the midst of the roll-out of the Disability Sector Quality System (DSQS). This new system is based on ten Service Standards, covering such things as service access, individual needs, decision-making and choice, privacy, integration, valued status, complaints, service management, legal and human rights, and staff recruitment. Within each standard a number of indicators exists to assist in gauging the level of compliance with that standard. Essentially this means that an organisation's performance can be measured by examining what it says it will do against what it actually does do. This is achieved via means of accreditation and external assessment with the overall aim being one of continual improvement.

While I believe that the Disability Sector Quality System is a positive step forward, there are two concerns that must be addressed before there can be a clearer understanding on the question of whether the system can keep people safe.

Firstly, the system must be administered with the sole intent of creating better lives for people with disability and their families. A tick and flick exercise will not do. Services must actively and positively engage with people with disability, their families, allies and advocates and allow them to drive the changes that place emphasis on the service users. For this to occur, services should also be open to innovation, creative responses and flexibility. Should these not occur, Disability Services Queensland (DSQ) must be prepared to take strong corrective action. Otherwise, what are we left with – smoke and mirrors?

I believe that people with disability, their families, allies and advocates must also get actively involved and engage with services on these issues. For the first time in Queensland we have the opportunity to *legitimately* get involved in services with the intent of improving what they do. For this to happen however, there is a need to address the power imbalance between people with disability and services, and to offer realistic, meaningful and independent resources for people to get involved. With enormous amounts of money already being poured

into services to allow them to implement the new system, a similar investment in people with disability and their allies is crucial, yet still to be seen.

My second concern is simply that I do not believe that any quality system alone will keep people safe. This must be openly acknowledged and discussed at all levels of community and government; otherwise we run the grave risk of becoming complacent and placing ignorant trust in a system. The irony of such a scenario would be the creation of services that will get all the ticks and flicks, but still leave people in great danger.

Keeping people safe is a complex matter that involves many strategies which are built around the person given their specific circumstances. Usually these strategies involve people who are committed to the individual, and most likely these will be family or close friends. However, when someone does not have such relationships this issue gets even more difficult to address, not only from an individual level, but also from the systemic level.

We need to look at why people have no close relationships in their lives. We need to examine what statutory powers exist to protect vulnerable people and, most importantly, we need to identify the level of political concern for taking real action when people are known to be 'unsafe'. There is no excuse for the lack of intervention when abuse of people with disability has been detected; it has quite simply been the lack of organisational, personal and political will to do anything about it.

The Disability Sector Quality System will not address this lack of will to act. For this we must look beyond the issue of quality. In particular, we must examine the underlying values our society holds for people with disability and lobby government to implement mechanisms that detect and counter the abuse of people with disability in a non-superficial way.

Quality systems can contribute to an overall strategy of safeguarding people with disability, as long as such systems are not seen as the be-all and end-all of safeguards for people with disability. Instead, there must be meaningful, active and supportive engagement of people with disability and their allies in this system, and strong legislation which protects their rights, including the right to choose, and to change services when things don't work out. We must have a fair and flexible funding policy, which not only allows people to create new and personalised options of support for themselves but actively encourages and invests in those options.

… we must, above all, have the political motivation and courage to act decisively when services desert the interests of people with disability.

Finally, we must, above all, have the political motivation and courage to act decisively when services desert the interests of people with disability.

Quality Strengthening, Monitoring And Evaluation And Their Role In A Broader, Multi-Component Quality Enhancement Strategy

Michael Kendrick *consults, writes and is active on matters of quality, values and leadership in many countries. He has a passionate interest in the provision of quality services to people with disabilities. Michael, who is Canadian but now lives in the USA, has been a regular visitor to Queensland over many years. With over 25 years of experience, he is well known for his work on Leadership, Quality, Advocacy, Safeguards and the promotion of community living for people with disabilities.*

When one steps back from the quality of the results obtained in a given service user's life, one can see that many good things might be possible for that person, but that it would mean the combining of the independent efforts of many individuals and interveners in order for such beneficial results to be obtained. Yet, we are often tempted to simplify this complexity by our attempts to reduce quality to a single active ingredient. This is understandable, as more complex formulations require a great deal more mindful care and attention than do 'shoot from the hip' panaceas for quality. In this regard, it is the cumulative result of various valid factors, acting together, under good direction that creates the most likelihood that a quality result will prevail.

Many things can help a person achieve 'the good life'. These would typically be distributed across all domains of a person's life, much as his or her needs and wants arise in highly particular ways from each domain of his or her life. Consequently, there might be many catalysts that, if activated and pursued, could help a person better satisfy their needs and wants. It is also true that many, if not most, of these active ingredients of quality could be recognised and combined in ways that make it more likely that good quality results will prevail in a given person's life. Naturally, these must be authentically relevant to what a person actually needs and wants, but assuming they are, then quality becomes probabilistically more likely.

Many quality assurance (QA) systems presume that quality already exists in our existing models, and so the task needs to be solely one of preserving or improving quality. Consequently, QA measures are added to the mix of existing service models on the premise that the model is already sound and that it simply needs enhancing. This may be mistaken, as many models of service do not significantly add to the quality of people's lives or their support and may even be holding them back. Recognising that this might be so, then quality enhancement, quality improvement, and quality assurance might better be rethought of as the specific means by which services can be modified to become more relevant and beneficial. This may even require that something of quality be created to replace, or at least contrast with, service models that are out-dated or ineffectual.

Quality Assurance measures are added to the mix of existing service models on the premise that the model is already sound and that it simply needs enhancing.

Quality can be strengthened if the person's quality of life is seen as the foremost guide to what remains to be done. Quality assurance cannot be tested as to its relevance in some general sense, but must repeatedly prove itself on a person-by-person basis in order to establish its credibility. Systems that only do this on a generalised basis are categorically suspect, since they fail to be tested one life at a time and instead impose an 'across the board', generalised and standardised methodology as a substitute for engaging in the highly specific issues of a given person's life and needs. If, on the other hand, the quality enhancement measure is predicated on learning about success with quality by examining the lessons that each person's life present as to what has actually been successful, then, we could genuinely claim that quality was being named and evaluated, based on the actual facts and outcomes in people's lives.

The process of strengthening quality must include processes of evaluation and monitoring; these are not the same, though they are often combined. Monitoring is a process of maintaining surveillance on key aspects of quality while evaluation involves analysing and interpreting what has been observed through monitoring. In this regard, monitoring and evaluation are processes undertaken alongside service development with the intention of appraising the extent to which quality is present in a given service. Monitoring and evaluation can point to the need for changes in service models,

practices and the theories upon which they are based, but they are not a substitute for competent service delivery, nor do they assure quality. They can only detect and analyse where and why quality may be at issue. This does not mean that evaluation and monitoring are not helpful, but rather that they are not, in themselves, capable of assuring quality, unless they are subsequently combined with feasible measures to improve service practice and models.

Evaluation and monitoring can be done in many different ways and with quite different results and impact. Many methods can be employed to monitor what is happening with individuals and systems; for instance, a given individual may be monitored solely and independently by a single staff person, or simultaneously by staff occupying different roles. These are both distinct forms of monitoring carried out by paid staff, yet they can co-exist and be helpful. In fact, the cumulative benefit to the person is greater than that of any single component, and demonstrates that each component of monitoring can add something special to the mix, while still being harnessed into a bigger effort of quality improvement.

Not all quality improvement measures are fundamental to assuring that people's needs are actually effectively met, and simply calling something a 'quality improvement' measure does not actually make it so.

Not all quality improvement measures are fundamental to assuring that people's needs are actually effectively met, and simply calling something a 'quality improvement' measure does not actually make it so. Rather, the real test will be whether the measure truly helps people get what they actually need and want. For instance, having detailed, documented protocols or policies for handling various developments that may arise in a person's life are often relied upon as evidence that the matter will be handled well. This is predicated on the belief that if something exists on paper, it exists in reality. However, something can only be meaningful if it is done properly at the time when it is actually needed. Failed protocols cannot be equated with actual quality outcomes, since they are ineffectual in reality, though they exist on paper. What will work in practice is the true source of quality, and this cannot be known except by cross-checking what is hoped for with what actually was beneficial to a given person's life. It is only then, for instance, that one might have the evidence to conclude that it was more important to assist people to develop relationships with other people who have the personal qualities of 'person-centred*ne*ss' than it was to have a formal person-centred plan. Yet, many systems may actually place greater emphasis on formal plans than they do on 'person-centred*ness*'.

There is danger in relying exclusively on minimal standards of quality interventions. Many service systems, in the hope of assuring at least a minimal 'base' level of quality of service often opt for various 'single path' methodologies for quality enhancement. Some of the common forms of these are seen in the reliance on accreditation, licensing, registration, professional credentialing and so forth. When a system places exclusive reliance on such measures, they become a kind of 'silver bullet' for quality due to the fact that they are the only show in town. Yet, this is contradictory to the fact that any number of measures, if properly mobilised, might enhance quality in a person's life. By narrowing service providers to have to rely solely on minimal quality standards mechanisms, factors that could go well beyond minimal thresholds in generating quality are ignored, despite the fact that they are capable of actually elevating quality well above minimal levels. These, more powerful, quality enhancement measures normally could include; selecting the right people, generating service models that actually fit with people's needs, the presence of values-based leadership, exposure to high quality solutions to needs, and so forth.

Often QA systems are used as a means of 'scandal proofing' or as protection from complaints that the system did not do what it should have. There may be much to be gained by being able to say that all of the staff had been properly trained and the agency duly accredited and licensed at times when a potentially scandalous failure occurs in a service, particularly one that generates a lot of unfavourable publicity. While such measures do provide a tangible amount of immunisation from attacks on one's competence and credibility, they rarely ultimately work to protect the authorities from the political consequences of scandals. So, as a form of 'scandal proofing', such measures are of limited use.

A much better defence is to be able to demonstrate that the system had gone well beyond minimal standards efforts for quality

improvement to the combined use and mobilisation of literally dozen of other catalysts for quality. This approach also reveals that the system is not approaching quality defensively, with bureaucratic window-dressing measures, but has an active, multi-faceted, pro-active, optimal quality strengthening program at work in every single provider organisation. The sheer diversity of methods being utilised in partnership with providers gives great weight to the fact that the attempt at strengthening quality goes well beyond bureaucratic minimalism. This does not make any eventual tragedy or scandal disappear from the scene, but it does counter any eventual criticism with the sheer depth and breadth of the quality improvement efforts.

Since many interventions can, at least in theory, feasibly help generate improved quality, it is important that the system's authorities appreciate this, as its policies can act to either diminish or enhance the provider's capacities to harness the right catalysts for quality. Rather than forcing providers to place inordinate amounts of energy and capital into a set of minimal standards – 'single track' methodologies, whose record of generating quality may be historically quite unimpressive – it is clearly worthwhile to be open to strategies of quality improvement that enable providers to be able to experiment with many promising quality enhancement methods, many of which share a bias towards optimal quality rather than achieving just the barely adequate. This may make the difference between whether they can effectively use 'high yield' versus 'low yield' strategies in terms of quality.

This can be achieved by simply shifting the regulatory emphasis from prescribing a singular means of quality improvement to emphasising the nature of desired quality, and allowing providers to self-select the use of approaches to quality that show persuasive evidence of measurably impacting on quality. Further, if the better use of these is allowed and expected to evolve over time, providers may gradually become multi-faceted in their capacities to constructively influence quality. In any case, providers would still be compelled to make active and credible investments in quality improvement each year. The difference would be the flexibility that would allow them to be both creative and possibly innovative in marshalling an annual or multi-year quality improvement plan.

Many factors can be combined to increase the likely generation of quality, providing that each of these factors is intrinsically valid. For instance, measures such as exposure of people to examples of high quality could easily be combined with mentoring or consulting with experienced high quality practitioners. In addition, values-based training, partnering with service users and families, strict *post hoc* analyses of why specific aspects of service are poor, and fastidious recruitment of the 'right' people can also be added to these initial quality improvement measures to generate increased likelihood that the service will be both 'person centred' and effective. Though none of these factors relies on minimal standards, their combined impact on quality would undoubtedly produce higher levels of quality. The reason for this is that the provider can select, evaluate and combine quality strengthening measures, on an ongoing basis, that are most convincing to them rather than concentrating scarce resources on minimally-useful measures that are largely oriented to assuring, not that quality is strengthened, but rather that people get the bare minimum.

The well-being of the service user is of crucial and fundamental importance in terms of service quality and the system must be able to know what precisely is happening to people (monitoring), and must be able to assess why this is so (evaluation). These are naturally linked, since monitoring allows a system to generate the information that would alert it to quality issues that may be present. The evaluation of these indicators is a genuine analytical problem. Since 'the data do not interpret themselves', information is not always self-evident in terms of how it should be interpreted. Consequently, evaluation is always a weighing of the facts as to what they mean.

A single system may conceivably use a variety of monitoring methods simultaneously, all of which may have a measure of validity and effectiveness notwithstanding also having a great number of limitations. For instance, most systems rely on monitoring the well-being of a given person by staff, sometimes, by multiple staff. This may involve people as diverse as case managers, supervisors, key workers, service coordinators, internal evaluators, licensers, clerical and administrative workers, consultants, funding officials, accountants, clinical professionals and many others who work for either the funding body or service provider. The quality question may well be whether they actually recognise their monitoring duties and execute these as anticipated.

Monitoring can also come from people who may be at the periphery of the 'paid' service system,

but who are perhaps more free to act on the basis of what they learn about the situations in people's lives. This could include board members, families, friends, advocates, neighbours, employers, and possibly many others, including journalists, unrelated professionals from other systems, academics, politicians and so on. The key question is whether the system is active in strengthening and effectively using these forms of monitoring by people who do not work for them.

In some instances, systems have invested in types of monitoring that are built around a partnership between the system and parties outside the system that might have an interest in monitoring services in regards to the well-being of the persons served. This has included efforts to have 'friendly visitors' to residential settings and institutions, and special monitoring training being made available to agency board members, advisory board members, and others in such roles. It has included special evaluation or monitoring of projects and systems by teams made up exclusively of families, service users or advocates, for example, to evaluate or monitor services. It has also included special projects to have independent citizen boards oversee management of the complaints and investigation processes to avoid the appearance of 'the police policing itself'.

Many worrisome matters of quality are more readily identified when people are educated to see them for what they are. Consequently, efforts at educating people about quality are helpful in enabling them to do better in their quality monitoring capacities and roles because they better understand what quality is and thus, will be more assured in their actions based upon their appraisal of quality issues. Secondly, when people are clear that they do indeed have a duty to monitor, and agree with this premise, then the chances of them being better able to monitor effectively increases. This might be thought of as 'role-consciousness', or perhaps, 'role entrenchment'.

Thirdly, when people know what they are supposed to do with what they learn, particularly by triggering the system's attention and action, they become *de facto* allies of the system in monitoring, i.e. the system's 'eyes and ears'. Fourthly, when people are supported in their monitoring role, their original orientation to quality will persevere rather than diminish and their capacities to act more meaningfully will increase. Fifthly, when systems act on what they learn rather than suppressing information that is critical of practice, other people are invited to step forward as they are less likely to believe that such actions are futile. Lastly, when monitoring of this kind is praised, recognised and highlighted it creates a greater societal sense of transparency and puts people on notice that quality is under scrutiny.

However, when monitoring and evaluation are embedded in conflicts of interest they are notorious for their lack of credibility, because they lack independence, impartiality and transparency. Typically, these are instances of the system investigating itself, and thus the monitoring and evaluation that is done is prone to take a view that is more consistent with the system's agenda. Often the practitioners involved have career or other interests that could be adversely affected by acting too independently. Consequently, many systems recognise the value of independent monitoring and evaluation by selectively externalising many monitoring and review functions, even if they maintain some internal capacities in this regard. The principle of independent evaluation applies to the evaluation of the system itself, and many systems recognise that there are occasions when this type of evaluation is necessary to establish a credible appraisal of events and results. This principle can also apply to provider partners of the system in that they may also be required to submit to independent review of their performance and quality on a regular cycle.

What has been suggested here is that quality strengthening in systems may be greatly helped along by seeing the precise role that quality making and strengthening plays, and how this can be monitored and evaluated. It also makes the argument that it is advantageous for systems not to bet all their money on a single strand of either quality making or evaluation and monitoring, when the combined use of a variety of these may be possible. Lastly, it suggests that not all of the inspiration, creativity and concern for quality will, or should, come from the system and its officials, and that it is possible for the system to work collaboratively on quality rather than to see itself as the sole safeguard on quality. Naturally, these insights have to be reconciled with the reality that quality may not always be all that important a factor to many parties both inside and outside of the system, but such considerations need not invalidate anything offered here.

Note: Michael Kendrick's paper was developed with the assistance and support of Community Living British Columbia, Vancouver, BC, Canada.