QUALITY

IN

COMMUNITY BASED

HUMAN SERVICES

by

Jacqueline F. C. Stokes

B.S.W., University of British Columbia, 1985

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

May, 1996

Abstract

Political ideology influences both the delivery of human services and the criteria by which 'quality[1]' in those services is assessed. As governments have experienced the seemingly competing tensions of increasing demands and reduced resources a shift has occured in service delivery. A wide range of personal and community services have been decentralized and privatized. Services that were previously provided through the public sector are now being contracted out to non-profit community based agencies.

Public sector services have traditionally ensured 'quality' through the implementation of standards of practice, cost-benefit analysis, and the development of objective program goals by which outcomes can be measured. These measures aimed at a universal minimum rarely recognize the uniqueness of small community service delivery, and do not reflect the community ownership thrust of current social policy. The time has come to re-think the definitions of quality so they more closely correspond to social policy. No longer are the definitions of politicians, bureaucrats and experts working in urban centres adequate. In order to understand quality in the non-profit sector we must enter into a dialogue with the multiple stakeholders in the community.

This thesis asked "What is quality in community based human services?" To answer this question the social policy literature was examined in order to consider how privatization and definitions of quality have developed. Small northern communities in B.C. provided the social context for the research which utilized an interpretive, qualitative approach.

---

[1] Although 'quality' can simply refer to a characteristic element of something it is often defined as synonymous with excellence. This latter meaning will be used predominantly throughout this thesis.

Interviews with sixteen service providers and clients in three small northern communities provided the data for the study. These interviews were transcribed and a hermeneutic interpretation was used to investigate the text.

This research concluded that 'quality' in human services is informed by both social policy and everyday practice. Service providers and service users in this study of small, northern communities defined quality in terms of accessibility, effectiveness, openness and acceptability. Taking into consideration the social context, the preferable model of providing services was shown to be under an umbrella organization. This model offsets the high visibility, isolation and transsituational demands the service providers experience in small northern communities. Quality can occur in community based agencies when there is a balance between the standards and accountability crucial to government and the humanistic perspective essential to service providers and service users.

Table of Contents

Approval i
Abstract ii
Table of Contents iv
Acknowledgments vii
Dedication viii

Chapter One - Introduction 1
The Social Policy Influence 3
Social Policy's Implications on the Definitions of Quality 5
The Practice Component of Quality 7
Conclusion 9

Chapter Two - The Development of Privatization 11
The History of Human Services in Canada 11
Privatization of Human Services in B.C. 14
Privatization and Non-profits in Northern B.C. 17
Conclusion 19

Chapter Three - Quality in Human Services 21
Introduction 21
The Service Provided: Is there a satisfactory product? 23
Unit Costs 24
Standards & Accreditation 25
Outcomes 27
The Organization that Provides the Service: Is there a satisfied customer? 29
Quality Management 30
Economic Efficiency 32
The Perception of the Customer: Is the customer empowered? 34
Conclusion 37

Chapter Four - Research Design 40
Approach to the Research 40
Method 42
Entry to the field 44
The First Round of Interviews and Analysis 45
The Second Round of Interviews and Analysis 49
The Third Round of Interviews and Analysis 51
The Interpretation 52
Issues of Rigor 55
Objectivity/confirmability 56
Reliability/dependability/auditability 56
Internal validity/credibility/authenticity 57
External validity/transferability/fittingness 58

Utilization/application/action orientation 58
Ethics....59
Conclusion 59

Chapter Five - Quality in Small Communities....61
"How its done" - The Standards 63
Where is the information sharing line?....64
"The Skills and Abilities to do your Job" - Being Effective 65
Jack of all trades....66
Working towards what the client is looking for....68
"Immediate and Direct Access to Programs" - Gaining Accessibility 69
Less choice, fewer alternatives 70
Just getting on with the job....71
Its easy to pick up the phone, and refer....73
Friends recommending....73
You're a person, not a number....74
What is that person doing in that counselling office?....74
Waiting rooms are out....75
"Having Rights" - Openness....76
Before I opened my mouth, I was told....77
I'll tell a friend, who'll tell a friend, who'll tell a counsellor 78
But he's a Good Joe 79
Putting it on the table for the safety of the client....80
"Providing a Good Service to the Clients" - Acceptability 81
Conclusion 83

Chapter Six - The Experiences of Service Providers in Small Communities....85
Pulling out the map...to move north....86
The Jumble....87
The Fishbowl 88
Rumours, Perceptions and "Profile" 89
Friend or Counsellor? 91
Isolation - Being on the 'inside'....94
Big Fish, Little Bowl...Living with your work 96
I need to get to know you....98
Conclusion 99

Chapter Seven - The "How" of Quality - Service Organization....103
Current Services: The Appearance of Horizontal Integration....106
The Multi-Service Organization: Horizontal Connectedness with Vertical Linkages....109
Providing support the for the service provider....111
Standards....113
Effective....115
Accessible 117

Openness 118
Acceptable 119
Cautions 119
Growth can lead to bureaucracy 120
Growth can lead to over-integration 121
Not reaching out to the community 121
Multiple contracts, multiple demands 122
Chronic under-funding 122
The Regional Picture: Linkages to the Vertical 123
Conclusion 127

Chapter Eight - Balancing the Multiple Needs in order to Provide Quality Service Delivery 129
1. Balancing the private and the public sector 132
2. Balancing the vertical and the horizontal 134
3. Balancing the measures of quality with the aims of privatization 136
4. Balancing the human values and the standards of service 138
5. Balancing the needs of the service provider and the demands of the community 140
6. Balancing integration with community contact 141

Conclusion 143

References 145

Appendices
A. Approval from Ethics Committee 157
B. Letters of Invitation to the Executive Directors 159
C. Brochure outlining Research 165
D. Explanation of Research and Overview of Questions 168
E. Agreement of Participation 170

Acknowledgments

Throughout the development of this thesis I received assistance and support from many people. In particular I would like to thank Dr. Gordon Ternowetsky, the chairperson of my committee, for his continual encouragement and his belief in the value of this study, to Professor Glen Schmidt who brought harmony and a sense of balance to the work and to Dr. Martha MacLeod who challenged me to struggle and 'find my voice'. In addition I would like to thank the Child Welfare Research Centre for providing the training in Nud.ist, as well as the use of other technology throughout this research.

To the people in Mackenzie, B.C., and in particular Mackenzie Counselling Services, who taught me about working in small communities, and provided the catalyst for this thesis goes a special thankyou. There are also sixteen very special people, in the northern region whom I am indebted to. They volunteered time in their overworked schedule and were willing to be candid and open about their experiences and perceptions. I have had the privilege of interpreting their words and ideas and putting them down on paper. For that I thank you.

I am also grateful to my family for their help. Thank you, Doug for holding the family together all those weekends, staying calm during my periods of angst, and always supporting my goal of completing this work. To my children Robert, and Kevin, thank you for letting me do my homework too. I hope that one day the word 'university' will no longer be associated with Mum disappearing for long periods of time and can be thought of as an exciting place to challenge old ideas and try out new ones.

Dedication

In 1988, I was one of sixteen thousand individuals who paid $5.00 to support the development of a university in northern British Columbia. After much anticipation the university opened on September 8, 1994 and I was among the first graduate students to enter the campus. I was excited by the idea that this university had the unique opportunity to study, and work with, people in the north on the issues that were pertinent to this region of the province. I felt that true mutual learning, and reciprocal benefits would occur when the expertise of northerners was interwoven with academic scholarship; and I wanted the work that I did at this university to be a part of that didactic process.

This work is dedicated to all the pioneering students who entered U.N.B.C. in September of 1994 and to the people of the north. In particular this dedication goes to the human service providers in small communities, who work in challenging environments and give so much of themselves to the people they work with, and the communities they live in.

Chapter One

Introduction

'Quality' is important in many aspects of our lives. Products we buy undergo rigorous quality control in order to ensure that they are consistent with the manufacturer's claims. Organizations provide managers with seminars that teach them 'quality management' in order to build a team that will work well together. The education system has even embraced the concept with the idea of quality schools (Glasser, 1990). But what about quality in the human services? Here, quality is often assumed and taken for granted. Even the definition, and by extension the measures of what constitutes quality in the human services, is not clear. Why is this the case? The answer to this question is complex and is informed by both social policy and everyday practice. It is social policy that drives the delivery of human services, and it is that same social policy which determines the criteria by which quality in those services is assessed. Everyday practice, on the other hand, provides the context in which quality gets played out, and understood at the 'gut' level.

My interest in the subject of quality in the human services stems from my own experience working in a non-profit society in the small, northern community of Mackenzie, as well as my familiarity with human service delivery throughout north-eastern B.C. Over the years I witnessed changes in the relationship between the agency and government. Initially, the contract that provided the funding for the agency, was considered an arms-length contract, and had virtually no stipulations attached to it. As time went by concerns were raised about the disparate clinical and administrative practices that were occurring in non-profit agencies throughout the region. The government began initiating audits and

agency reviews. Through this process it became apparent that many non-profit agencies in the small communities lacked written clinical standards and guidelines, and concerns were raised about counsellors experiences and skills (Trolley, 1993). The government's response was to invoke measures to ensure some accountability. Because the government's experience was in delivering services through a large bureaucracy in a centralized format, criteria for service delivery in the non-profit agencies developed the same way. The contracts began changing. Some ministries included the idea of unit-costs into the contract (e.g. they would pay 'x' amount of dollars for a particular service provided to a specified kind of client), while others began insisting on compliance to a set of standards and/or piloting accreditation projects.

My experience of the first method was that it disregarded the breadth of work provided in small communities. The unit-cost system of accountability emphasized the issues and clients that government saw as a priority, and disregarded the unique requirements of the community. However I was aware and concerned about the varying levels of service throughout the north. When accreditation was discussed as a possible way of ensuring minimum standards I volunteered the agency I worked in, to participate in the pilot project. I then set about to fulfill the prescribed paper trails. But as I began working through the necessary procedures I started asking myself whether the formal processes could in fact ensure quality? More than that it started me thinking about the whole notion of quality in small community service delivery. The question that evolved, and became the basis for this research was "What is quality in a community based agency?"

The Social Policy Influence

Canada's social welfare system was developed to provide programs aimed at promoting national unity and furthering economic goals (Irving, 1995). Its development was influenced by the depression of the 1930s and the concerns about the economic upheaval that would follow World War II. Education, health care, income support and unemployment insurance were the four main areas of intervention that emerged as pillars of Canada's Welfare State. These programs were administered through a centralized government in order to reduce regional inequities and provide essential public services of reasonable quality to all Canadians. Over the years these programs, through the application of national standards, "played a critical role in reducing poverty and mitigating the effects of a turbulent labour market" (Torjman, 1995, p. 2).

In recent years social, economic and political realities in Canada have undergone another transition. Canadians have experienced social upheaval as the nature of families has changed, the population has aged, and the workforce has been restructured (Maxwell, 1995). These changes have resulted in a growing need for state intervention. The growing demand for human services has meant an increase in social spending, which has risen five-fold since the 1950s (Battle K. & Torjman, S. 1993). In order to reduce the costs of social programs, privatization (the ideological umbrella of the corporate sector which promotes the selling-off of government assets) has been utilized in the delivery of human services. In addition to the fiscal pressures, neo-conservatism in the early 1980s saw governments as wasteful, meddlesome and overly bureaucratic (Crane, 1994; McQuaig 1993, p. 102). Privatization was seen as a way of reducing the size of the public service and restructuring the role of

government. Work that had previously been carried out by the public sector was reallocated or transferred to community agencies.

Privatization in the form of contracting-out services with non-profit organizations aims to reduce the size of government and to use public money more efficiently. But it also provides an opportunity for services to be more responsive and accessible to consumers. Providing services through the private, or non-profit sector, was initiated during the 1970s in British Columbia (B.C.) when the former Department of Human Resources[1] in conjunction with the Alcohol and Drug Addiction Commission[2] formed locally controlled societies to operate their programs (Clague, Dill, Seebaran, and Wharf, 1984). As subsequent governments accepted contracting out to non-profit societies as the 'modus operandi' for human services, these socieities began to expand and develop new programs. Today, the majority of personal and community human services aimed at providing counselling, support and information are delivered through the non-profit sector. The trend towards community based models of care continues to be the thrust of health and social policy. On February 2, 1993 the *New Directions* program was announced for British Columbia's health care system. The principles of the new health policy include 'greater public participation and responsibility.' 'bringing health closer to home' and 'effective management of the new health system' (Ministry of Health & Ministry Responsible for Seniors, 1993).

In summary the purpose and emphasis of social policy has changed over time. Initially the goals were to provide standard programs to all Canadians alike through strong

---

[1] now known as the Ministry of Social Services
[2] now known as the Ministry of Health - Alcohol and Drug programs

government bureaucracies. When the growing demand for social programs created a costly tax burden and caused a strain on government budgets, the government turned to the private sector as a cost efficient alternative. The shift from centralized government services to community based services was based on political and economic decisions. The question should be asked how does this shift affect the quality of human services provided to people in need. In order to address this we must first consider "What is quality service delivery in community based agencies?"

Social Policy's Implications on the Definitions of Quality

As the centralized welfare state continues to be dismantled, a largely unplanned, uncoordinated and compartmentalized delivery system has resulted. A benefit of privatization, which has led to decentralization, is the opportunity it affords communities to develop local services. The drawback, however, is that the arms-length relationship with government has decreased universality and led to widely disparate levels of service. Korbin (1993a) noted in her study of the non-profit sector that different rules, policies and management requirements have developed depending on the individual Ministry contracting, and the region of the province. Government's response to these disparities has been to tighten the arm's-length relationship.

Government's own experience with accountability was through the imposition of guidelines and policies that could be monitored through their vertical hierarchies[3]. These

---

[3] Vertical and horizontal patterns of interaction are a conceptual tool for understanding community structural and functional relations. Vertical linkages occur when local community organizations and institutions are linked directly to social units outside of the community, and horizontal linkages occur when locally based community groups or organizations are linked to one another (Warren, 1972; Williams, 1983).

public sector mechanisms were then simply transposed onto the non-profit sector through stipulations in the contract. Pfeffer & Coote (1991) referred to this as a transfer from the principles of 'control by ownership,' as is the case in the vertically integrated, bureaucratically-controlled public sector to 'control by contracts' (p. 11). In order to answer my main question of "What is quality in a community based agency" this study will address the sub-question of whether accountability constitutes quality in community based agencies.

There are incongruities between the aims of privatization, which are to have more community responsive services with less government intervention, and the imposition of government standards and protocols in order to prove accountability. I am not against accountability, in fact I am very much in favor of it. However, it could be well argued that accountability measures should be meaningful in relation to the services being provided. There is an inherent incompatibility when social policy initiatives are promoting horizontal integration within the community and accountability measures are based on a strong vertical hierarchy through which the 'experts' tell the community how and what to provide. Although there has been a shift in the thrust of social policy, the measures used to assess the quality of the services have remained the same, thus creating a mismatch. What is being measured and the way it is being measured are incongruous.

There is no doubt that quality, or at least quality assurance, is expected throughout human services. Judge Gove (1995) in his recent investigation into child protection in B.C., alluded to the difficulty of providing quality assurances in child welfare (delivered through the public sector), because of the dependence on professional judgments. However in his

brief discussion of contracted services he comments on how quality is virtually ignored in the non-profit sector.

> *Because the Ministry has no effective way to monitor the quality of services delivered by contracted agencies and individuals, contracting agencies are largely left to their own devices to ensure that their employees practice competently. They often have no financial resources and little bargaining power to provide any sort of quality assurance program. (p. 101)*

While Gove (1995) indicates there are few resources to provide quality assurance programs, he says that mechanisms to measure performance and outcomes could be developed. Whether performance and outcome measures are in fact a measure of quality in the non-profit sector will be addressed in this research. However Judge Gove (1995) does legitimize the need to understand quality in human services.

The Practice Component of Quality

Social workers were divided in their response to the devolution of services into the community. Some saw it as an undermining of government's responsibility for the nation's social ills and an attack on the principles of universality and equity. Others saw an opportunity to develop meaningful services that were responsive to community needs and open to community input. Regardless of the point of view taken there is general agreement that privatization is largely an outcome of political and economic forces and that the ideals of social work were on the whole disregarded[4]. When quality in the human services gets reduced to 'hard' scientific and quantitative measures, such as unit costs, outcome measures and implementation of standards, the challenge for social workers is how to maintain their

---

[4] The exception to this was the group of people who were responsible for the transformation of social services in B.C. between 1972 and 1975, who including the Minister, all had social service backgrounds (Clague et al. 1984, p. 31).

professional integrity. This means ensuring that the values of egalitarianism, self-determination, participatory democracy and humanism, as well as the ideals of flexibility, pluralism and responsiveness have a place in the practice of community based services (Mullaly, 1993, p. 43).

In order to address the issue of quality in community based agencies from a social work perspective it was important to understand the perspective of practice. I thought the best way to find out what people on the 'front line' think was to go back to the communities I knew best: the small, northern communities in B.C. In fact, they provided an ideal social context in which to study community based agencies. Firstly they are understudied. Much of the literature is based on the experiences of rural America and was undertaken in the 1970s and 80s. Although there are some notable authors[5] who write about social work in Canada's remote communities, their discussions are mostly based on the rural aspects of small communities. The reality is that, in B.C., many small communities are based on a resource economy and people residing there would not think of themselves as living in Webster's definition of 'rural' which is the "rustic countryside." Secondly, small communities have been identified as lacking in good quality services. People living in smaller communities face increased health risks, fewer health care resources per capita, and have a lower life expectancy than people living in metropolitan centres (Hoekstra, 1996; Ministry of Health and Ministry Responsible for Seniors: The Policy Framework on the Health of Children and Youth, 1995; British Columbia Royal Commission on Health Care and Costs, 1991, p. b58).

---

[5] For more information on Canadian rural social work consult Jane Abramson, 1979a & 1979b; Ken Collier, 1984; Karen Ingebrigtson, 1992; Sharon McKay, 1987; Kenneth Millar, 1977; Brian Wharf, 1985; Barbara Whittington, 1985; Kim Zapf, 1985.

Thirdly, there is an identifiable sense of community in the less populated areas which should provide the parameters for understanding community based agencies.

Conclusion

As we move towards the 21st century the rapid changes that are occurring in family and work are going to place increasing demands on the field of personal and community services. Contracting out, as the most popular method of privatizing human services seemingly provides an ideal method for service delivery in small communities. The public sector provides the financing and services can be delivered in a flexible way, while retaining community oversight and involvement. However the goals of privatization are not based on the humanistic principles of social work. The thrust of privatization is based primarily on political and economic motives.

Along with the concern to ensure cost-efficiencies and to reduce the size of government there is a growing demand for quality assurances in the delivery of services. Paul Ramsey, when he was the B.C. Minister of Health, noted the commitment to quality in his comments in the Minister's Foreword to the 1994 Core Services report. Here he reassured "all British Columbians that under no circumstances will the quality of their health services diminish" (Ministry of Health & Ministry Responsible for Seniors, 1994). But the traditional definitions of quality, based on accountability through centralized bureaucracies are inconsistent with the community based models of service delivery. The emphasis on top-down, expert decision making leaves the community without any input. Social workers providing service in the small communities want to provide quality human services, congruent with their professional ideals. However, like the communities where they work,

they are rarely consulted about the definitions of quality. If privatization has anything to do with "greater public participation," and bringing services "closer to home" as Ramsey announced, then the voices of the community, the voices of the service providers and the social workers, as well as the voice of the politician must be heard in the discussion of " What is quality in a community based service?"

This research aims to tie social policy and the practice of providing human services together in order to understand quality service delivery in small communities. The next chapter will summarize the privatization movement in Canada, and in particular B.C. including one example of a small community in northern B.C. Chapter Three will consider the concept of quality in human services. How quality is defined will be examined in relation to the changing priorities of service delivery. An argument will be made that decentralization assists quality service delivery in some ways but detracts from it in others. Subsequent chapters will describe the research process as well as discuss the findings. The dynamics of small, northern communities will be used to illustrate the complexities of providing community based services. Concluding remarks will include an examination of how the vertical hierarchies affect horizontal community integration as well as how policy issues affect practice issues in the pursuit of quality in small community, human service agencies.

Chapter Two

The Development of Privatization

The History of Human Services in Canada

Delivering human services through the voluntary, non-profit sector has its roots in Canada's colonial inheritance. When the British North America Act was developed in 1867, welfare in Canada was primarily a matter for the individual, the family, and the church; the state's role was largely confined to rudimentary poor relief administered at the municipal level (Banting, 1987, p. 47). "Up until the [First World] War the only type of public assistance available was that provided on an emergency basis by municipalities or by private charities" (Guest, 1980, p. 36).

The effects of industrialization on the provision of social welfare were profound. As people moved away from the rural environment into cities to find work, many of the existing structures (such as the church and the family) that had previously provided some aid were either unavailable or unable to meet the demand for assistance. Similarly, municipal and provincial governments had insufficient resources to respond to the scope of emerging welfare demands and the federal government came under increasing pressure to be involved (Rekart, 1993, p. 8). The emphasis of social intervention was shifting from an individual problem to a "stress on the well-being of the group and the wider interests of the community as a whole" (Wallace, 1995, p. 18).

The depression in the 1930s was a significant force for change in the development of Canadian social programs. The interdependence of citizens in an industrial society was recognized as the costs of unemployment relief were increasingly assumed by the federal

government. World War II sped up the urbanization process and the federal government accepted that social services "were a vital element in the smooth functioning of the war economy" (Guest, 1980, p. 105). A comprehensive social security system for Canada was initiated. The blueprint for Canada's 'safety net' was outlined in the 1943 Marsh Report which proposed "a set of measures to guarantee all Canadians a social minimum: a concrete standard of living below which no one would be allowed to fall" (Pollak, 1994, p. 17). During the next two decades an array of income supplement programs were developed. The federal government became involved indirectly in the areas of social assistance and social services through the redirection of funding using the mechanisms of the Canada Assistance Plan (CAP)[6], and the Established Program Financing (EPF)[7]. The development of personal and community services were cost shared using the CAP funding arrangment (Armitage, 1988, p.211). The expanding role of the federal government in social programs was aimed at providing a full employment economy as well as providing entitlements to income and social supports in the event of illness, old age or unemployment. The programs were driven by a sense of societal responsibility for meeting social needs and a strong allegiance to the needs of the whole nation (Rekart, 1993, p.12). This remained the prevailing ideology until the mid 1970s.

The mid 1970s saw the end of the post-war economic boom. Canada was not immune to the onset of monetarism, and like other industrial nations was adversely affected by the worldwide recession (Drover, 1984; Lightman, Freiler and Gandy, 1990). Ottawa

---

[6] CAP created in 1966 pays 50% of the cost of provincial expenses in the areas of social assistance and welfare services.

[7] EPF created in 1977 is a block funding method based on demographic and economic indicators.

became preoccupied with inflation and deficit reduction. Social welfare expenditures were frequently identified as a financial burden, items of unproductive expense, and incongruent with the government's goal of economic growth and self reliance (Armitage, 1988, p. 21). This view has remained pervasive even though Canada is a modest welfare spender[8]. Believing that social spending was out of control and in need of reduction, governments in Canada, and indeed worldwide, shifted to the political right, and turned to neo-conservative policies to shrink excessive government intervention. However in Canada, the dismantling of the welfare state has been gradual[9] which Lightman, Frieler, and Gandy (1990) attribute to the complicated federal/provincial distribution of power. Ottawa controls the fiscal and financial tools, whereas the provinces are responsible for the direct services. Privatization and decentralization of services were considered alternatives to the publicly provided services of the welfare state. Ismael and Vaillancourt (1988) conclude in their review of privatization in the 1980s, that six of the provinces had made "explicit commitments to the process of privatization" (p. 219).

In February 1995, Mr. Paul Martin, the federal Minister of Finance, announced that in April 1996 CAP was to be terminated and the Canada Health and Social Transfer (CHST) would be implemented. The CHST was to consist of a "single block fund for federal transfers to the provinces for health, post-secondary education, social assistance and welfare services" (Pulkingham & Ternowetsky, 1996, p. 9). The Caledon Institute of Social Policy

---

[8] While Canada spends a higher percentage of its Gross Domestic Product on social security than the U.S., it is considerably lower than many other developed countries (McQuaig, 1993, p. 16).

[9] Canada has not experienced the massive widespread cuts or the active dismantling of the welfare state apparatus that occured during the Thatcher regime in the United Kingdom. Nor has privatization been centre stage for health delivery as it is in the United States

predicts that this change means that "federal cash transfers to all the provinces and territories will disappear by around 2009-10" (Vaillancourt, 1996, p. 86). As the federal government squeezes the provinces a number of social service programs including child care, child welfare, homemaker, attendant and respite services, and counseling will be at risk (Torjman, 1995).

Provinces may respond in a variety of ways to this projected decrease in funding. Inaction, even in the face of new and emerging needs, may occur, but more likely, the current trends of contracting out and off-loading of responsibilities to voluntary non-profit agencies will continue. As a result the non-profit sector will assume an increasing importance in the provision of personal and community services.

Privatization of Human Services in B.C.

In the 1970s, British Columbia (B.C.) represented Canada's most comprehensive, and conspicuous privatization effort in which every available mechanism was used to reduce government involvement in the economy (Ismael, 1988, p. 220). In 1972, the New Democratic Party (NDP) had taken office with a clear mandate for changing the system of social service delivery in British Columbia (Clague et al., 1984, p. 29). Although there were few precedents for a major reorganization, and certainly no master plan, decentralization, integration and community participation were accepted cornerstones of the NDP's new approach to social service delivery. The thrust of the changes between 1972 and 1975 came from the social service community. Those directly involved, volunteers, professionals, consumers, and community activists, recognized a need for reform; and those responsible for developing a framework and implementing the change had social service backgrounds. In

addition, the professional association of Social Workers (The British Columbia Association of Social Workers), advocated reforms (Clague et al., 1984).

The social democratic NDP government began the privatization process in B.C. Their philosophy was to increase citizen participation and reduce inequities in the service delivery system. No mention was made of economic goals or spending cutbacks. The process was intended to increase community control and equalize rural and urban differences by breaking up large government monopolies (Callahan & McNiven, 1988, p. 16).

The mechanism that allowed for privatization was Community Grant Funding which was allocated to community organizations, often non-profit societies, in order to provide a wide range of human services. The services contracted for were usually non-statutory, preventive, or remedial and included child care workers, parenting programs and outpatient counselling services. During the three year period between 1972 and 1975 the Ministry of Human Resources budget more than doubled (from $148.5 million to $367.4 million) while the Community Grant funding program increased 38 times from $242,678 to $9.3 million (Rekart, 1993, p. 52). Many agencies in existence today can trace their origins to the Community Grants Programs.

In addition to the above funding mechanisms, organizational structures called Community Resource Boards (CRBs) were formed to engage in a whole range of activities. By the end of 1975 there were sixty boards in existence, or in the process of formation throughout the province. A third thrust was the development of five prototype Community Human Resources and Health Centres (CHRHCs). Services provided in these centres included public health and mental health services, primary medical care by physicians

engaged on contract, and the statutory and non-statutory services of the Department of Human Resources (now the Ministry of Social Services). The centres had discretion to add other services as feasible. Local planning, while still functioning within the general standards set out by the province was a cornerstone of their restructuring (Clague et al., 1985, p. 129).

On December 11, 1975 the NDP government was defeated, and the Social Credit party was elected. This represented a new era in governance, and a different rationale in service delivery. Social Credit had actively campaigned to rescind the Community Resource Boards Act and abolish the CRBs. The CHRHCs which had just started to provide services, and had yet to develop strong links with the community and health system, were given a short reprieve in order to evaluate the functions and effectiveness of the centres (Clague et al., 1984, p. 143). The only long term legacy of community ownership was the community grant mechanism, although the motive for it had changed with the new government. Service delivery was now being directed away from government ownership and into the private sector, in order to reduce the size, and cost, of the public sector.

By the mid 1980s, the perceived need to downscale the government's role in social services had become a shaping force in British Columbia's politics. Economic goals, in terms of social spending reduction, were now a central plank in the Social Credit's offloading. "Unlike the federal government and most other provincial governments, which did not relish an overt attack on the welfare state" (Moscovitch, 1986, cited in Rekart, 1993), the Social Credit government of British Columbia in 1983 "endorsed that attack and provoked a major confrontation with labour and social movements opposed to its neo-conservative agenda"

(Rekart, 1993, p. 15). The social credit government adopted the rhetoric of the New Right, slashed spending on social services and reduced the number of public service employees. Services such as the Family Support Workers, and Child Abuse Team were eliminated. Other services such as transition homes for battered women, group homes and special services for disabled children were shifted to the private sector in order save money (Rekart, 1988, p. 9).

In late 1991, the government once again changed. By this time, the non-profit sector had assumed an increasingly important and integral role in service delivery. Community based agencies operating under local boards of directors provide a range of personal and community services. The emphasis on community empowerment and public participation has once again come to the forefront of B.C.s politics as the new NDP administration is restructuring services under locally elected and appointed citizen boards.

Privatization and Non-profits in Northern B.C.

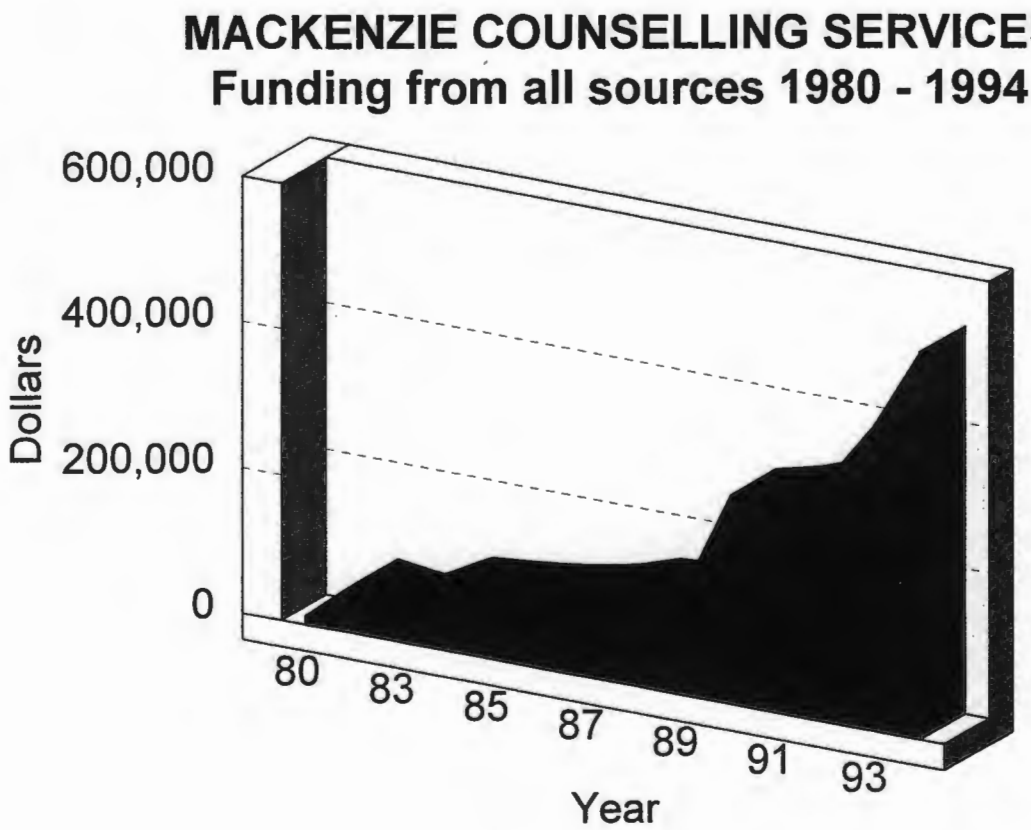
In B.C., contracting-out to non-profit organizations[10] has become the privatized, decentralized model of choice. Despite the cutbacks in government services and the federal reductions in transfer payments, government funding of non-profit service agencies has risen over the last 15 years. In Rekart's (1993) study of 133 B.C. agencies, she found that 70% of the revenues were from provincial sources. Mackenzie, a resource based, forest community of 5000 people, located 200 km north of Prince George provides an example of how

---

[10] There is evidence that the for-profit sector is assuming an increasing role in the provision of human services, and governments are beginning to contract directly with private entrepeneurs. The profit motive in these organizations raises questions about concepts such as accessibility, equity, and universality (Azim, 1987, p. 44) and the appropriateness of developing a two tiered system for social health. It is an area that requires further research and attention in the changing social service delivery system.

contracting-out has provided for increased funding and increased services. Eighty percent of their funding in the 1993/4 year came from provincial government sources. Services were provided in the areas of family support programs, community based mental health, alcohol

GRAPH 1



and drug prevention programs and others. Graph 1 shows the substantial increase of funding in that community agency since funding was reallocated from the public to the private sector (Mackenzie Counselling Services, 1995). It is noteworthy that these services previously had not been provided in the community at all. These figures represent an increase in funding, and therefore services, for the community; not just a shifting of funds within the community.

Human services aimed at social well-being are increasingly being provided in local structures in small, northern communities. In 1994 the majority of health dollars in the Northern Interior Health Area (which is the area surrounding Prince George) was delivered through community contracts. Over 92% of the $85 million allocated for health care was delivered by non profit societies (Ministry of Health & Ministry Responsible for Seniors: Funding data, 1995). They are funded by the public sector and held accountable to government through the contract mechanism.

Conclusion

The worldwide response to increasing deficits and increasing costs of social and health programs has been to downsize government and devolve responsibility to the community. This trend continues in Canada as B.C. (along with Saskatchewan, Manitoba and Nova Scotia) is completely devolving a wide range of health services to community and regional boards (Hurley, Lomas, & Bhatia, 1994). In B.C., which has been at the forefront of privatization in Canada for three decades, and has been referred to as Canada's "privatization laboratory" (Lightman et al., 1990), devolution is continuing to occur through the New Directions initiatives in the Ministry of Health. Small communities in northern B.C., it would seem, so far, have been positively impacted by these changes, and experienced an overall increase in the provision of locally based personal and community services.

The devolution of services into the community is the result of a change in political ideology. The focus of social programs has shifted from a nation-building strategy which held all of society responsible for the nation's ills, to a fragmented system that is returning to a philosophy that the family and community must take responsibility for their own. A

parallel shift has occurred in government's role. The strong central government with its vertically linked hierarchy and rigid rules for the delivery of social policy, is now considered too expensive, too meddlesome and too bureaucratic. Instead the horizontal alliances and linkages within communities are considered better able to respond to the social and health problems of the community members.

These political and economic decisions impact all the way to the front lines of service delivery. Carniol (1990) notes how the vested interests and priorities of the political party in power impacts, at least partially, on the quality of social work provided in an agency or organization (p. 73). Little attention has been paid to how the changes occurring in social policy affect not only the quality, but also the definitions of quality in human services. The next chapter will show how the changes in social policy have impacted on the definitions of quality. As service delivery moved from a centralized model to incorporate the business world's model of economic efficiency, i.e. privatization, so too have the definitions of quality. The question of how well the corporate models of quality can be transferred to human services will be considered.

Chapter Three

Quality in Human Services

Introduction

Privatization has shifted the focus of social programs away from a "concern with the issue of providing assistance to the needy, to a concern with the issues of public expense" (Ismael, 1987). While governments are increasingly under pressure to contain the costs of the welfare state, they must remain conscious of the public impetus for greater accountability in the provision of services (Gelman, 1983; Osborne, 1992; Perez, 1991). Although there is a plethora of literature on things like quality control,[11] quality assurance,[12] and program evaluation,[13] little attention is given to understanding what quality is, in order to control it, assure it, or evaluate it.

The development of the concept of 'quality' is associated with the evolution of the post-World War II assembly line production of consumer durables in the private sector. Increased competition among manufacturers, the globalization of production and the increasing wealth and sophistication of purchasers meant the market had to respond quickly and effectively to consumer preferences (Alaszewski & Manthorpe, 1993). Thus the idea that quality is connected with the idea of 'value for money' has emerged. A 'quality' product is superior to others, and likely more expensive (Pfeffer & Coote, 1991). However this

---

[11] "Quality control is a process of maintaining day to day quality of a service; it is intended to weed out non-conforming products, and necessarily takes place after the service has been produced and before it is used" (Alaszewski & Manthorpe, 1993; Walsh, 1991, p. 505).

[12] "Quality assurance involves both the assessment and regulation of service delivery in order to satisfy accepted standards of practice developed by service providers and professional organizations" (Green, 1984, p. 567). The implication is an optimal program for all concerned parties.

[13] Program evaluations "concentrate on providing information to stakeholders regarding the success or failure of a program" (Green, 1984, p. 567).

approach has little relevance to the delivery of services. Human services, in Canada, are usually provided free of charge[14].

Quality in the human services cannot be tied simply to the material aspect of owning or being able to purchase a good or service. As service delivery changes with political ideology, so too do the ideals of quality. When the welfare state emerged, quality was related to the concepts of universality and a social minimum. Did the programs provide equal opportunity for all Canadians to access them? Did they help redistribute the economic effects of industrialization? As privatization emerged during the NDP tenure in the early 1970s quality would have been conceptualized in terms of community needs and integration. The more conservative governments that followed emphasized cost as the predominant indicator of quality. However, in community based services there are a variety of stakeholders and tensions. The question of who defines quality is more complex. Should the person who receives the service, or the person who pays for the service (i.e. the government) define quality? In the corporate, private sector model the philosophy is that the consumer will demand quality at a reasonable cost. This assumption is based on the notion of the consumer as a shopper. But consumers can only buy what is available. When human services are privatized, the range of producers (a prerequisite for competition) are not necessarily increased. Therefore, human services can not be defined only in terms of economic or business criteria.

---

[14] As universal programs are dismantled, and a two tiered system of care begins to emerge, there may be increasing perceptions of the value of this approach to quality. There is often a perception that the private practioner provides a higher quality services.

Ultimately, quality is a complex concept and it is influenced by the values and objectives of a variety of interests (Gaster, 1991; Pfeffer & Coote, 1991). Wilding (1994) in his article on managing Quality in the Human Services in Britain set out four key elements of quality. These are: accessibility, acceptability, effectiveness and openness. These elements provide a different perspective on quality than economic or business viewpoints that focus on competition.

The remainder of this chapter will consider a variety of approaches to the idea of quality. Initially the cost benefit, or economic approach will be reviewed. Secondly, the corporate influence on the management of services and the emphasis on economic efficiency will be explored. Thirdly, the literature will be examined in relation to consumer satisfaction. And in the conclusion, Wilding's approach to quality will be considered.

The Service Provided: Is there a satisfactory product?

Various criteria have been used to ensure that a quality product or service is provided. Not surprisingly, one criteria is economic: quality is considered achieved if the cost of providing a unit of service meets a pre-agreed upon figure. This is usually referred to as a unit-cost. But dependence on unit-costs can run the risk that services will deteriorate in order to keep the cost down. In order to ensure a minimal, acceptable level for services or products, standards by which the product or service can be assessed, are implemented. However, in human services it is possible that a service may meet a standard without actually benefiting the consumer or providing any change. Attention is then turned to the notion of 'outcomes'. Does it do what it is intended to do? Does it bring about change? These

different views (unit costs, standards, and outcomes) focus on the product, or service that is provided and will be discussed in more depth separately.

Unit Costs

Even though human services are service driven, and individual rather than product driven using assembly line technology, the maximum service for the least cost has been a primary indicator of quality. This cost-benefit analysis is based on an economic concept of investment. All costs and benefits of a given course of action are identified in order to assess which course of action is likely to be the most productive (Brawley & Martinez-Brawley, 1988). However, as Brawley & Martinez-Brawley (1988) point out the difficulties of doing this in the human services are enormous. "Deciding what costs and benefits to include and assigning monetary values to all of them is much easier in theory than in practice" (p. 403).

Related to the cost-benefit argument of efficiency is the service volume or unit cost approach. The major focus is on tying compensation to the delivery of units of service (Kettner & Martin, 1993). What this means is that an organization will agree to provide a certain number of hours of service, or see a required number of cases in order to receive remuneration. In Kettner & Martin's (1993) study on performance contracting in the human services in the U.S., they found that provided there were clear performance expectations (as expressed by valid output and outcome measures), and the agency stressed funding and fiscal considerations over other contract decision factors performance contracting was positive. On the other hand they recognized that when programs shift toward more complex, long-range or holistic goals, using outcome measures as a contracting requirement had limited success. The emphasis on unit cost analysis in the United States seems to be gaining importance as

they move towards a managed health care model (McFarland, Smith, Bigelow, and Mofidi 1995). However, the unit-cost approach to quality remains a primarily economic argument and I found no Canadian literature on the benefits of unit-costs in the human services.

Standards & Accreditation

Standards provide for a set of guidelines, or measures, set by professionals which get interpreted as a minimum, satisfactory level for the delivery of service. This is sometimes referred to as the scientific or excellence approach to quality. This method is driven by the expert or professional who prescribes levels or standards of acceptability (Pfeffer & Coote, 1991). Accreditation can occur through an external inspection in which an independent body applies objective standards to an agency's process or through a professional peer review system (Alaszewski & Manthorpe, 1993).

Accreditation processes, in Canada, are now including the notion of quality. The Canadian Council on Health Facilities Accreditation (CCHFA) in 1983, introduced quality of service as an essential element in hospital accreditation, and in 1989 it was extended to Mental Health Centres (Perez, 1991). In B.C., Alcohol and Drug Programs of the Ministry of Health initiated a pilot accreditation project of six agencies in 1993, which has subsequently been extended. Mental Health Services initiated their pilot project in 1995. These programs are quite new and time will tell how this process impacts on the ability to provide quality service delivery. There is very little literature on the accreditation of human service agencies even though accreditation is well established in hospitals and in education (Nichols & Schilit, 1992).

National accreditation and setting of standards is consistent with the welfare state model of service delivery. In order to ensure the notion of universality (consistent and equitable services, accessible to all persons), performance standards are required so that minimal acceptable levels of services are maintained (Azim, 1987, p. 7). The social legislation developed in the 1940s was based on having 'experts' plan for the general social betterment of the country (Irving, 1995). There is a risk in privatization that as the role of government decreases the standards that their bureaucracies monitored, may not be maintained. Quality of care in services such as foster home and group homes which are provided under service contract agreements have already come under question (Azim, 1987, p. 43). And in Trolley's (1993) review of Mental Health services in the northern region he noted that few small community agencies have developed their own written clinical standards and guidelines (p. IX).

A paradox occurs in the implementation of standards in community based organizations. As concerns are raised, and policies and guidelines are imposed on grassroot's, community based agencies, the organizations must, out of necessity, shift into more formal arrangements. As formalization and professionalization occur, local citizens who initially developed the services are left out of the decision making (Rekart, 1995). And in due course, Smith and Lipsky (1993) suggest the norms of the organization will shift to government priorities. The dilemma is: How to monitor for universal standards and still allow for community responsibility? A further question is: Do universal standards promote quality service delivery? As noted in Coulton's (1982) review of health care quality assurance programs, there is a general feeling that "many programs that meet the structural

standards do not produce services of adequate quantity and quality ... thus appropriate inputs [or standards] should be viewed as a necessary but not sufficient condition for services to be of acceptable quality" (p. 399).

Outcomes

As has been suggested it is possible that a product or service meets standards and yet may not be acceptable. Another issue is that with the rapidly changing pace of technology and knowledge, products and services quickly become out of date if the standards do not change. So the idea of 'fitness for purpose', or that the product or service is fit for what it is intended (Walsh, 1991, p. 504) has some appeal. The underpinning of this view of quality is that organizations exist to achieve desired ends (D'aunno, 1992, p. 344). In order to meet the desirable objectives the organization has to set program goals or outcomes, which then become the criteria for evaluation.

In order to evaluate outcomes, program goals must be defined in measurable and quantifiable ways. Brawley & Martinez-Brawley (1993) suggest that the preoccupation with outcomes is problematic, especially when defined exclusively in terms of program goals. They suggest that often modest programs are aimed at highly ambitious goals. An example, provided by Brawley & Martinez-Brawley (1993), is of a volunteer Big Brother/Big Sister program that includes a reduction in juvenile delinquency among its goals. While a program such as Big Brothers/Big Sisters may have some impact on juvenile crime, evaluating it in those terms would be absurd. Another problem is raised by Coulton (1982) who suggests that outcomes in human services may be attributed to many factors, besides the adequacy of the service. Because of this complexity, outcome research when it takes place at all, is often

flawed and conclusions about the effectiveness of services can not be credibly established (Epstein, 1992, p. 158).

The emphasis on outcomes has tended to be accompanied by a reduction in social work functions; tasks are routinized and broken into discrete parts. In extreme cases, clients become merely a form of input in the production process, similar to any other form of raw materials or machinery, so that an analogy to the assembly line would be apropos (Patry, 1980, cited in Brawley and Martinez-Brawley, 1988). This process severely curtails worker discretion. The splitting of work tasks into small bits and pieces separates the 'thinking parts' of the job from the 'doing parts' which reduces the range of judgment exercised by the front line workers (Tudiver, 1979, cited in Carniol, 1990). Thus a paradox occurs. Outcomes may be a measure of quality; but if the system becomes too bureaucratized in the attempt to gain those outcomes, quality suffers as workers lose their autonomy to make humane, holistic, and professional decisions in their interactions with clients.

Focusing on the product alone is not a sufficient enough criteria for quality service delivery to occur. Kagan (1984) in his study of organizational change in psychiatric settings also found that it was not enough for agencies to simply comply with requirements and standards, staff had to be committed and dedicated to the notion of quality in order for quality services to be provided. Similarly, Arches (1991) noted that the emphasis on outcomes, which necessitates compartmentalization of work into narrowly defined tasks, eliminates the ability of social workers to provide professional judgments in their aim for overall quality output. An alternative approach to quality is to shift the focus from the quality of the product

to the ability of the organization to produce quality goods and services (Osborne, 1992, p. 441).

The Organization that Provides the Service: Is there a satisfied customer?

As governments felt the pressure to reduce the costs of the welfare state they could not simply cut services. Any obvious reduction of services creates a hostile response from voters (as we have seen in the recent public sector strikes in Ontario following Mike Harris's budget), and so restructuring is preferable. In order to meet the objective of cost efficiencies, while still promoting effective delivery of human services, the ideas for privatization were drawn heavily from the corporate world (Alaszewski & Manthorpe, 1993; Carniol, 1990).

Quality through managerial effectiveness has emerged in the business world as a driving force. The philosophy of this approach is that in order to provide customer satisfaction a closer relationship between the consumer and the provider of a product or service must be formed (Pfeffer & Coote, 1991). Through smaller, more flexible organizational units which are horizontally managed, companies can identify and be responsive to the changing and diverse needs of individuals. Delivering human services through the locally based, community organizations have the potential, according to this business philosophy of 'quality,' of providing both quality management that provides for consumer satisfaction and economic efficiencies. However, this needs closer inspection. In order to consider how organizational structures and quality service delivery intersect, the remainder of this section will consider two common views of quality: Quality Management and Economic Efficiency.

Quality Management

Mission statements, guiding philosophies and a clear statement of values are, according to the 'management by excellence' approach, essential to quality service. The Total Quality Management (TQM) philosophy which was made popular by Deming in Japan's auto industry asserts that the whole organization is responsible for the quality output (Martin, 1993; Pfeffer & Coote, 1991). In order for an organization to provide quality services or goods a commitment to quality has to occur from the front-line staff level, to managers and all the way up the administrative hierarchy to the politicians. TQM emphasizes that the quality of program products and services, encourages the involvement of consumers in program decision making, and empowers employees through cooperation and team building. Lawrence Martin (1993) in his discourse on the appropriateness of TQM philosophy in the human services concludes that there appears to be "a basic compatibility ... between the human services, and social work in particular, and TQM as a philosophy of management" (p. 13).

Decentralization of human services from large bureaucracies to small agencies provides an opportunity for quality management, which according to this managerial approach leads to quality service. But does the existing model of privatization really allow for quality management according the TQM philosophy? We need to look a little closer.

The privatization model of contracting-out is supposedly an ideal method of delivering services: the public sector provides the financing and services are delivered by the community in order to meet local needs. But who makes the decisions? Kettner & Martin (1993) in their study of privatization and contracting of human services found that decision

making was dominated by funding and fiscal considerations. Funding will only continue if the agency's activities match the government priorities. Personal and community services that are provided through the private sector, may be decentralized but are controlled, through the contracting out process, by the centralized authority. (Wharf, 1985; Rekart 1993, p 128; Rekart, 1995).

This has been shown to be the experience in other countries as well. For example in Britain, in the 1980s, there was an increase in decentralized, community oriented services due to the same fiscal and ideological pressures experienced in Canada. However Hadley (1993) observed that the key features of the centralist system of administration remained intact, and that "the power of the national government to control public service at all levels was probably greater today than at any time since the end of World War II" (p. 43). Similar conclusions have been drawn in the United States. In Hardina's (1990) study of 53 social welfare organizations in Chicago she found a link between the acceptance of government funding and the ability to have local autonomy. She concluded that government funded organizations are less likely to encourage self-help advocacy efforts, that citizen participation was less likely to be fostered, and that client eligibility was based on income rather than need (p. 44).

It would seem that privatization has not met its goal of reduced government intervention. What is troublesome is that the devolution to small, horizontally integrated organizations is a mirage, the decision making is still very much tied to the vertical bureaucracy. The belief that the public sector has bought into from the corporate world is that the management practices of the private sector are superior to those of the public sector.

However, Wilding (1990) cautions that although private sector management is worth considering it is not a universal panacea. But, one could argue, the government's primary concern has not been quality management but economic efficiency.

Economic Efficiency

The economic argument for privatization is that the large public sector is a costly tax burden. The private sector, if given a larger role, would increase competition and lead to greater efficiency in the public sector (Walker in Rekart, 1993; Azim, 1987). This is based on the assumption that the free market is more efficient. Wilding (1990) in his critique of privatization in Britain contests this and argues that there is no systematic evidence which demonstrates that the private provision of health care is more efficient. Closer to home we only need to inspect the U.S. models, which rely heavily on the commercial sector, to dissolve the illusion of economic efficiency. It is commonly known that the U.S. system is inequitable in terms of results; what is less well understood is that their "administrative costs are five times higher ... than in Canada" (McQuaig, 1993, p. 157). It is important to note that British Columbia manages its health-care system for more than 3 million residents with a relatively lean staff of 435 provincial civil servants. In contrasts the private insurer, Blue Cross/Blue Shield of Massachusetts, which provides coverage for 2.7 million subscribers, employs 6,682 workers - 15 times as many as B.C. (McQuaig, 1993, p.157).

There are costs associated with providing quality services for both the private and the public sector. If minimum standards are required, and accreditation procedures are undertaken, then the service will cost more. As Segal and Hwang (1994) point out a "licensed facility always costs more" (p. 130). Brawley & Martinez-Brawley (1988) note the

cost not only in financial terms, but also comment on the wear and tear experienced by personnel in carrying out procedures designed to demonstrate accountability. Currently, the accreditation procedures that have been undertaken by non-profit organizations in northern B.C. have been paid for by the sponsoring Ministry. However, not every Ministry is undertaking that responsibility, and at this time it is entirely a voluntary procedure. As long as the requirement is voluntary and the costs are not included in the contract arrangements, services will be inconsistent between communities. Nichols and Schilit (1992) noted the voluntary nature of accreditation as both an asset and a liability. While a voluntary system supports self-regulation, it makes the social control function selective and weak as accreditation has no impact on those agencies which do not participate in the process.

Human service programs are labour intensive and wages consume a large share of their budgets. Privatization, as an economic restraint method, hypothetically does not mean wage reductions. But there have been strong and entirely reasonable suspicions that privatization will undermine union gains in wages (Starr, 1989, p. 43). However, as governments increase their regulatory role in the non-profit sector, increased professionalization occurs. As agencies are required to have competent staff who are well trained, and are provided with continuing education in their respective fields, the costs of labour will rise.

The corporate sector influenced the human service delivery by introducing the concepts of quality management and economic efficiencies. However providing quality human services is not like producing a product for consumption. Efficiency is not achieved by cutting costs, cost containment or lowering quality. In Moore's (1995) study of social

work practice and administration he notes that cutting the budgets of effective programs can lead to a decrease in efficiency if such cuts lead to a reduction in program outcomes" (p. 603). Pruger & Miller (1991) also warn against simple budget cutting because "if cost reduction is accompanied by disproportionately large reductions in the quality or quantity of the results, *in*efficiency increases" (p13). Overall there are few economic efficiencies realized by the privatization of human services, unless one is willing to forsake outcomes or quality. There may even be an argument that there is an increased cost by having many small structures in all the remote communities.

The Perception of the Consumer: Is the customer empowered?

So far in this chapter on quality we have considered how quality in the human services may be thought of in terms of the service provided, and through the organization that delivers it. The focus of government has been on the product, or service provided, in terms of ensuring that minimum standards are met and that the cost per unit of service is maintained. The corporate sector, which provides economic efficiencies through the application of quality management techniques, offered an alternative way of considering quality services. However it was shown that the centralized decision making was still prevalent and that the ideal of economic efficiencies does not work the same way in the public sector as it does in the free market of consumer purchases. As services continue to be privatized quality has to be viewed from a broader perspective which takes into account consumer empowerment and the social work ideals of public participation and community responsibility.

According to Guest (1980) the comprehensive, national coverage of social security was intended to contribute to a sense of community solidarity by virtue of its universality. But the welfare state has been criticized for failing to effectively address the diverse needs and interests of individuals and groups, for undermining people's self-determination and for its inability to allow people to have input into decisions effecting their own lives (Roeher Institute, 1993; Vaillancourt, 1996). Privatization of human services, particularly when administered by social democratic governments, was supposed to strengthen the community focus and be more responsive to individual circumstances and needs. By having locally controlled community structures, members of the community could feel ownership and give input into the delivery of services.

Clague et al.'s (1984) review of the Community Resource Boards (CRBs) and the Community Human Resources and Health Centres (CHRCHCs) which were developed in the 1970s by the NDP government of the time, provides the best account of how the social democratic goals of increasing community control and equalizing rural and urban imbalances help provide quality services. The CRBs were publicly visible, people had mechanisms to provide input and in many communities they were achieving the kind of credibility that meant, in Dawson Creek for example, that "If we said something it was listened to" (p. 67). Clague et al. (1984) found that identifiable communities, and rural areas, benefited most from the increased integration and coordination of services in their health centres. The health and medical elements in the CHRCHCs were particularly important to people in the rural areas, and the centres represented a net increase in basic human services. Interestingly, of the four centres, that continued to exist after the Social Credit government gained power, one was in

an urban neighborhood as part of a larger community, and the other three were in rural areas: one operated as a rural regional system, one in a rural resource town, and one was in a growing rural resource town. The CHRCHC experience provided an opportunity for input from communities, particularly in the small communities.

On the other hand there are disadvantages to community control. One of them is the domination of affairs by local elites, another is the lack of management and planning capacities (Wharf, 1985). A further criticism of the private sector is that it is more selective in targeting particular needs and populations (Azim, 1987). If that selection includes servicing clients who are easier to deal with or more likely to respond to treatment, what happens to the harder to serve populations? Smith & Lipsky (1993) suggest that human services have to come to grips with the tensions between the particularistic tendencies of private agencies and the universalism of public policy norms (P 216).

Gaster (1991) in her research on quality and decentralization acknowledged the difficulties and problems as well as the limited real impact consumers and citizens have on service delivery; but recognized the advantages to receptive organizations of public involvement. She says "there is a better chance that services will meet actual need; consumers will know more about the services and there will be a closer, more trusting relationship with the service providers" (p. 260) if services are decentralized. The importance of the consumer perspective in assessing services is being increasingly recognized as essential to understanding quality service delivery (Russell, 1990). Pfeffer & Coote (1991) advocate for a model of quality which puts the consumer in an *active* role.

Rather than just satisfying the customer, the consumer's power is increased so that they can hold sway over the decision making of the providers.

Conclusion

Quality in the human services is complex. As Osborne (1992) states it is ultimately a concept and not a thing. The definitions of 'quality' are constantly evolving and changing, partly due to increased knowledge and changing expectations in the human service field (Coulton, 1982), but also because of the changing environment that human services are delivered in. Focusing on the product alone is not sufficient. Quality in the human services is not as simple as looking at a cost-benefit analysis or being able to provide volume, assembly line service delivery. Standards may provide minimal levels of service, but quality does not mean the pursuit of tighter regulations and irrational standards which result in over-bureaucratization and the loss of professional flexibility (Pruger & Miller, 1991). Quality service delivery may be related to outcomes; but what to measure, and how to measure it, needs further work in order to ensure that service delivery remains holistic and outcome research is effective. This researcher has come to the conclusion that simply considering 'the product' in human services does not assist very much in understanding the concept of quality.

Organizationally there are competing tensions in the privatization-welfare state debate. Contracting-out services, as one way of reducing the size of government, has become a prevalent method of providing services throughout Canada. If one accepts Pfeffer and Coote's (1991) argument that smaller, horizontally linked organizational units are more amenable to consumer input, then small, non-profit organizations are in a good position to deliver quality human services. Gaster (1991) in her research into decentralization and

quality also concludes that "decentralization can bring about improved quality" (p. 265). However she argues that is not a necessary requirement for quality and suggests a planned approach to decentralization by considering which services - or parts of service - would be improved by going local, as opposed to the doctrine 'if it can go local, it should go local'. But attention has to be paid to whether services are truly decentralized or not. As pressure is placed on governments to implement regulations in order to ensure economic efficiency and accountability, the ability of organizations to provide quality management may be undermined. As non-profits professionalize in order to obtain government funding they begin to look like mini-government structures (Rekart, 1995).

The economic, product driven, and managerial emphasis to quality is associated with political agendas of the right. Public participation and consumer responsiveness are associated more with social democratic views. As the review of the Community Resource Boards and the Community Health Centres of the 1970s showed, small communities benefit from increased input into decision making. Alaszewski & Manthorpe (1993), in their review of the restructuring of social services in Britain, note that there has been a shift from the large, hierarchical, centrally controlled administrative bureaucracies with the emphasis on cost control to a new consumer-oriented and sensitive public management. This latter orientation is characterized by its emphasis on the quality rather than the quantity of service provision.

Ultimately there is no single approach to understanding quality which is going to please all the various stakeholders in human services. But to date, the emphasis has been on

political and business interests. As services are moved into the community and the notion of quality in human services is more accepted, a broader definition of quality can occur.

Pfeffer & Coote (1991) suggest a democratic approach which recognizes the tensions between the desires or wants of individuals and the interests of the community as a whole. The approach also recognizes the differences between commercial enterprises aimed at making profits, and the aims of human services which are to provide opportunities for everyone to participate in society and realize their own potential.

Another model which reflects a humane approach to delivering quality in the human services is presented by Paul Wilding (1994). He suggests that "quality is not simply a technical, clinical matter, because how things are done is important" (p59). He supports the scientific approach, which he calls "effectiveness," and Pfeffer and Coote's democratic approach, which he refers to as "openness." To these he adds "accessibility" and "acceptability." Accessibility requires that people can get to a service easily and without stigma. Acceptability refers to the ambiance or the environment that is supportive and empowering rather than routinized or patronizing. He further contends that quality can only occur in organizational and management structures which are conducive to generating staff commitment and promoting a culture of quality.

The concept, meaning and measurement of quality is complex and fraught with competing tensions. The traditional definitions of quality no longer fit in the new models of service provision. This research is aimed at broadening the understanding of quality in community based agencies by undertaking a dialogue with the service providers and service users in the small communities in northern B.C.

Chapter Four

Research Design

This thesis is about the interrelationship between policy and practice and the understanding of 'quality' in the human services. The previous chapters showed how the privatization of a wide range of personal and community services had been a social policy response to the changing socio-political environment. It was also shown that the concepts that measure quality need to be broadened to reflect the component of privatization which emphasis increased public participation. The focus of this research is to explore the practice component of quality from the perspective of service providers and consumers in small communities in northern B.C. As this research germinated from a thought, into a process, it was important that the research design complemented the topic being studied. It had to reflect the informality and the people-oriented philosophy prevalent in small communities while maintaining the rigor of credible research. In keeping with these commitments, two central tenents were held throughout this study. The research needed to remain meaningful to the participants, and the findings needed to have practical implications for the delivery of personal and community services in the north.

Approach to the Research

The principal deciding factor when approaching research is to plan a method of inquiry that fits the problem and goals of the research question (Addison, 1992). The research design provides an action plan, or road map, which guides the investigator from the defining of the research question, through the process of collecting, analyzing and interpreting the data, to a set of conclusions about the initial questions (Yin, 1994). In this

case the work was exploratory. It necessitated going to the 'field' and hearing what the people, whose ideas were being studied, thought. It required a flexibility and an openness to hearing various understandings of what people thought 'quality' in the human services involved. It also demanded that I, as the researcher, stayed close to the work, and that the data analysis not be bound by the objective distancing required of quantitative research. Qualitative research lends itself to studying what 'real life' is like from the people's own viewpoints. The resulting well grounded, rich descriptions of day-to-day situations provides a holistic overview of naturally occurring phenomenon in the everyday lives of individuals and organizations (Miles & Huberman, 1994; Taylor & Bogdan, 1984).

There are many forms of qualitative research. The task of this research was to take the complicated concept of 'quality' and through words describe and understand it. Trying to understand, or take meaning from that which is not yet understood, is an essential aspect of living, and is a central task of hermeneutic inquiry. (Gaddamer, 1976 & Heidegger, 1962, cited in Addison, 1992). Hermeneutics is a big word, that means interpretation. It is a Greek word that is derived from the name of the wing-footed messenger-god 'Hermes' who is associated with the function of bringing a thing or situation from unintelligibility to understanding. Hermes, according to the Greeks, is credited with the discovery of language and writing, and these are the tools which humans employ to grasp meaning as well as to convey understanding to others (Palmer, 1969). To put it more simply, hermeneutics is an attempt to render the unclear clear. It goes beyond a description and structural analysis of the text in order "to advance hypotheses regarding the hidden meaning of the text" (Bauman, 1992, p. 10). As van Manen (1990) says "it interprets the texts of life" (p. 4). In this type of

research the phenomenon, rather than being isolated is contextual. This approach to research is sometimes referred to as 'grounded hermeneutics' because it reflects the situational, cultural, social, political and historical affairs of a phenomenon (Addison, 1992; Rothe, 1993).

Method

A hallmark of a qualitative research design is flexibility. The research question is redefined and reformulated throughout the research process and the data collection methods can vary as the study proceeds. Miles & Huberman (1994) suggest that this flexibility provides for "further confidence" in the study as it shows that the researcher has really understood what was going on (p. 10). However, while there are no prescribed sets of techniques for qualitative analysis, and to some extent it is 'arty' and 'intuitive' it does need to be thoughtful and systematic.

The initial research begins in the form of a vaguely formulated questions (Taylor Bogdan, 1984, p. 5). This research started off with the question: "*What is quality service delivery in small, northern communities?*"

Consideration was given to who could best answer that question. The selection of participants for a research study depends on the problem being studied as well as one's approach and theoretical framework. In qualitative research, small samples, selected purposively, in order to learn about the issues of central importance are the typical focus. The aim is to speak to individuals who possess special knowledge and who are willing to share their information (Gilchrist, 1992). Various terms have been used for these people including consultant, friend, respondent, interviewee, source and informant. I have chosen to

call them participants to indicate that their role was not just to give information, but to actually participate in the research process. Their role was to identify new areas of interest related to the initial topic, provide insight and then give feedback during the interpretative stage.

The next step in this research was to articulate where the participants would come from - the setting of the study. For the purposes of this study a northern community is one which is located on or north of Highway 16 in B.C. According to some definitions this research was conducted in an area referred to as the 'provincial north', or the 'middle north' (Rutherdale, 1994; Coates & Morrison, 1992). The participants in this study strongly identified that they were living in isolated, northern, small communities and would concur with Hamelin (1989) that the north is defined less by the geographic area it covers and more by how the residents define their own situation in psychological terms. For this study, small communities were defined as a community with a population base of approximately 5,000 people. Of course, there are many smaller, more remote, and more northern communities in B.C. which have different problems than the communities considered within the context of this study. In the end, only those small communities within a reasonable mileage of Prince George were actually considered due to the constraints imposed by finances and time, although it is reasonable to expect that the conclusions in this study would pertain to similarly sized communities throughout the entire north.

Privatization has impacted on the small communities in the north, and the private sector provides the majority of personal and community services. As services have been developed in the small communities many of the non-profit societies developed multiple

contracts with government. Therefore the question being studied was modified from: What is quality service delivery in small communities? to How is quality conceptualized in multi-service agencies in small communities? Influenced by Tsui's (1990) multiple constituency model which is based on "the premise that organizations exist to service a multitude of interest groups" (p. 458) I identified the stakeholder groups as Executive Directors, Clinicians, Board Members, Consumers, Referral Agents and Contract Managers.

In order to get at the 'quality' part of the question it was important to interview people that had thought over some of the complexities of quality service delivery. Both the Alcohol and Drug Programs branch, and the Mental Health Services branch of the Ministry of Health were pursuing the process of accreditation as a component of their quality assurance initiatives. As agencies receiving contracts from either of these sources had some experience with that kind of process the sample group was narrowed down to non-profit societies who received at least one contract from either Alcohol and Drug Programs or Mental Health Services. At this point I was ready to enter the field and begin the research.

Entry into the field

Subsequent to approval by U.N.B.C.'s Ethics Review Committee (see Appendix A.) permission was received from the Ministry of Health, Alcohol and Drug Programs and Mental Health Services to contact their agencies for voluntary involvement in the study. Their only proviso was that the client participants provide informed consent, and that contact be initiated through the agency, not directly by myself. Ten agency executive directors were sent an introductory letter (see Appendix B.) outlining the research study and inviting them to participate.

After the Executive Director in the multi-service agency had agreed to participate, a brochure outlining the research (see Appendix C.) was distributed by the agency's staff, to the agency's board of directors, clients, and clinicians, as well as other organizations that referred clients to the multi-service agency. This procedure was intended to ensure that the viewpoints of each identified stakeholder group were included in the research. Each of the stakeholder groups were invited to contact me directly, calling collect if necessary, or to inform the contact person of their willingness to be involved. Interviews in each community were arranged either by the contact in the agency (executive director or clinician), or by myself, and were held in the agency offices, in another office, or the individuals home, depending on the requirements and request of the person being interviewed. Each participant received an explanation of the research and an overview of the question areas (see Appendix D.), and a copy of the Agreement of Participation (see Appendix E.) prior to the interview. All participants were asked to sign the informed consent letter giving permission for the interview to be audio-taped at the time of the interview.

The First Round of Interviews and Analysis

Participants in the first community were interviewed in August 1995. The Executive Director of a multi-service agency volunteered to participate and contacted the various stakeholders. One board member, one referral agent, two clinicians, one client and the executive director all volunteered to participate. Times and locations were arranged for the interviews.

The interview formed the basis of this research. A semi-structured interview approach was used, which Miller & Crabtree (1992) describe as a "guided, concentrated, focused, and

open-ended communication...that is co-created by the investigator and interviewee" (p. 16). This process enabled me to follow the lead of the participants and explore areas that they considered essential to the understanding of quality in small communities.

Developing rapport and trust is essential in the interview process (Hosie, 1986; Spradley, 1979; Taylor & Bogdan, 1984). Because I have spent so much time working and living in the north, it meant that I already knew some of the participants in this research. In other cases, even though I had not met the person, they had heard of me because after all, the human service community in the north is quite small. On the one hand this was extremely useful; rapport and trust was often already developed, and it was a fairly speedy process to get to some very insightful viewpoints. On the other hand, I had to be particularly sensitive to participants saying what they thought I would like to hear. For example the following exchange occurred during one interview:

> *Jackie: If you were going to set up, in a small community, some kind of human service provision to help people with their personal problems, what would be the important facets of that? How would you set that up?*
>
> *Anne[15]: I'd ask you. Isn't that what you did? (397-406)[16]*

This obviously caused some laughter, but I was aware I had to be cognizant of any preceding reputation (good or bad) that I might have. Overall though, I think my familiarity with the region was helpful to the research and the tone of the interviews was pleasant and informal. Each interview lasted approximately 1 - 1 1/2 hours.

---

[15] Pseudonyms have been used throughout this thesis in order to protect the anonymity of the participants.

[16] Citations at the end of participant quotes refer to the line numbers in the transcribed interview. If the participant is not identified, the citation would refer to their number, as well as the line numbers (e.g. 10:18-24 would refer to participant no. 10, line 18 to 24.

Doing the interviews in this first community provided a glimmer of the difficulty I would have using the design format of stakeholders in a multi-service agency to understand quality service delivery. It was very difficult to keep the referral agent focused on how she thought quality in the multi-service agency should be conceptualized. The problem was that she was also providing service delivery in the small community, and that was her experience, and that was where her answers were coming from. This was going to become even more problematic in the second community.

The next stage was beginning the analysis. Qualitative research results in large volumes of text that must be interpreted and summarized (Crabtree & Miller, 1992). While at first glance it may look fairly elementary to grasp the essence of the phenomenon under study, in practice it is demanding and requires utter concentration (Spiegelberg, 1982). The process of analyzing is to abstract those features which are most salient from the immense detail and complexity of the data (Dey, 1993).

The collecting of data, and the categorizing and analyzing occurred concurrently. Interpretation and analysis began immediately and occurred throughout the interview process. Collecting the data, and conducting the interviews was fun, but the next task of categorizing demanded rigor and intensity. Generating categories was not a simple task, at least partly because there are no hard and fast recipes for the development of them.

Qualitative analysis is most often associated with inductive analysis, which begins with specific observations and builds towards general patterns (Patton, 1987). However some researchers such as Dey (1993) and Rothe (1993) are beginning to acknowledge the

usefulness of using an existing theoretical perspective or conceptual framework as a vehicle for data analysis.

The overriding principle that I endeavored to maintain was to keep the integrity of the data, and the meaningfulness to the participants. However at times the sheer volume was overwhelming. I also struggled with my own desire to be organized and have clear categories in which data could be firmly placed. In short, I wanted it to be nice and tidy.

Initially, I took a theoretical perspective and drew upon existing theories to use as categories. This was particularly true in the analysis of the questions about quality. As I did this I allowed for the generation of new categories, from a cognitive standpoint, but I struggled with my 'gut' which seemed to say I was forcing the data to fit into the categories in order to make neat my mess. This deductive approach did not 'feel' comfortable for me and I set this aside in order to try a different approach.

When I looked at the interview guideline that I had given to the participants prior to the interview there were three major foci. Questions had been around the experience of being a service provider in a small community, their conceptualization of quality, and how services could be provided to take into consideration both 'quality' and the context of small communities. Using the research questions as a framework for categories I ended up with three main categories: 'small community', 'quality' and 'service delivery', with the sub categories of 'multi-service' and 'linkages' under service delivery. The transcripts were re-read and analyzed using notes in the margins to explain or highlight questions or thoughts that I had. The coding process then began to occur again. Strauss (1987) refers to this process as "In vivo" coding, which consists of selecting words or phrases that stood out to

me as potentially significant for understanding (cited in Addison, 1992, p. 117). In this way sub-categories were developed, most often using the participants own words, underneath those three main and two sub headings. As I was turning to a more inductive approach I interviewed the second community.

The Second Round of Interviews and Analysis

All agencies located in, or around Prince George that received funding from Alcohol or Drug Programs or Mental Health Services had received an invitation to participate in this research. In the second community the alcohol and drug program was contracted through the hospital board and so services were organized quite differently than the first community I had been in. Recalling the problem which had begun to develop in the first community of the referral agent wanting to speak about her own experience, I realized that the research design needed to be modified to reflect the differences in each community. In keeping with the focus of my original question and reflecting the initiative in social policy to community based services, it was modified from: How is quality conceptualized in multi-service agencies in small communities? to: What is quality in community based agencies? This new question still reflected the privatization aspect of this research, but took into account the differences in service delivery models. This is part of the circular procedure of hermeneutic analysis and as I continued through the process I began to relax with the notion that I could let the story of quality service delivery in small communities emerge the way the people in the small communities wanted it to emerge.

I conducted the interviews in the second community at the end of September, 1995. Two counsellors working in a non-profit agency, one executive director of a multi-service

agency, one administrator of a contracted service, and one client were interviewed. It was also becoming clear that the original research design that separated job descriptions was becoming absurd. In this community where I interviewed two counsellors I had the problem of identifying who was the referral agent and who was the counsellor; also the board member was a health provider in another organization. I was beginning to think that generalizing to service providers would be more helpful in understanding service delivery in small communities.

During this second set of interviews I had a lot less tied to my original questions, and although the participants were provided with the same framework of questions the interviews went in the directions that the participants led it. However the downside of this more emergent, inductive approach was that the analysis generated more categories and themes. It was during this process of coding that I turned to available technology to assist with the huge amount of data. While early researchers of the interpretive tradition frowned on the use of computers for the analysis of text, some researchers recognized their usefulness, particularly as the data base got larger and the time consumption and difficulty increased (Kelle, 1995). I utilized the Nud.ist (Q.S.R. Nud.ist 3.0) program which has been described by Weitzman & Miles (1995) as "one of the top two or three programs available for coding-oriented qualitative data analysis." This process of coding eventually developed into 256 categories.

My original plan had been to interview participants in three communities. Although I was already feeling overwhelmed with codes, I also wanted an opportunity to explore some of the themes that have come out of the second community where I had conducted less structured interviews.

The Third Round of Interviews and Analysis

The interviews in this community provided confirmation that the change of focus in my research question to simply: What is quality service delivery in community based agencies? was the right decision; and that the original decision to delineate participants by job distinctions was irrelevant. In developing the design I had, much to my amazement, completely ignored the interrelationships that occur in the community. During this set of interviews the clinician was the executive director, and the client provided services in another non-profit organization. Having already decided to accept the process of modifying the research design I now chose to think very broadly about the question of quality service delivery in small communities, and consider the issue from the perspective of service providers and consumers. The term service provider, included those providing front line practice and board members who are responsible for service provision from the policy perspective.

At this point it was becoming clear that the common theme, or the emerging story, in this research was the unique experiences of providing services in small communities (as opposed to larger centres), rather than the unique experience of particular job titles. Because that was becoming the emerging theme I decided to drop the contract managers as an interview participant. Their standpoint would be from an urban focus anyway, which could possibly detract from the importance of the small community perspective. As it turned out this may have been a fortuitous decision as government offices began restructuring during the time of the research and key people moved out of the region. However the primary purpose

for the change was the shifting focus to service delivery in small communities, rather than a focus on the constituents of the multi-service agency.

In the third community one counsellor, one executive director (who was also a clinician), one client and one referral agent were interviewed in December 1995. As the notion of considering all the stakeholders together as service providers was taking hold, it also became clear that the role of social work in this thesis had to be clarified. The service providers had various academic backgrounds; some had a social work education either at a bachelor or masters level; others had social science university education, also at the bachelor and masters level; and yet others had minimal post-secondary education. While the various backgrounds may affect their viewpoint on appropriate clinical interventions, it was less important in understanding their experience of providing service, and/or their view on quality service delivery. Therefore, throughout the rest of this thesis the terms "service provider" and "human service worker" will refer to any person providing human service. When the term social worker is used it will refer only to people, or to view points consistent with the profession of social work, as taught in universities. This increases the scope of the research in terms of being applicable to many service providers, but limits it in what can be said about social workers in particular.

The Interpretation

Sixteen interviews were completed in all. Thirteen service providers (comprising five clinical staff of non-profit agencies, four executive directors or program administrators, two board members, two referral agents and three clients). Over four hundred pages of single spaced transcription resulted from these interviews which were then developed into 256

separate categories. All these categories then had to be reviewed for themes. I tried a number of approaches. I made lists of groups, wrote definitions of codes, redefined categories and felt like a linguist. Eventually, after spending so much time in the parts I went back and re-read the interviews to try and work back from the parts to the whole. During this time, I finally understood what immersion meant. I not only thought about my data during the day, I dreamt about it at night, and really believed that it had replaced the blood running through my veins. Miller and Crabtree (1992) refer to this style of analysis as immersion and crystallization and define it in the following way:

> *Immersion and crystallization consist of the analyst's prolonged immersion into and experience of the text and then emerging, after concerned reflection, with an intuitive crystallization of the text. This cycle of immersion and crystallization is repeated until the reported interpretation is reached. (p.19)*

Eventually, at the point of exhaustion some clarity emerged and some central themes that I felt comfortable with began to show up. The central theme was the interconnectedness between the personal attributes of the service provider in the small community and the definitions of quality service provision.

Keeping this theme in mind I then went back to reanalyze the interviews and transcripts to see if this was a legitimate theme. With the help of a large piece of newsprint roll end (I am after all from a pulp and paper mill town) a diagram emerged connecting all the themes: Social context was connected to personal qualities which in turn was connected to service delivery; the themes of quality were linked to the social context, which were linked to the delivery of services; the themes of political needs were linked to service delivery; the context of small communities were linked to multi-service agency, which were then linked to surviving the social context; and so on and so on. The diagram was a mass of

linkages and curvatures, which through the eyes of my eight year old son was "a mess", but in reality it was a part of the hermeneutic circle of interpretation. The process had moved "from understanding to interpretation to deeper understanding to more comprehensive interpretation" (Addison, 1992, p. 118).

The moving backwards and forwards from the data to the analysis, and using various approaches to try and understand the story the participants were telling meant sometimes I came full circle. When I had begun reviewing the literature for this research I had been drawn to Paul Wilding's (1994) article on quality in the human services. He described the concepts of 'accessibility' 'openness' effectiveness' and acceptability' as essential to quality human services. While I was in my theoretical perspective of organizing the data I had used these concepts in a deductive way to categorize the information. However, as described previously, I had overwhelming guilt that this process was not being true to the data, and the process was not as inductive as I felt was necessary. After putting that work aside and immersing myself in the data in order to gain some crystallization and to find the central story line, I eventually was drawn back to some notable quotes. In particular one by John, which is quoted in its entirety at the beginning of Chapter 5, held my attention:

> *A quality service would take into account the needs of the client, and by that I mean it would be honest, it would be fair, it would be productive and it would be done fairly quick. (379-382)*

John's words were synonymous with Wilding's concepts. In the end I had used both an inductive approach, and a deductive approach to get to the same place. This time I accepted this framework as a loose way of organizing the interpretation.

The interpretation of qualitative research continues on through the writing stages. I used the central theme of connectedness, and linkages as the 'story-line' for writing (Taylor & Bogdan, 1984, p. 153). For each section I decided on the major point, and then considered how each of the specific categories related to it. This process is essential in the iterative process of qualitative research design. As Miller & Crabtree (1992) said "Data analysis begins shortly after the first data are collected. This analysis creates new understandings, generates changes in the research question, and uncovers new anomalies. The result is often a change in the sampling strategy, new collections tools, and thus changes in the analysis style" (p. 20). The process continued right through the writing stage.

Issues of Rigor

The aim in qualitative research is to gain accurate and true impressions of the phenomena being studied (Rothe, 1993). But without the use of standardized procedures how does the reader judge the quality of the interpretations made in qualitative research. While some qualitative researchers argue that there is no 'fact of the matter' and that it is not really possible to specify criteria for good qualitative work, the need to authenticate findings will not go away (Miles & Huberman, 1994). Ultimately it is up to the researcher to provide the information to show the accuracy and replicability of their methods, and the reader to decide on the merit of the research. Miles and Huberman raise five main issues in the standards for qualitative research. They are:

- objectivity/confirmability
- reliability/dependability/auditability
- internal validity/credibility/authenticity
- external validity/transferability/fittingness

- utilization/application/action orientation.

Miles and Huberman have paired the traditional terms of research with the alternatives offered by Guba & Lincoln (1981), and Lincoln & Guba (1985) of "trustworthiness" and "authenticity."

Objectivity/confirmability

The basic issue here is the neutrality and reasonable freedom from unacknowledged researcher biases (Miles & Huberman, 1994). The reader has to decide whether the studies methods have been described explicitly and in detail, and whether the researcher has been explicit and self-aware about personal assumptions. In this research, the reader, of course, will need to decide that. Suffice it to say that this research began because of my personal experience providing services through non-profit organizations in small communities. My aim was to find out more about how to provide 'quality' services in that context. I was not free of bias, however I hope the rich descriptions provided in the following interpretive chapters, provide the reader with a sense that this is the participants' story.

Reliability/dependability/auditability

The underlying issue here is whether the process of the study is consistent and reasonably stable over time. Would other researchers using a similar research process, obtain the same results? In other words could it be replicated? As Rothe (1993) asks: Have we represented the social world of actors as the actors themselves see it? This is sometimes referred to as an 'audit trail' or a transparency of process. Again you, as the reader, will have to assess whether there is enough information contained within the text of this chapter in particular, to

be able to conduct a similar study. Whether the findings would be similar would depend on the context of the study.

Internal validity/credibility/authenticity

As Miles & Huberman (1994) say, this is the crunch question. The truth value. Do the findings of the study make sense? In order to assess the authenticity the readers must ask themselves whether there are context-rich and meaningful descriptions. Does the account 'ring true'? and 'make sense'?. As Bauman (1992) suggests the text itself can advise the reader as to the plausibility of the researcher's interpretation. While there may not be conclusive proof that the researchers choices were right, the reader should be able to attain a sense of 'plausibility' or 'implausibility' of the interpretations (p. 10).

This research dealt with the issue of internal validity by getting feedback from the participants. Each of the participants were sent the three chapters of interpretation and asked to assess it in terms of their experiences, and understandings. They either responded in writing or I spoke to them on the telephone. The following comments are representative of the responses:

> *I really liked it, it was interesting. I could relate to the isolation, and it was nice to know I'm not the only one that feels that way. (4)*
>
> *It depicts a true picture of the north, it's long overdue. (14)*
>
> *The report inspired me to reflect upon my work and my position in the community. (1)*
>
> *It captured the essence, and the voice of the service providers - it should be mandatory reading for policy planners. (10)*

External validity/transferability/fittingness

Do the conclusions of this study have any larger importance? Lincoln & Guba (1985) refer to this as a "fit", or the degree of transferability. The key concept for 'fittingness' according to Guba & Lincoln (1981) is whether there is a fit between the context in which the working hypotheses were generated and the context in which they are to be next applied. (p. 120). For example in this research do you, as the reader know enough from the rich descriptions provided, about the context within which the study was undertaken to be able to fit the findings into another community? The conclusions for this research would not necessarily 'fit' for large urban centres in Canada, or in a political system which had a strong centralized government. However the conclusions in this research should fit for other small communities in B.C., and perhaps other provinces provided they were devolving their human services to a community level.

Utilization/application/action orientation.

The question of pragmatic validity, or what it does for the participants is an essential addition to the rigor of qualitative research. Is there any usable knowledge that comes out of the research and does it lead to any specific actions. This research will be available to all the participants. At this time the participants would be happy for some consciousness raising at the urban centres. As one participant told me when I called for feedback: "*This should be mandatory for all bureaucrats in urban centres*" - he was feeling a sense of frustration after receiving yet another form to complete that was totally irrelevant to his community's context.

Ethics ✓

Areas of ethical concern include obtaining informed consent. That issue was dealt with by sending the participants information about the study beforehand, and then at the time of the interview reviewing and asking the participant to sign an informed consent. The other main ethical issue is confidentiality and anonymity which are extremely important in small communities. Confidentiality was maintained by ensuring that the audio tapes were stored privately, and participants could either have them returned or have them destroyed at the end of the research. Anonymity, in the writing was managed by providing pseudonyms. This was done by assigning 16 letters of the alphabet to each participant and then assigning a name to that letter. As six of the sixteen participants were male, the group was simply divided into half, and half were given male names, the other half were given female names.

Conclusion

A qualitative research method, using interpretive analysis was undertaken in order to consider the question: "What is 'quality' is community based agencies?" Sixteen people, thirteen of those involved in either the policy or practice of service provision, and three clients, were interviewed about their thoughts on small communities, on service delivery, and on the concept of 'quality'. These interviews were analyzed, using a mainly inductive, in-vivo, categorizing process. Out of that categorizing, major themes emerged which formed the basis for the written material in the next three chapters.

There are two major ways of ensuring rigor in qualitative research. The first is the consideration of accuracy and credibility. Is there enough rich description given to the reader for the account to seem plausible? The second area of concern is the replicability. Would

another researcher given the same constructs reach similar conclusions, and could a different researcher generate similar findings in a similar setting? My hope is that the reader will consider those two issues as they continue reading this work and judge the work positively against those criteria.

Chapter Five

Quality in Small Communities

The discussion of quality in Chapter 3 suggested that there are many ways it can be viewed. It was concluded that there is likely no one approach by itself that will satisfy all the various stakeholders in the delivery of human services. However, an approach which takes into consideration the individual client needs, and the interests of the community is preferable. This chapter moves from the theoretical and policy perspective to explore how the participants in this study understand quality service delivery. It becomes clear that service providers and service users broaden existing definitions of quality. Their interest is less in the dry, quantitative, economic measures and more in the practical day-to-day humanness of interacting with people who are experiencing distress in their lives. Further than that, a sense emerges of the unique social conditions experienced in small communities and how these directly impact on service providers and their ability to provide quality services. Chapter 6 will address some of the predominant issues for service providers in small communities. The subsequent chapter will consider how those factors as well as the ideas for quality described in this chapter, can be taken into consideration when developing organizational structures for the delivery of service.

Most of the people I spoke to in this research found it difficult to explain what quality was - they could feel it, and sense it, but not express it. However John was able to summarize how he perceived quality:

> *I think a quality service would certainly take into account the needs of the client, and by that I mean it would be honest, it would be fair, it would be productive and it would be done fairly quick. The problem is being out in an isolated area like this, is what options exist. I'm just a small part in the*

system, even though I'm isolated and in control of many aspects of it. Because I am tied into a bigger system I can only do so much for my clients.

The other thing is confidentiality, very important, and I think we can certainly match what the city does in terms of that....I think, at least what I strive for, is to be a little more human than what you might encounter in a city kind of environment. The reason being that I see these people on the street, and I may have to answer to them for my responses or actions. So there's a little bit more pressure for me to be fair and honest and quick, and you know, all of those kinds of things. (379-412)

In this quote quality is described as a consumer driven process. Services are there to meet the client needs. In order for this to take place, John in his simple and eloquent description highlights key characteristics which he seems to take for granted - honesty, fairness, productivity and speed. Unknowingly he has just described the four dimensions that Wilding (1994) considered essential for quality. A word synonymous with honesty is '*openness*'; to be fair is to be '*acceptable*', being productive is being '*effective*'; and in order to be quick, a service must be '*accessible*'. But John also reminds us not to forget the complexity of living in a small community. There is isolation and the links to the centres of expertise and specialization are fragile. These latter factors complicate service delivery in the small community. Despite all that, John says that standards of service (he uses the example of confidentiality), can, and should be maintained - the scientific model of quality has value.[17] Standards though are only a part of what constitutes quality, services also need to be personalized. Because service providers in the small communities meet their clients wherever they go, they experience a heightened sense of responsibility for the people's well-being, as well as a need to maintain congruence in their own lives. John concludes that the

---

[17] The scientific approach refers to the process by which experts or professionals prescribe minimal levels or standards of acceptability. (For further clarification see the section on standards and accreditation in Chapter 3.)

attributes that are important in service delivery are the same personal qualities that he ought to possess in himself - I have to be 'fair' and 'honest' and 'quick'.

John is expressing that standards are important to service delivery in the north, but for 'quality' to occur it must also be honest, fair, productive and quick. These ideas will form the backdrop and Wilding's (1994) dimensions will provide the framework to explore the views of the participants in this research. The remainder of this chapter will discuss: "How its done" - The Standards, "The Skills and Abilities to do your Job" - Being Effective, "Immediate and Direct Access to Programs" - Gaining Accessibility, "Having Rights" - Openness and "Providing a Good Service to the Clients" - Acceptability.

"How its done" - The Standards

Professional standards provide guidelines for performance, however it is up to the individual provider, or organization to interpret those standards into day-to-day practice. That interpretation is often difficult. In small communities where there are fewer resources and complicated interrelationships, the application of standards become more complex. Charlene describes her views on standards of service in small communities:

> *I don't think there should be differences, between urban centers and smaller communities in terms of service delivery, although how its done will differ because of populace and location. People don't always believe that they should be delivered the same way, but I think the accreditation process has proved that we can do the same thing, and at the same level, and so there shouldn't be any differences. Small communities have to watch that they don't justify skipping stuff, and not doing things appropriately. Just because you're in a small town, and work closely with many of the same families, doesn't give you the privilege to share information. You should still have consent forms, and confidentiality. Just because you know these people better doesn't mean you can disclose information without proper consent. In this community there tends to be a lot of - we'll just have a chat. No, that's not done in this agency without a consent. You don't loosen up on those standards just because of where you are, and that is something that small communities need to be aware of. (858-906)*

Charlene is clear that standards can, and should, be maintained in small communities. Both Charlene and John raised confidentiality as an example of a standard, and therefore it will be considered further.

Where is the information sharing line?

Guidelines on confidentiality provide restrictions on how information about clients gets transmitted. In small communities where close relationships develop between the workers in different agencies, the information sharing line is easy to cross. David describes how inter-agency connections can easily lead to unintended confidentiality breaches:

> *I enjoy being close to everyone, I enjoy being able to cross the street and talk to workers at the Transition House on more of an unofficial kind of a basis, or more relaxed basis, rather than in a big city where you just talk to a person you've never seen before and probably will never see again....But there's a problem...you really have to be hypersensitive to, and that is confidentiality, because you get on such a good working relationship that you sometimes forget where the information sharing line is. So I find myself really catching myself, and watching what I say, and that's a part of what makes it harder. (37-67)*

David enjoys his "unofficial" conversations with people in another agency, but recognizes how easy it is to lapse into practice that breaches professional standards. He also raises the point, that emerges throughout this chapter, and is expanded on in the next chapter of how personal monitoring is essential to professional practice. He alludes to the difficulty of this self-monitoring.

Other participants in this research described how confidentiality may be maintained differently. Charlene said that in her community, some workers will "*just have a chat*," and in another community the interpretation of this standard was expressed as a "*community caregiver confidentiality*" (11:1149). This was described as a process in which the relationship between service providers becomes comfortable, and as trust develops mutual

clients may be discussed without the client's informed consent. Although it was recognized that this did not meet the code of confidentiality outlined in professional standards, there was an understanding between the two service providers that it would go no further, because each agency had confidentiality guidelines that wouldn't allow it to (11:1206-8).

A question to be asked is whether these varying interpretations of confidentiality can affect the perception of the quality of an agency? Confidentiality is a primary concern for clients, as Opal, one of the clients in this research explained: "*When you're looking for help, you're afraid 'cause you do know everybody, you're afraid of the confidentiality you know*" (93-95). Another question is that if the informal method of exchanging information is prevalent in small communities does that add to the perception that small communities do not provide quality service? Charlene, aware of a slackening in some areas of standards, says that the fact that services are provided in a small community doesn't justify it, and John maintained that he can "*match what the city does.*" Others may view the slackening as justified client care. This issue cannot be resolved within the context of this study, but it illustrates how the social context of small communities can affect the application of standards. Does the social context also affect the ability to provide effective and productive services?

"The Skills and Abilities to do your Job" - Being Effective

Standards alone are not sufficient for quality service delivery and Maureen provides some further insight for us into quality service delivery:

> *Standards of services are inter-linked with quality. Your quality is dependent on a number of factors including the skills that your people have, their abilities, the time they have to do their job, and the supervision. (630-634)*

Maureen has identified the need to consider the concept of clinical competence, which Korbin (1993a) also identified as central to the delivery of quality community human services (Korbin 1993a). Heginbotham (1990) described competence as "staff properly trained to provide a competent service" (p. 44), and Wilding (1994) included staff competence in his description of effective services. To further the discussion on quality, and in particular on effectiveness, two themes will be explored: competence in terms of being "jack of all trades" and productivity in terms of "working towards what the client is looking for."

Jack of all trades

Due to the small population base, and to some extent, the difficulty in attracting workers to the north, it is unreasonable, even if it is desirable, to believe that a range of specialists will be attracted to small communities. The question becomes what kind of worker would be the most effective in the north? Grace has some ideas about the ideal workers for the north:

> *I think to thrive and enjoy working in a small community you're going to have to recruit individuals who are generalists. You may recruit them into specific positions, with specific areas of expertise. The population base in these small communities is not that large, but you still get a very wide range of human conditions that you're going to be working with, so you're going to have to be able to be fairly flexible. (487-496)*

Grace notes the wide range of social problems found in small communities and the appropriateness of the generalist worker to manage them. We will first consider the range of issues. Professionals in small communities encounter clients experiencing major mental health and social problems, family violence, unemployment and poverty (Millar, 1976; Ministry of Health & Ministry Responsible for Seniors: Report of the Northern & Rural

Health Task Force, 1995; Waltman, 1989). Flavelle (1989), in her study of social and economic issues in non-metropolitan communities in B.C., found that alcohol and drug abuse were the two most critical social issues followed by violence against women and child sexual abuse. The variety of problems workers are faced with requires a worker to have a range of skills to draw upon, and the generalist, as Grace suggested may be the most suitable .

Generalist human service providers, in this research, were compared to General Practitioners (GPs) who are generalist medical physicians. Just as they may provide some surgery, some psycho-social counselling, some diagnostic work and some referral, so too can the generalist human service worker provide a variety of services. John referred to himself as "jack of all trades" who has to be prepared to deal with anything. Collier (1993), Ginsberg (1974), Martinez-Brawley (1986), Mermelstein and Sundet (1974), Nelson, McRae and Baldwin (1988), Walsh (1981), Waltman (1989), Wharf (1985) and others have postulated that the generalist social worker is the logical and necessary professional for the rural context. The generalist, with informed flexibility, offers a range of resources, can pick from a variety of interventions, and borrows from a spectrum of conceptual materials and social science disciplines in order to move toward a solution, at a pace suited to the client. The strength of generalist social workers is that they can adapt their practice to unique work settings, and therefore they are particularly suited to small communities.

Effective workers may be generalists, but they also have to, as John told me, "*be prepared to step into areas that you might have little experience in, or feel very uncomfortable with*" (256-258). Once again it is apparent that the personal and the professional merge - to be an effective worker in a small community, knowledge to deal with

the broad range of problems is an important consideration, but not the only one. Personal flexibility in order to try new things is just as significant. The generalist worker will have to be personally, not just professionally, versatile and adaptable to a variety of situations. Competence, as described in this section on the generalist worker is one component of effectiveness. Productivity, or "working towards what the client is looking for" is another.

Working towards what the client is looking for

Consumerism provides the backbone for quality in the corporate sector. If consumers are satisfied they will return to the restaurant, purchase another product or support the organization again. This consumer oriented view of quality is consistent with the social worker's value of client self-determination; that is the client will be satisfied if he or she receives what they think they want or need. Anne expanded on this thought:

> *I think quality occurs if the person gets what they are looking for - within reality. I mean as long as they are not hoping to get instantly fixed, that person is getting quality if they set goals and work for themselves, towards what they are looking for. (568-571)*

Time and time again in this research, services were seen as being quality services, if they fit with what the client was looking for. This is entirely congruent with social work practice that is posited on "the theory that clients will only invest in those areas of concern that they feel are important" (Schulman, 1979, p. 46). Using goal setting, as Anne suggests, is a common technique used to achieve "directional growth" (Anderson, 1981, p. 10). Whether these goals are in line with what the funders describe as 'outcome goals' may be a different story, and that wasn't investigated well enough for comment. What is clear is that the idea of 'outcomes', or productivity in this research was related to client needs. This finding coincides with Smith and Lipsky's (1993, p. 217) observations that the non-profit

sector places an emphasis on responsiveness to clients. This focus is where the non-profit societies tend to depart from the mandate of centralized government services which is to provide minimum, essential services to all citizens.

This research shows that effectiveness as a component of quality services in small communities includes the ability to satisfy a given need. In order to do that the technical element of clinical competence is necessary. Service providers are faced with a myriad of social problems and human conditions for which the generalist is ideally qualified. The literature supports this notion, although places more status on them, than John did in this research. Martinez-Brawley (1986, p. 106), says the "*generalist is not a "jack-of-all trades, but rather a skilled social worker who knows about people and environment and the subsequent transactions.*" She stresses that generalist social work is a specialty because it requires advanced knowledge and expertise. However, northern agencies experience inherent difficulties in attracting the generalist-specialist because of recruitment and retention problems. These problems are further compounded in the non-profit organizations because there are no regulations covering training requirements (Korbin, 1993c).

"Immediate and Direct Access to Programs" - Gaining Accessibility

The lack of resources and the issue of accessibility were important themes in this research. Accessibility, the next of Wilding's (1994) four dimensions will be considered in terms of the reduced choices available, the lower waiting times that are related to the generalist "just getting on with the job", and the ease of referrals for both service providers who can "just pick up the phone" and consumers who "recommend friends." But as is becoming clear, the social context has an impact on the provision of quality services. In

small communities the increased sense of community assists the humanness of services by treating clients "as a person, not a number." However the high visibility can provide opportunities for town gossips to wonder "what that person is doing in the counselling office" and lead clients to believe that "waiting rooms are out."

Less choice, fewer alternatives

Recent reports, such as Gove (1995) and the Northern and Rural Health Task Force Report (Ministry of Health & Ministry Responsible for Seniors, 1995) have identified gaps in northern services. The paucity of services affects the overall quality of service delivery in the community. Many of the "problems with existing services stem from deficiencies in accessibility" (Blunden, 1990, p. 25). Numerous participants in this research raised this issue. As Maureen said "*you don't have immediate and direct access to the programs that would be immediately available in the larger urban areas*" (52-54). Larry, one of the clients, expanded on this further:

> *One of the things about being in a small town is there's not a lot of choice. One of the things I would really like to see is another counsellor, probably female, because there's a man here right now. The last counsellor was female and there was a lot of men who wanted to go, but refused because it was a female. It would be neat to have one of each. (798-811)*

Larry indicates there may not be choice even in terms of gender. That is important in small communities where the gender roles tend to be stereotyped (Abramson, 1979). Another issue of choice was raised by Norman who pointed out the difficulty of starting self-help groups, which he considers imperative in order to provide quality service delivery. As he said: "*you aren't able to offer alternatives because they are just not available*" (599).

The concept of choice in the discussion of quality is important. In the commercial world, from where the ideas of quality evolved, if a customer is unhappy with a service or a product they can shop elsewhere. This is sometimes referred to as an 'exit' option. Similarly, one of the underpinnings of providing human services through the private sector is that consumers will only utilize quality services, and the poor services, no longer used, would fall by the wayside. However in order for that to occur there must be alternative services. If, as is the case in small communities, there are few if any alternatives, then the free market philosophy will not work as a mechanism to control the quality of services. A lack of choice and few resources impact negatively on the quality aspects of accessibility. Another aspect of accessibility which needs to be considered is the idea of being 'fairly quick' which John had raised at the beginning of this chapter.

Just getting on with the job

In this research many providers were proud of their short waiting times. In other communities referral agents had to resort to "*wheeling and dealing*" (13:119) to circumvent the long waiting lists. These differences in access are a symptom of the fragmentation and gaps that occur in a decentralized system. Charlene was in one of the communities that provided a fast service, and she describes why she thinks that occurs:

> *Charlene: Small communities are intimate, you get to know what agency does what. In a city you don't necessarily get to know the people or their philosophies but when you're in a small community you do. I think that is especially helpful when you're referring, and you know how to work better with the client because you know whether that service will help them or not.*
>
> *Jackie: You mentioned that small communities provide more of a generalist service and perhaps a broader service.*
>
> *Charlene: Yes, a range of services.*

Jackie: Is that an advantage?

Charlene: It can be an advantage and a disadvantage. It's an advantage in the sense that you're not caught up in the bureaucratic stuff of who does what, and you basically do the job, whatever needs to be done whether it's in your mandate or not....It is a disadvantage though in that there's not always the level of expertise because the generalist tends to know a lot about everything, and not necessarily a lot about one area....But then again, clients get served faster.

Jackie: They get served faster in small communities?

Charlene: Yes, most definitely. There's less numbers and less waiting lists. I think its because of the generalist perspective. I think you just do it. You don't wait around to see if it's in your job description or that kind of thing. (60-114)

Charlene implies, as others have, that the generalist services may actually speed up the process for clients. They do this because they are not as likely to worry about whether that particular problem falls into the mandate of the agency. They *"just do the job"* and provide the services, whereas specialists may limit themselves to particular admission criteria in terms of issues or clients. Government services often do the same thing. Generalists in non-profit societies, as the preferred worker in small communities, could be said to not only provide a more effective role but also to enhance accessibility. But when the skills of the worker are insufficient and a referral is necessary, the social context of the small community helps the process. Charlene suggests that the personal friendships that develop between workers in different organizations eases the process of getting clients to the services they need. Referral mechanisms both formal and informal are noteworthy aspects of accessibility to services.

Its easy to pick up the phone, and refer

As noted earlier the service providers get to know each other well. Therefore when they have a client who could benefit from another service "*its quite easy to just pick up the phone and talk to that service provider*" (1:345). This ease of communication helps with all aspects of client service including the provision of options for clients, and case management. As Grace said:

> *If somebody comes in my door I make sure they're aware of all the other services and vice versa, everybody's aware...and we refer back and forth all the time. (1254-1257)*

In small communities it seems that the service providers have an easy time working with other agencies. Do the consumers enjoy the same luxury?

Friends recommending

It seems that the 'rumour mill' works effectively for virtually everyone in terms of awareness of services. Norman described how people accessed services in this way:

> *In a small community a lot of the referrals are word of mouth or because you are known. Instead of going down the yellow pages and saying hey, that sounds like a neat place to go, its basically friends recommending. (75-79).*

Accessibility, in terms of knowing the availability of services, may be easier in small communities for both service providers and consumers. However just as there are implications for the service providers in the social context of the small communities, there are also ramifications for the clients. Sometimes these social factors assist in developing accessibility by, for example, increasing intimacy and neighborliness, while at other times accessibility is negatively impacted. The increased visibility can deter clients from seeking service.

You're a person, not a number

The literature on rural social work refers to the positive sense of community. Farley, Griffiths, Skidmore, and Thackeray (1982) refer to rural communities looking after their own; and Ginsberg, (1974); Mermelstein & Sundet, (1974); Myers-Walls & Coward, (1983); and Wharf, (1985) refer to the prevalence of natural helping networks. Although many participants in this research didn't identify strongly with the sense of community that epitomizes truly rural communities, there was a sense of mutual support and neighborliness which Katherine described:

> *You don't get lost in the shuffle quite so badly I don't think, as you might do in a larger centre or a larger community where you don't know your neighbours. There is a fairly good support, generally of the community members. (495-502)*

Katherine indicates that the increased awareness of all community members translates into a more human approach; you are not just a number which can get lost, but a person who needs some service. The system is accessible by being helpful and supportive; not surprisingly, there is a down side to this neighborliness.

What is that person doing in that counselling office?

In small communities everyone is highly visible. This impacts on the clients, many of whom are concerned about being seen attending counselling services. As Anne noted:

> *It is very hard in a small community. If a car is parked downstairs, it's very easy for people to drive by and say, okay that person's either at one of three places. I wonder what that person is doing there and what they are talking about. Or even people just walking in and out of here. (1053-1057)*

While agencies can take measures to ensure confidentiality, anonymity is much more difficult to guarantee in small communities. Charlene raises the dilemmas of trying to off-set the lack of privacy clients experience:

> *Anonymity is very important. It's hard to please everyone so you do the best you can in terms of ensuring that you have a location that's accessible to people, and that they have some level of privacy. (254-257)*

Opal, one of the clients, told me how she would look around the corner before entering the counselling office because she did not want someone in the adjoining office to see her. She also raised an important consideration in the lay-out of offices.

Waiting rooms are out

Virtually everyone has difficulty beginning counselling for the first time. Small community counselling agencies have an increased responsibility to provide a private and discrete atmosphere. Office design is a salient feature as Opal explains:

> *how the office is laid out is important. Waiting rooms are out...I don't know anybody that is comfortable walking into a counselling building where they all have to sit in a waiting room like you do at the doctor's office. I don't think those waiting rooms should even exist, especially in small communities. (163-167)*

Participants gave me two suggestions to compensate for the lack of anonymity. One was to have different exits from the counselling area to the public corridors of the building and the other was to have staggered appointment times.

In summary there are a number of components to accessibility. Accessibility for Wilding (1994), included the notion that people must be able to get to the service easily - geographically, physically and psychologically. Among the participants accessibility was viewed as an extremely important dimension.

The context of small communities assists the services to provide quality in some ways but detracts in others. If services are located in the community, then waitlists, usually, are minimal and people can see a counsellor within a week or two at the most. In general, however, there are reduced resources in the smaller communities, and the gaps in service lead to diminished choice and severely limited alternatives. The close relationships that form in small communities assist with referral and case management issues. However the high visibility for everyone, including clients can deter access to services, and make it difficult for a new client to enter the front door of the agency. So even though services may be available geographically there is sometimes a psychological reluctance to actually use them. In small communities, it becomes contingent on the organization to be aware of the client's need for anonymity in order to enhance accessibility.

"Having rights" - Openness

An open service, according to Wilding (1994) refers to the organization's commitment to communicate openly about its services, including being sensitive to complaints. In terms of openness participants talked about knowing their rights and being informed of agency guidelines "before they even opened their mouth about their problem." They also described how complaints and feedback occur in a small community, often by "telling a friend" and they alluded to how small communities quickly defend their own people, and are reluctant to listen if he or she is considered a "good Joe." However the philosophy of being honest, that John had described earlier, was important and "putting it on the table for the safety of the client" was considered essential.

Before I opened my mouth, I was told...

Ethel, one of the clients, described how her initial contact with the agency included an explanation of the processes and standards.

Jackie: Should counsellors tell you about the standards of practice?

Ethel: I think they should. I guess maybe because I experienced it here. Before I even opened my mouth about what my problem was, I was told about the standards. That is, I was asked to sign forms that described the agency's policies.

Jackie: Was that helpful?

Ethel: It makes you feel more comfortable, and puts you at ease.

Jackie: Is that because you then know what to expect, or that it's a sign of a credible professional organization.

Ethel: I guess with me, it's because they are so confident in their service, that it makes you feel more comfortable going there, and then you're going to go back. If my personality doesn't click with the counsellor, and they don't put me at ease right off the bat, I can't sit there, and I can't be there with that person, and then I can't go back.

Jackie: If you don't click, should you have the right to say this isn't working for me, and I would like to see another counsellor.

Ethel: Yeah

Jackie: Have you ever tried?

Ethel: Oh yeah. Oh, Yeah. I've done that

Jackie: And how did that work?

Ethel: Holy...not very good. It didn't work very good. I ended up going back to my doctor and getting transferred outside of my community. (659-728)

Ethel has clearly said that being told about the standards and procedures within an agency makes her feel comfortable. Wilding (1994) suggests that organizations should be

open about their aims and objectives, their standards, as well as what it can and cannot offer. However, many consumers are not informed of policies, or even their rights. As Larry, another client, told me, he knew that "*he had rights as a person...but he felt that he had absolutely no rights whatsoever*" in one agency he dealt with. Actually, he continued, "*I still don't know if I do or not.*"

Ethel also raises another important issue of openness. The ability to raise issues, concerns and complaints. In her case she had tried to complain, and although we don't know exactly what happened, from her perspective it was not helpful to her. Larry also told me that although the service he was receiving now was "*absolutely wonderful...if something was to happen I have no idea of what to do*" (700). One of the ways that complaints do get back to the agencies are through informal lines of communication.

I'll tell a friend, who'll tell a friend, who'll tell a counsellor

In small communities, with the closeness, rumours and informal networks, one would think that it would be easier to complain. In fact, the reverse seems to be true. Because everything is so personalized people seem more fearful of complaining and circuitous routes are used instead. For example, Irma described how a group got changed in their agency:

> *Irma: We used to do a night support group. The worker decided that the night support group was getting trying on her personal time. Most of the people who came to it were unemployed anyway, so why not do it during the day? After some discussion of pros and cons the group started to meet in the daytime, but the clients hated it. They really did, so it's back at night again now.*
>
> *Jackie: How did they make it known that they hated the daytime group?*
>
> *Irma: They told each other first of all, and then one person leaked the information to their counsellor as part of the reason that she was feeling so anxious. So then that counsellor said to the counsellor/facilitator - I wonder if your group participants really like daytime groups. And then it was just*

followed up with phone calls and then they were quite willing to tell her that, no, they didn't want to do this anymore. (1000-1022)

Irma's example indicates that the initial change was due to the counsellor's needs, even though they thought they had taken the interest of the clients into consideration. However, even in an agency which would consider itself well known, and accessible to feedback, the discomfort over the change of time only came to light through an indirect route. While this feedback works because of the interrelationships in small communities, and it is to the agency's credit that they changed the program, this example indicates that clients are hesitant and unwilling to complain directly.

<u>But he's a Good Joe</u>

Reticence about complaining is not only a problem for consumers in small communities. It also occurs within the professional population. Buxton (1974) identified the reluctance for small communities, to accept that all is not well. He asserted that if people who are known as "Good Joes" in other settings are criticized, especially if it is by an outsider, the community pride will come to that persons defence. As John described concerns about colleagues:

I have numerous concerns about the approaches of two colleagues here in town, but how do I approach that because I'm dealing with people here. It's not a system per se, even though it is a system, it's personalities ultimately that I'm dealing with. Whereas when I worked in a larger Centre, the system could address my concerns. (610-618)

For John, the personalization of the 'system' affects his ability to voice his concerns. When service systems are larger, as they are in urban centres, there is an ability to complain about the service itself. In small communities if one complains about the service, they are really complaining about a person. For most people, that is much more difficult.

Complaining, or giving feedback, is an essential component of openness, but is difficult for people to do. Clients may end up not being able to use local counselling services, and professionals may lose the ability to refer clients to service providers, or be affected in other ways by the rift that often occurs when one person complains about another person's professional practice.

Being open to hearing complaints is one aspect of openness. John, in his quote at the beginning of the section referred to another element: the concept of honesty. He then noted that there was also pressure for him to be honest. Honesty, in this research, related to service providers being up front and sincere with the consumers.

Putting it on the table for the safety of the client.

When consumers walk into a counsellor's office they make some assumptions. As Opal said she "*took it for granted that the counsellor was a professional and knew what she was doing*" (530). Because of an experience in which the counsellor did not have the credentials she claimed she had, Opal's recommendation was to at least "*do simple things like a criminal record check, and reference checks, and ensure they went to the school they said they did*" (510-512) for the safety of the client. It is important for service providers to remember that clients are in a vulnerable position. Many have low self-esteem and so when they have negative experiences with counsellors it is easy for them to internalize the experience, rather than perceive that there is a problem with the system. Small communities are particularly susceptible to the poor professional practice that Opal describes because, as we saw earlier, people are reluctant to complain directly. Also when professionals are

working in isolation, with little, to no supervision there is no method of remedying poor practice.

It becomes incumbent on the counsellor, and the agency, to be "up front" about credentials, limitations, expectations, etc. and to "*put it right on the table before the client even starts counselling*" (5:908). Some agencies have developed orientation packages that outline information such as hours of service, counselling philosophy, appointment scheduling and complaint mechanisms (16:980-984). The consumers in this research respected counsellors who were honest about their limitations and would refer them when necessary (12:759).

In summary, in small communities where everyone seems to know everybody else's business, it would seem that openness in the human service organizations would be occurring. However, there are some idiosyncrasies. Certainly the informal links between agencies, and the proximity of people, often means that information can transmit easily. On the other hand, the formal links seem to be more difficult to utilize. Most clients are unaware of how to complain officially, and for people who do know how, they are fearful of personal ramifications. Ultimately the adage of 'honesty is the best policy' comes through. Clients can make their own decisions if the service provider can be forthright about their policies, strengths and limitations.

<u>"Providing good Service to the Clients" - Acceptability</u>

To be considered a quality service the service has to be acceptable to those who use it, and this was Wilding's (1994) fourth dimension. John, in his opening quote said that services have to be fair, and in turn he must be seen as acceptable. Coulton (1982) suggests

that some avenue should be provided for consumers' definitions of acceptable services; and that for certain aspects the consumers may, in fact, be in the best position to evaluate the services. This is especially true in the areas of convenience and atmosphere. I asked Frank, a community board member to whom services should be accountable:

> *I guess you want to keep your funders happy, because if you don't have funds then you don't have program. But I think there has to be a really good balance. I think you have to provide good service to your clients too, which will keep the funders happy. Lastly the Board of Directors would have to be kept happy. (288-300)*

According to Frank, acceptability is more than providing a fair service to clients. It involves a combination of government, client and community accountability: Are services being provided in a way that is acceptable to tax payers? Are the needs of the clients being met? and, Are the services agreeable to the community, through the mechanism of a board of directors?. In this research there were a variety of responses to the question of accountability, and it was the only area where the initial response seemed to be dependent on the role the person played in the service delivery system. Board members tended to say that accountability should occur through government because they provided the dollars, and without their blessing, no service would be provided at all. Clinicians tended to say that they felt responsibility to the clients or to the community, and Clients thought accountability should initially be to the consumer, and then to the community and government. These findings confirm that definitions of quality need to broaden to include all the relevant stakeholders.

I also asked how accountability should occur. Most non-profit organizations I spoke to provided some kind of questionnaire to clients who attended either groups or individual

counselling in order to assess their satisfaction and to gain client input. While "consumer surveys are one source of information about levels of satisfaction...the level of detail they can reasonably collect is limited" (Gaster, 1991, p. 261). Some also provided avenues for general community input. Many were also somewhere in the process of accreditation with CARF (Commission on Accreditation of Rehabilitation Facilities) which is the process that was initiated by the Ministry of Health. And one agency was initiating a pre- and, post-test mechanism in order to assess the longevity of outcomes.

Acceptability means that the environment and ambiance is supportive and empowering. Ultimately the service has to be considered acceptable to the user as well as the funder. However it is interesting that the forms of accountability discussed in this research such as accreditationand outcome measures are related to standardized measures that can be quantified in some way. These measures, as we've learned earlier are typically associated with the philosophies of centralized public-sector services. Although participants in this research emphasized the human element of service delivery they seem bound to the government's method of proving they have quality services.

Conclusion

Quality human services in small communities are similar to quality services anywhere else. There needs to be minimum standards in place, that can be potentially measured through accreditation procedures. However quality services go beyond that minimal level. Service has to be effective, accessible, open and acceptable to consumers, communities and governments. However, no one counsellor will be able to provide quality services to all clients in all situations. As Katherine points out about quality:

It's so individual. I mean one client may feel that the counsellor is doing exactly what they need and is a wonderful person, and the next client doesn't get along at all, I mean that's normal. (764-768)

Quality has a lot to do with personal preference, and in the human services it has a lot to do with the individual personality and skill of the service provider. That is true anywhere, but in small community this connection seems much more apparent. John identified in his opening quote that he had to be "fair, honest and quick." He linked personal qualities and professional obligations to each other, and to quality service delivery. The integration of the service provider's professional values into their personal lives emerged throughout the research. David told us how maintaining professional confidentiality required personal monitoring; and we were told that the generalist worker required personal flexibility in order to be able to approach situations, or client problems, that were new or created discomfort.

Personal and professional congruence are necessary for any service provider in the human services, but are essential for service providers in small communities. Service delivery in small communities is reliant on the individual service provider; but the service provider is impacted by the community. Therefore, in order to understand quality service delivery in small communities it is essential to understand the service providers' experiences.

Chapter Six

The Experiences of Service Providers in Small Communities

One of the successes of privatization has been to provide services aimed at alleviating personal distress directly in small communities. The social setting is where private troubles connect with public issues, or social policy (Wharf, 1990). To have a quality service in the small community the social context has to be taken into consideration. This research found that the social environment of small communities had a notable influence on service delivery. In the previous chapter a theme that emerged was that in small communities the service providers personal qualities are intertwined with the quality of the human service they are providing. This chapter will show how the environment the service provider is working in intertwines both with his, or her, own personal qualities, but also with his, or her, ability to be perceived as providing quality service delivery.

I recognize that that might sound jumbled and confusing, and, to some degree, that is what it is like for a service provider trying to provide quality services in small communities. Perhaps it is easier to use a clinical analogy. When social workers work with clients they do not isolate the problems the client is facing from their circumstances. Individuals are considered in terms of their environment, and its impact on their functioning. Similarly, if we want to understand quality service delivery in small communities, we need to consider how the individual service provider is impacted by the social environment in which he or she works.

The more remote areas of the province experience many difficulties attracting skilled workers (Flavelle, 1989; Ministry of Health and Ministry Responsible for Seniors: Report of

the Northern and Rural Health Task Force, 1995). The non-profit sector, which commonly offers lower wages, limited benefits, and insufficient post-employment training opportunities, has even greater difficulties (Korbin, 1993b). In spite of these disincentives, people do relocate and find themselves working in the north. This chapter will consider the common themes that emerged for service providers as they live and work in the small northern communities of British Columbia.

Pulling out the map...to move north.

For many service providers in this research, including Charlene the north is seen as a place to gain experience in order to later transplant those skills to the southern job market. Thus new workers "pull out their maps" (10:18, 16:28) and relocate, and the north becomes an unofficial training ground for new graduates. Others are attracted to the north for more intrinsic, personal reasons. As Harry told me, he had grown up on a farm and felt most comfortable in small communities (1158-1162), and Grace referred to the north as the "*world's biggest playground*" (60). On the whole, helping professionals are attracted to the north either because of the external motivation of a career opportunity or because of an intrinsic comfortableness in the north. When the extrinsic job opportunities, joins with the intrinsic enjoyment of northern communities, a sense of "fit" occurs. As Maureen identified:

> *I prefer small communities, rather than the large cities. I was born and raised in a small community, and in an atmosphere where everybody knows everybody, or knows someone who knows somebody. I like the quietness outside of the community, I find people in a smaller community to be much more helpful, and they tend to pull together more. From a professional perspective working in a small community is an advantage. I like the challenge of taking the primary responsibility for a situation I'm dealing with. Most of my life I've been a very independent kind of personality, I like being out there, with few resources and looking for ways of being creative and developing strategies to deal with a family situation. (18-94)*

This interweaving of the personal (enjoying the quietness and the enhanced interdependence), and the professional (more autonomy and opportunity for creativity), which Maureen describes emerged as an essential theme throughout this research. Considering personal life versus professional work as a dichotomy is an inappropriate way of describing life in small communities where each person has to find his or her place in the community both as a service provider, and, more importantly, as an individual.

The Jumble

The fact that *"everybody knows everybody, or knows someone who knows somebody"* and the inability to separate who you are from what you do, complicates the provision of human service in small communities. Psychological accessibility was identified as a component of quality in the previous chapter. In small communities it is essential that the complex intricacies, and the social context are understood in the provision of services. Pat explains:

> *I think just because the town is small, doesn't mean the issues are simple. In many cases the smaller the town the more complex the issues because...nothings clean - everything gets jumbled up together because the place is so small. The bottom line is because we're in a small town, and because we're isolated we cannot fool ourselves into believing that things are easier. It makes it even more important that the people who work in isolated areas know what they're doing, and have a good, not only a good clinical base, but a good ethical base and that there is some sort of quality assurance going on. (1194-1210)*

Pat's thoughts epitomize some essential ingredients in small community life and work. The jumble she describes refers to the fuzzy lines around professional relationships; the interrelationships between clients and clients, and between clients and counsellors; and the blurring of boundaries between the public-counsellor and the private-person. However, the issue of isolation that occurs within this jumble of relationships further confounds the

situation. It is somewhat like the adage of being alone in a room full of people. Everybody's lives are inter-related, and entangled with each other and yet there is often a sense of being alone. What does this isolation refer to? Is it simply geographic isolation, is it the separation from other centres of expertise, or is there a psychological isolation experienced by workers in the north?

Notwithstanding the complicated relationships and the isolation, Pat sees a necessity for quality in service delivery. Furthermore she interweaves personal and professional attributes. Quality service delivery is dependent not only on the knowledge (clinical base), but also on the personal integrity (ethical base), of the service provider. In order to begin to understand quality service delivery, Pat says one must first grasp the social context: the complexity of small communities. A person doesn't just work in a small community, they are a part of that community, and so are their clients. Peoples lives are interconnected within the community; and the people who are providing human services get drawn into this jumble. Service providers in small communities are faced with a range of circumstances which impact on their ethical practice, their professional and personal life, and ultimately upon quality service delivery.

The Fishbowl

High visibility and lack of anonymity are well known aspects of working in the north (Zapf 1985; Ingebrigston 1992; Ginsberg 1977; Jackson 1983). What is not so clearly depicted in the literature is how this impacts on every aspect of the workers' lives, and can eventually affect not only the people as individuals but also the delivery of service. David describes the uniqueness of providing service in a small community:

There's lots of things that make it unique. There is the aspect that the service provider is in a fishbowl, he can't leave his job at work, there is no anonymity. You can't be a counselor eight hours a day and go home. You have people approaching you in the mall, you've got people approaching you at the supermarket, with your kids in the park. You keep running into clients. (1153-1160)

All aspects of the service provider's life are impacted by the visibility of his or her job. Even buying milk or playing a game of catch means you will be seen and watched, and perhaps approached as a service provider. It also impacts on the family, as David mentioned, and it becomes incumbent on family members to learn to deal with the service provider's occupation.

Rumours, Perceptions and "Profile"

One of the consequences of being visible, is that service providers are identified by their role, or job title, even during off-work times. The helping professions are particularly susceptible to transsituational demands[18]. Usually through the professional socialization, process workers develop strategies to separate their role as a 'helper', from that of citizen; they may be selective in their friends, or even conceal their occupational role (Barbour, 1985). However, separating the private world of home and the public professional role is not as easy when you live in a fishbowl. Therefore, many workers strive to act in a manner that they feel is consistent with their profession. Anne describes how she has accepted the merging of her personal and professional roles:

I can't separate the counsellor part of me, totally from the person part of myself. When I play baseball, or am involved with other clubs, those people know me as a person, and I'm a representative of the agency, and whether I like it or not, those two parts of me are associated together. So it's important to keep up a good profile here, in the sense of not hanging out at the bar until

---

[18] Transsituational demands refer to the expectations that professionals behave in situations where they are not functioning as professionals in a manner which is nevertheless congruent with their claims to that title. (i.e. their identity as a professional is transferred from one situation to another).

closing time, or other things like that. That's how reputations occur. Rumours start a lot quicker in a small town - good or bad - people just talk a lot more. (766-804)

Anne talks about the reality that perceptions occur and "*whether she likes it or not*" rumours will start, and reputations will be made, or broken, on her overall conduct. Perceptions and rumours often start from something small. As Anne remarks she ends up playing ball with clients, which results in dual relationships, and potential boundary problems. Sometimes these relationships are perceived as inappropriate. Other service providers, trying to avoid interacting with clients, develop friendships with other professionals in their community. This can lead to perceptions that professionals are discussing mutual clients. Harry described how the perceptions get distorted:

Let's say you have mental health stress which results in alcohol and drug problems, and spousal abuse has occurred. Maybe the husband is going for Alcohol and Drug counselling and the spouse is going to the mental health counsellor to deal with the abuse issues. Then when the alcohol and drug counsellor and the mental health counsellor are seen having lunch together, and the clients see them, they wonder what side they are going to take? (299-307)

Harry described a situation where there was no evidence that confidentiality had been broken, but the association of the professionals led to perceptions that it had. Either of the above examples (playing ball with clients, or having lunch with colleagues) can, and do, create rumours that, as Anne points out, are just a fact in small communities. However, it is Anne's perception that it is incumbent on the service providers to ensure that they maintain a "good profile" and a "good reputation" in order to represent their organization appropriately. This sense of responsibility towards the agency perpetuates the sense that service delivery is more associated with the personal attributes of the provider, than the organization's strengths.

Another perception problem that service providers face in the north is that their work is not valued sufficiently. Some people view professionals working in the north as unsuccessful southerners. Norman described some of his stereotypes about northerners:

> *When we moved north we thought the only people who ever moved north, or lived in the north are those that can't make it in the south. So somehow we're lesser beings, we're up here doing our job because we weren't smart enough, or educated enough or whatever to do a good job down south - so you don't have to pay attention to those people. (1206-1216)*

Norman is saying that in addition to worrying about perceptions within the community, one is also faced with negative outside viewpoints. Service providers in the small communities experience a myriad of influences on their behaviours. They must blend their personal needs, with their professional ethics and withstand the scrutiny of community members and outsiders alike. The issue that becomes most conflictual and has the most potential of impacting on the perception of quality service delivery is that of dual relationships.

Friend or Counsellor?

Professionals in small communities are constantly encountering clients in their social lives, which creates a great deal of difficulty in terms of the issue of dual relationships. Throughout their professional education, social workers are trained to maintain clear and unambiguous boundaries in their relationships with clients because confused boundaries in clinical relationships can be very destructive. While there are clear prohibitions on sexual contact with clients, Ramsdell & Ramsdell (1993) suggest that social and business relationships between client and counsellor are also coming under scrutiny. This makes it

difficult for service providers in small communities who meet either past or present clients at many of the social groups they belong to.

Friendships and therapeutic relationships are different. As Kagle and Giebelhausen (1994) point out, therapeutic relationships may be friendly, but they are not a form of friendship. They argue that any dual relationship, including friendship, involves boundary violations. This ethical argument forces workers in small communities to make some very difficult decisions regarding their social conduct vis-à-vis their professional lives. Irma describes the issue:

> *You know, there are not very many things that happen in small communities, and when an event does occur, you know that you're going to be there and so is your client. And it's not only the events. It's going to the post office for your mail. You meet a client in the doorway, now do you say hello, or do you not? You wouldn't have said hello last week before they were a client because you didn't know them. (1158-1171)*

The visibility and chances of dual relationships occur in virtually every activity. The reality of living in small communities is that in order to lead a satisfying non-work life, which usually means interacting in the community, non-therapeutic contact with clients is inevitable. Charlene describes her experiences in this dilemma:

> *I think when I first started, I was very conscious of being a professional 24 hours a day, and still am to a certain extent. But I've also relaxed personally...I mean, Saturday night at a dance and I want to have fun, I'm going to have fun - respectfully, of course. I think you would burn yourself out if you had to be rigid and not respect that. Sure, I'm the counsellor [but] do I have to be professional in everything I do? To me that's not human. You have to have a release. You can't live your job 24 hours a day. (766-783)*

The continual visibility, lack of anonymity, and the attempt to avoid dual relationships can affect the service provider's willingness to enter into the community in a meaningful, normal and social way. Some workers, to avoid role conflict, become insular.

However, that leads to limitations for both individual service providers and their families, as well as a distancing from the community. This withdrawal can lead to mistrust and a problem with credibility which, as Ginsberg (1974) notes, is such an essential part of effective practice in small communities.

While the literature on 'burn out' in social work is by no means conclusive, Soderfeldt, Soderfeldt, and Warg (1995) indicate that high demands in work, combined with low work control and little social support, are associated with stress and health problems. They refer to this as the 'demand-control-support' model. Service providers in small communities would seem to be particularly susceptible to this. Norman described how he went through different phases of dealing with the stress of being high profile.

> *My partner and I enjoy this community, we know a lot of people and enjoy going to different things and trying new things. That hasn't stopped, it did for a while but its back on the go again.*
>
> *Jackie: Did it stop because of the professional role?*
>
> *Norman: Yes, it was to the point at one time, when everything peaked, that we couldn't go out for dinner. Everywhere we went it seemed that the people would come over and join us, uninvited....The only people who really knew that I was in distress were my family. The distress which was a result of a number of things, including the isolation and the stress of the job, resulted in my taking a month off work. (182-194 and 551-560)*

Norman, very candidly, was able to express how he tried to be a part of the community, but at one point it simply overtook him, and he was unable to control it. To counter this he withdrew from the community, which meant that he withdrew from his support network. Not surprisingly, that didn't work either. The confusion of how to live successfully with high pressure and high visibility eventually led to such distress that he was encouraged to take time off work. Norman is now working on developing other strategies to

be able to look after himself, and still lead an effective professional life. One strategy that is sometimes used, is to develop friendships with other helping professionals in the community. This reduces the chance of mingling with clients and provides an avenue for relaxed social time when the worker can be just him or herself - no longer 'the helper'. It also has the added benefit of providing some collegial support. Grace, who works in a stand alone office, describes her relationship with another counsellor:

> *The mental health worker here and I get along very well as friends. It's a network that started professionally, and partly personally. She has a different area of expertise, which has allowed for some clinical mentoring, and we can bounce ideas off each other. That has been valuable to me. (91-97)*

Grace describes a personal connection with her colleague. Friendships that develop between peers serve to reduce the risk of dual relationships with clients as well as reducing the transsituational demands described earlier. However, there is still the risk that the same friendship will be perceived as breaking client confidentiality. Harry described how that can happen earlier in this chapter. Grace, in her quote above, notes that in addition to friendship there is a professional need to mentor and network which is lacking in her own organization. Through Grace we are beginning to understand the isolation that occurs at a personal level, and also at the professional level. Who provides support and feedback to the service provider if he or she works alone?

Isolation - Being on the 'inside'

Professional isolation has been well documented (Zapf 1985, Ginsberg 1979, Farley et al., 1982). Components of this isolation include lack of a reference group for support, consultation and supervision; geographic isolation, and a loneliness that is associated with being 'the only one'. My conversation with Anne raised some important considerations:

Anne: I think we should have contact with the outside world. We aren't always going to have the answer here for something and if it's something difficult, maybe we can go outside to see what everybody else is doing.

Jackie: For what sort of things would you go to the outside?

Anne: Training. Holidays. (506-516)

Anne identifies the need to seek expertise and specialization, particularly for the more difficult cases. Mentoring, among social workers, has been shown to impact positively on both the mentor, and the protégé and serves to enhance career satisfaction as well as personal competence and self-esteem (Collins 1994; Wright & Wright, 1987). However, the building and maintenance of a professional network is often not available for the service providers in the small community. For Anne, the desire for positive professional connections interacts with her personal need for a break. Her reference to the 'outside world' indicates some of the feeling of being cut-off, and somehow separated. Some of that is for the ongoing stimulation of ideas and knowledge, but I suspect part of it is a need to get away from all that jumble and high involvement.

Geographic isolation is also a reality of working in small communities (Farley et al., 1982; Millar 1976). The harsh climate and the long distances between communities increase the feelings of being 'cut off' from the outside world. Norman recalls his early days in the community.

I remember when I first moved out here, I found it rather difficult. The isolation - I can remember when they closed the [road] - I panicked, I thought I was stuck, and all the "what ifs." If something happened to my family on the island, how was I going to get there? And just irrational thinking because I felt trapped. (12-18)

The feeling of being trapped by the closure of the road passed, for Norman, after about five years. But the feelings of being isolated, and 'trapped' are real, and a physical

need to 'get out' exists - holidays are a necessity. "Getting out' also means getting away from the 24 hour responsibility of being empathetic, genuine and congruent in your personal and professional values.

Although everyone knows everybody, and the service provider is highly visible, ironically there is also a corresponding sense of personal isolation. Often the only other professionals working in small communities are nurses and school teachers, each of whom have colleagues within their own discipline. Professionals providing human services may be the "only one" doing that kind of job. As Farley et al. (1982) noted in their work on rural social work "being the only professional person in the area can become very lonely, [and] people in the community begin to expect a lot from the professional and the pressures can build" (p. 10). Building networks, collegial support and opportunities for the service provider to feel connected can assist service providers in small communities coping with their day to day work.

Big Fish, Little Bowl...Living with your work.

As workers become better known in their communities they often, as Ginsberg (1974) noted, experience an increased sense of responsibility as well as a high degree of scrutiny. This occurs without planning, or even desire, on the part of the service providers, who find themselves becoming big fish in a small fishbowl. Harry describes this heightened leadership role in his description of providing services in small communities:

> *Maybe that's what health care is all about in the rural sector, you can't just do it and walk away. You have to live with the results, you have to live with the relationships, because you see the people on the street. (1212-1221)*

The commitment to providing health delivery, that Harry describes, is one where the individual provider will live with the consequences. This sense of responsibility for other people's care can be very rewarding, but on the negative side, it can place unrealistically high expectations on the worker.

Service providers end up living with their work, partly because they have few available options for disassociating themselves from their work. Zapf (1985) cited a study by Pajak and Blase (1984) in which teachers used a bar as a transitional setting to unwind after work. This option is clearly not available to human service providers. In particular alcohol and drug counsellors, whose own substance use will be under scrutiny in the fishbowl, lose this method of relaxing after a hard day's work. As Bob noted:

> *I don't think I have the right to go to the bar on a Friday night and get absolutely plastered. I mean I think I would lose my credibility within the community. I feel all professionals should conduct themselves in a certain way. (762-769)*

The pressure to always conduct oneself beyond reproach, coupled with the difficulties of unwinding, and the feelings of isolation, lead workers to swing back and forth between over-involvement and a sense of defeat. Irma, a long time employee in the north talked about how she struggles to put her work life into perspective.

> *One of the things I do, and make a point of doing, is to keep my personal life separate....Over the years I've worked on being able to forget about it, go home and just put it behind me. It takes a while, but my health figures that out. I used to lose a lot of sleep over it, but...*
>
> *Jackie: And I guess the hope is that you don't get too jaded. Like there's always that line between being...*
>
> *Irma: Oh, I think I've been there. And back and there and back. I think you do that. And I don't think there is anything you can do about it. There have been times when I have felt so negative, and I hate myself for the things that I think. And that's hard too. (1441-1456)*

Irma indicates the constant, ongoing struggle that counsellors in small communities experience. Balancing the caring, genuine, involved person and the need to have time away, and experience a personal life is sometimes formidable. Many workers 'burn-out' or leave small communities. As Pat told me "*the longest anyone stayed in my position before me, was five months*" (10). Northern and rural Canada have long been noted for staff turnovers. Korbin (1993b) noted that the non-profit sector is particularly susceptible to turnover. "Funded agencies think that they have become training grounds for the school districts and government-run agencies, where wages, benefits, and working conditions are superior" (p. 7). For quality service delivery to occur in small communities the issues of supporting staff, and reducing the personal pressures need to be considered.

I need to get to know you...

The high turnover of staff has a particularly negative impact on small communities. When relationships are developed on an intimate, personal level new workers are expected to 'prove' their abilities and commitment to the community. This occurs at the community level, but the professionals who have stayed in the community also look towards the new worker to 'prove' him or herself. As Norman described:

> *It takes a lot of time and energy to get to know people. I'm very cautious about referring people to people I don't know, particularly when they first come on board. Just because they have a degree, or just because they say they do this, that or the other thing, doesn't mean anything. Sorry, but I want some proof. First I want to get to know you. (426-434)*

Another issue inherent in the high turnover, and the small numbers of people providing service is that the client service gets very individualized. Trolley (1993) noted, in his evaluation of Mental Health contracted services in the northern region, that in many of the

programs, "clinical staff person/people are operating within their own definitions as to what is appropriate clinical practice" (p. 4-4). He referred to this as the "private practice model in an agency-based system." John noted the change of style between himself and his predecessor:

> *Having replaced Yolanda, who was my predecessor, the styles were totally different. She was more community oriented, and that's something I would like to do, but right now I feel a little bogged down with my office hours and that kind of counselling. But then again it's my assessment of what the community needs are, as well, and how I can serve them best. Now that I've been here for a couple of years people sense what my style is, and they feel comfortable with it. We've met in the middle ground, whereas in the beginning, I couldn't say that was the case. (343-354)*

When there is a change in service providers, adjustment occurs at two levels: the individual learns about small community practice, and the community has to accept a different professional style. With patience and acceptance from both parties a new relationship can be developed which is satisfying to both - until the next, inevitable change.

Conclusion

Service providers in small communities are identified as the service delivery system, and have many pressures placed on them. They are often new, idealistic or inexperienced workers who planned a short stay in a small community. As Maureen said "*those people came to the north because of a job opening, got a couple of years experience, and then they are gone*" (661). As they begin their career in a stressful position, they have to work out their place in the community and how to maintain a sense of balance in their own lives while living in a fish bowl. The personal transition is compounded by the nature of the work, which is complex and requires a range of knowledge. Professionally, they must learn to deal with ethical issues such as boundary development, and the inevitable dual relationships. This

is all further complicated by their working alone with minimal, if any, clinical support or mentoring. The consequence of all of this is that many workers experience frustration about their ability to help. This is particularly so when they are newly trained themselves and lack experience, but are still expected by the community to 'do something'.

For quality service delivery to occur the people providing the service have to be both congruent, and be seen to be congruent with what they are providing. The separation of the person and the professional is not a simple division of where his or her body happens to be - at the office or in the supermarket. The community will assess the service provider on his or her personal qualities, and the qualifications will be considered only after the person is perceived as having genuineness and integrity.

Nevertheless, many service providers do enjoy small communities. Whittington (1985), in her study of social workers in non metropolitan communities, found that seventy-five percent of them enjoyed their work, and planned to stay in their community. As Pat says

> *I don't like the isolation, and I don't like the lack of resources, particularly that I've got no back up in a crisis, but so far the good has outweighed the bad, and I'm still here. (64:66)*

There are good things and bad about providing services in small communities. Pat told us that small communities were complex, and certainly service providers in small communities have issues to deal with that urban providers do not. The difficulty in recruiting qualified people, and the high turnover does leave many people with the impression that quality service delivery cannot occur. As Anne says:

> *Sometimes there has been the idea that if you're in a small community there can't be anything of quality here, and it's something that we have to work on exposing to the community. (766-769)*

Anne seems to think that quality can occur in a small community. Quality in small communities means ensuring the social context is considered in the delivery of services. Service providers require collegial support and opportunities to network with other professionals. When service providers have no avenue to connect with colleagues in the larger Centre they feel isolated and 'cut off' from the *"outside world."* Although service providers often work hard at developing horizontal linkages within the community it doesn't seem sufficient. The strong connection the service providers have with the community, while on the one hand is beneficial also leads to a pressure to be all things to all people, which leads to burnout and turnover in staff. Finding ways to reduce that pressure would enhance the ability of service provider to provide quality services. The social context also affects the psychological aspect of accessibility because service providers, as well as the clients are visible. This causes jumbled relationships. Effective services are compromised when there is frequent changes in staff and newly trained workers are the norm. Being accepted in small communities is related to knowing the service provider as a person, which means they must be a part of the community, while maintaining a professional profile. And around it goes.

The question then becomes: Can small communities provide quality service delivery, without placing undue expectations on the individual service provider? To consider this question the organization of services needs to be looked at. The organizational structure within which the service is provided has a great deal to do with the implementation of quality. The total quality management (TQM) movement recognized the responsibility of the organization, and one of the purposes of privatization was to allow for smaller organizational units that were more flexible and responsive to consumer changes. The best people to tell us

about how services are organized, and could be better organized are the participants involved in this study. The next chapter will consider how services could be configured in order to develop quality service delivery.

Chapter Seven

The "How" of Quality - Service Organization

To answer part of the 'how' to organize services in small communities, we have to return briefly to social policy. In the not so distant past, many of the services in the small communities were provided through the government public sector. Lockhart (1986) in her study of human services in the northwest region of B.C., found that a 'core trinity' of services consisting of the Ministry of Human Resources (now called the Ministry of Social Services), the federal employment and unemployment services (now called Canada Employment), and the police (RCMP) were established early in the development of small communities. She noted, that other services, were "fragmented and dispersed in some cases, centralized in others and lacking altogether in some instances" (p. 212). Since Lockhart's (1986) report there has been a substantial increase in services due to the increase of non-profit societies providing human services, although they may still be fragmented.

The public sector still plays a role alongside the non-profit sector in small communities. This combination of services has sometimes been referred to as a 'mixed economy of welfare' (Kamerman & Kahn, 1989: Rekart, 1993). Each sector provides different services and seems to serve different populations. The private sector has been noted for its tendency to be more selective in targeting particular needs and populations (Azim, 1987), and Jansson (1979), in his study of non-profit societies found that they were less likely to serve people from minority or low income groups. In this research when I asked what quality service delivery was, Irma's response was typical:

> *It's very difficult. I know that your client would have to be happy. The client would have to feel comfortable, they would have to feel secure, they would*

have to feel like their needs were being met. They would have to be happy with the outcome of their needs. (789-796)

Irma's response reflects the community based, consumer oriented approach to quality service. Client need, as identified by the client is the criteria for admission. Service delivery then becomes focused around goals the clients set for themselves, and in conjunction with the service provider works towards an outcome that the clients see as being worthwhile. This is central to goals of self-determination and client empowerment. The dilemma is, what happens to clients who are unwilling to acknowledge the need for help, but society has decided that assistance should be given to them. For example, clients involved in child protection issues, or other court appointed counselling services, who are likely unwilling participants in service provision and may not identify any problem that needs addressing. As a probation officer who refers to a non-profit society, said:

When I first got here, I would get calls from the non-profit counselling service, and she would say I don't know why you're sending me these clients, they don't want to be here. My response to her was, well what did you expect, the judge ordered them to go. I mean, anyone you get from me, with a few exceptions, is not going to want to be there. And she said, well we can't really work with them. I was in a position that these people are court ordered to attend counselling, my only other option was to go back and say, your Honor, the counselling agency isn't willing to see any of these people because they don't want to be there. And I don't know what kind of response I would have gotten from the judge. (212-276)

The purpose of including this quote is not to have a dialogue about how to work with resistant clients, but to indicate how providing services only when the client identifies, and takes responsibility for his or her actions, eliminates a segment of the population that could benefit from service. This problem becomes exacerbated by quality control programs which consider outcome measures[19] as the criteria for assessing good service delivery. If one has to

---

[19] For a fuller discussion on outcome measures see Chapter 3.

prove they are making a substantial change in someone's life, in order to maintain funding, it is to the agency's advantage to serve the client's who are most likely to benefit from counselling and to develop functional life skills.

The public sector, as has been described earlier is characterized by its consistent approach to services, with universal norms applied uniformly regardless of social context or individual circumstance. Having worked, all my social work career in the non-profit sector, I was unaware of how far that philosophy actually went. I asked one service provider in the study about the need for flexible programming in the north. His response surprised me, and indicates the dangers of all services being provided through centralized hierarchies in uniform ways:

> *They [referring to Vancouver & Victoria] are still planning programming for up in this area based on their experience down there, and they are very controlling. I mean very concrete stuff, like our building. You know it is totally controlled from Prince George. We don't control our heating, or nothing, everything is done by computer from Prince George. So if its 30 below there, then the assumption is that its 30 below here too - and it's not necessarily the case....They can tell us if there's a window open and how much its open by, and in which office. They can tell us if the door is open a crack. (818-835)*

Aside from my amazement at the technology of being able to do this, it indicates the degree of centralization that can occur - and the absurdity of it. If providing services through the public sector means the service providers cannot even take responsibility for their own temperature, its difficult to imagine how they could respond to the flexibility of work needed in small communities.

The answer to part of the 'How' question is to maintain a mix of public and non-profit services. Privatization has allowed for services to be delivered locally, and to meet client needs, as the clients identify them. But the services in small communities have, to

date, mainly been modeled on urban experiences (Collier, 1984; Mermelstein & Sundet, 1977; and Martinez-Brawley, 1980). The preceding two chapters have considered how quality in the remote centres is conceptualized and how service providers working in those settings are affected by the social context. It is not sufficient to understand what quality means in small communities, or even the social context of service provision in small communities, if the practice settings do not reflect those understandings. This chapter looks at the organizational 'how' of providing quality services in the small communities.

Current Services: the Appearance of Horizontal Integration

The imposition of urban models on remote communities continues to exist, even though Zapf (1985, p. 33) and Collier (1993, p. 31) express the inappropriateness and harm in doing that. Pat, from this research said:

> *If all help originates from Victoria then all help has an urban flavor, and an urban mandate, and an urban set up. Victoria does not understand, and I know everybody says this, but if you live in a city of 1/2 million people where it never snows, then you really do not grasp the reality of having to go to an appointment that is an hours drive by car in 40 below weather with 2 feet of snow. Urban centres because they have different issues, they have different personalities and when you see programs that are set up for urban centres then you have problems. (718-732)*

Over the last fifteen years a number of different methods of providing services to small communities has occurred. The typical model of service delivery, to the best of my knowledge, during the 1970s and 1980s was the 'circuit rider' approach. In this model a single professional - the circuit rider - delivers outreach services (Poole & Daley, 1985). Disadvantages of this model include heavy travel demands and the associated costs, the absence of team support, and more importantly from the small community perspective, the 'circuit rider' is often unaware of community dynamics.

Another approach is to have a scaled down extension of an organization located in the small community. The local "satellite" is affiliated with a larger regionalized agency and is presumably able to call on the wider resources of that centralized office when necessary. Another approach which has been used to provide services in other remote communities has been to make use of technology in creative ways. Segal (1973) described a community in New Hampshire which linked the physicians by closed circuit T.V. to the Department of Psychiatry in the major Centre. The patient and the physician would go to the hospital studio where they could see and talk to the psychiatrist. After the psychiatrist interviewed the patient, the two doctors conferred. They found that television was a good medium for psychiatric consultations, and the patients accepted it. Plus it had the advantage of maintaining the patient in his or her home community.

The latter approach, to my knowledge, has not been used in northern B.C.; the first two have with moderate acceptability by either the service providers or the consumers. For the last fifteen years the most prevalent model in northern B.C. has been what Trolley (1993) referred to as "the private practice model in an agency based setting." This describes the non-profit sector in the north. An arms-length contract is developed between government and a non-profit society. That society then hires service providers who work in isolation, or in offices with few employees. Because there are few guidelines either in the agency, or imposed through the contract each service provider, and agency, adopts their own style and definitions of appropriate clinical practice. This sometimes has disastrous results, as Pat describes:

> *If you have an administrator and/or a board that is made up of people with serious personal issues of their own, boundary issues, power issues, money issues...then that is really bad. There have been situations, many times in*

different places where everything from money disappearing to confidentiality being breached by board members reading case files, and gossiping about them, to administrators walking in on counselling sessions because they are the boss, all that stuff just makes my hair stand on end. (263-277).

In the small agencies, there are very few checks and balances, and with no guidelines in place and few accountability mechanisms unethical practice can continue for a long time. Fortunately that is not the norm. In some cases, the community benefits from the particular expertise and strengths of an individual worker and when there is a good relationship it seems very good. But, a major downfall of the undue reliance on individuals, is that when they leave (and the good ones eventually will), the community is placed at risk. A consequence of the private practice model within the agency system is that it does not have longevity and continuity. Different providers entering into the community must learn the intricacies of the community, must learn how to deal with ethical and boundary issues, as well as develop their own style of community practice. In addition, it is difficult to provide growth and expansion in community care when each provider is having to relearn basic small community practice.

Even when there are several programs working together under a single roof - what appears to be a multi-service agency - in most cases is a number of programs working side by side. The agency holds a number of contracts with government, with each contract stipulating the various programs' needs and accountability measures. This results, in some cases, in service providers working in a small community being paid by the non-profit society they work in, but identifying more with the Ministry program they are contracted to provide. Bob describes his professional relationships:

I've been very fortunate that when I worked for Social Services there was a fair amount of networking and workshops provided and meetings and that. Now that I'm in Alcohol and Drug I'm finding that it's fairly good there also. (201-204)

Bob, in fact works in a non-profit agency, and has never worked for either of these Ministries, but his role in the agency is to delivery services that are contracted by the agency with those ministries. Bob shows us how subtle, but real those vertical connections are. This occurs partly because each Ministry has separate accountability mechanisms, and some have their own paperwork to complete which perpetuates the vertical linkages. Social policy is still being delivered in a vertical stovepipe fashion. The agency may be able to project horizontal integration at the community, and practice level, but eventually through audited financial reports and statistical analysis reports, each program will have to be broken down separately.

The Multi-Service Organization: Horizontal Connectedness with Vertical Linkages

A multi-service, or umbrella organization, is one that provides a range of services, that under other organizational arrangements would be provided by several categorical service agencies. The idea is not new. Webster and Campbell (1977) recommended a consortium model for rural areas in the U.S. And, of course, B.C. experienced the Community Human Resources and Health Centres (CHRHCs), in the mid 1970s under the NDP government[20]. These were mostly based in small communities, and it was found that integration worked, and that a higher quality of service could be provided when energies, information and expertise were shared (Wharf, 1985).

In this research there was almost unanimous agreement that personal and community services need to be provided under a single umbrella organization. Grace explained some of the reasons:

---

[20] For further information look at the review of privatization in B.C. in Chapter 2

I have heard from other communities that they keep a firm boundary between, for instance Alcohol and Drug Programs and Mental Health Services. They say, look, our mandate is different, and we want to maintain that degree of autonomy. Here we are in separate facilities which I think is to the detriment of the community. But also personalities factor into it, it tends to be that "Yes, this is my mandate, and these are the guidelines that I work in", and "No, that's not mine, that's on your plate", and "I'll help you, but it's not my responsibility and I'm going to hand it back to the person that foisted it off on me.

Jackie: How would you like to see services?

Grace: I would like to see the health Centre concept go ahead. I would like to see all the various clinicians in one physical spot because for clients, a lot of the clients are multi-serviced so they are currently going to various people.

If we're all in the one spot, and we're all working together it makes conferencing simpler. It basically gives people one stop shopping. It would also be easier for the interchange of information.

Jackie: So it would be easier for the clinician?

Grace: It would be easier for the clinician and for the client. With common administration and screening staff at the front end, you could say well who would you like to see, we've got this, this and this service and this is what's available here, this is who's here today and carry on that way. (201-240)

Grace describes how the regional mandates that currently exist have led to a fragmentation of the services - different agencies working with different mandates, located in different settings and promoting rigid boundaries between them. However she is suggesting that if a multi-service model was used, the integration would benefit both the client and the service provider. The client, who may have a multi-faceted problem is more likely to receive complementary services and the clinician would benefit from collegial support. This model has the added advantage of being consistent with the current political structure which encourages fiscal responsibility through the streamlining of administration and reduction of duplication in services.

Hookey (1979) describes three principles of multi service agencies - 'coordination', 'collocation' and 'fusion'. Coordination refers to the centralization of such things as board functions, reception and files and data banks. It also provides for joint endeavors such as publicity, staff responsibility, client intake and follow-up functions. Collocation pertains to the physical setting of the offices in one building and Fusion refers to the provision of multi-disciplinary work groups. Fusion, at its best, would also include acknowledgment, through the amalgamation of contracts, of the collocation and coordination at the community level.

This research indicates that multi - service agencies in small communities can provide much more than simply collocation and coordination - they can work towards providing quality service delivery. The remainder of this chapter will explore how a multi-service agency can mitigate some of the more difficult aspects of the social context for the service provider, by diffusing the pressure and reducing the isolation of workers, as well as providing an organizational structure that promotes quality by enhancing the effectiveness, accessibility, and openness; all the while being considered acceptable to the client, community and government funders. Of course, no organizational structure is without its disadvantages, so the potential pitfalls of multi-service agencies will also be considered.

Providing support for the service provider

The essential nature of small communities is not going to change. The geography will remain the same, with long distances between regional centres and the small communities. It is unlikely the small communities are going to have vastly increased populations; and the climatic conditions in the north will continue to provide long, hard, cold winters. However the isolation, the visibility, and increased responsibility which so

profoundly affects professionals in small communities can be reduced when they work together in a multi-service agency. As Bob said:

> *I think it would work better in a small town for everyone concerned to share resources, to have that network. There would be less chance of isolation when you're together. (549-554)*

When the providers of personal community services collocate, opportunities for mentoring, networking and collegial support occur, although the downside is that some of the individual autonomy may be forsaken. However, with more staff working together, the responsibility for the community's problems are spread over more people. Even the never ending requirement to attend planning and community meetings is distributed among more staff.

One of the issues for service provision in small communities is the lack of training and mentoring and general support. Irma tells us of some of the possibilities in multi-service agencies:

> *If you have all the service providers under one roof you can do neat things with them. Like you can have your own in-services and have everybody there. Also they are never alone, you can plunk down in any spare or blank counselling time and use it for networking or support. I think one of the biggest things with programs when they first start is that there is no support for them whatsoever, and they feel very, very alone. There was no training, there was nobody to talk to, you know, it was horrible. (239-255)*

As training opportunities increase, and there is an increase in staff, the reliance on expertise in the Centre is reduced. Therefore a multi-service agency can provide accessibility through increasing the options available to clients and providing a larger range of services.

An issue that was raised earlier was the difficulty service providers had with dual relationships in small communities. This problem can be significantly decreased when service providers are working together. Anne tells us why:

If you know that person ahead of time, it makes it very awkward when they come in for counselling. In a multi service agency you have more freedom to say that I know this person, and maybe someone else can work with this person instead. (225-230)

Anne suggests that ethical practice for the service provider may be enhanced in a multi-service agency because there are more choices for the counsellor to identify that they have a conflict, either due to knowledge or acquaintance of a client, or because of their own apprehension about certain clinical issues. This, in turn, provides more choice for the client as they also can identify dual relationships and be offered an alternative counsellor. If services were to amalgamate under one umbrella it would be important that services maintain, at least the level of quality that exists now. Can multi-services, or umbrellas provide that? Let us look at the five areas that had been raised earlier: Standards, Effectiveness, Accessibility, Openness and Acceptability.

Standards

As stated earlier, standards provide a minimal or 'bottom line' for quality. A multi-service agency has an opportunity to unify standards across all programs in the agency. As Pat describes the advantages of multi-services:

I think several things happen when you put all services under one umbrella. You lose the turf wars. And clients are in a 'win' situation because they know where they need to go. As well, if you've got good administration and unified standards across the board then they know they are getting a quality service. Or they might not know, because they don't know what to expect if they've never been in counselling before. But, you know and the community eventually knows just because there are fewer complaints and client's satisfaction increases. Also if you have a family in trouble, it's easier for the services to work together, whereas now, that sometimes works but it depends on the case, how good a working relationship the service providers have, and the personalities involved. (485-507)

Pat is identifying that in a larger structure, there are opportunities for an administration role that includes the development of procedures that enhance quality.

Service providers who are working alone, rarely have the time or opportunity to enhance administrative practice. While the community is unlikely to recognize immediately how the administration and standards effect the quality of the service, over the long term the organizational quality will be noticeable. As the service becomes stable and consistent, and encourages openness of its policies, clients will understand more about the services they should expect, and client satisfaction will increase, decreasing the number of complaints in the community. While Pat recognizes that good client service sometimes works now, she recognizes that it is dependent on the individual personality involved, and that it may change as clinicians move. Currently, in many cases, it is not built into the organization to provide quality services, or minimum standards. Even case management is dependent on the personalities of the individual service providers. As the clinicians work together and understand each others strengths and weaknesses, families will not be as dependent on the *chance* that their counsellors happen to get along. The multi-service agency reduces the reliance on the personal, and places responsibility on the organization.

Confidentiality, as an example of a standard, was raised earlier as a big issue in small communities. Anne describes how the balance of ensuring ethical confidentiality and sufficient information gathering to assist with client care can be accomplished in a multi-service agency.

> *I think it is more advantageous, in a multi-service agency because we can talk with people and stuff like that. There isn't boundaries up. I can't break confidentiality, well we are all in the same agency, and we all had to sign the same forms, that they're coming here and we can talk with other counsellors and things like that. (174-179)*

Umbrella organizations can develop systems to ensure conformity to standards. The issue of agencies 'crossing that information sharing line' can disappear when service providers are now located together. Of course, the standard by itself does not stop confidentiality breaches. However, as clinicians work together, and the agency promotes a climate of openness, clients can be informed of processes such as clinical meetings and inter-staff supervision. In this way consumers can make decisions about their treatment, ask questions about how inter-professional consultation is conducted, and provide, or deny, informed consent for the case management practices of the agency.

Effective

Effectiveness included the idea of clinical competency and whether a need was satisfied. Martin (1992) noted in her study of amalgamating two non-profit organizations that the resulting stability enabled the board of directors to "attract and retain better qualified staff, maintain adequate and pleasant facilities and generally provide continuity of service" (p. 214). Therefore the larger umbrella organization has a better chance of recruiting and retaining the kind of expertise needed in small communities. But it is also important to maintain client services as the focus of effectiveness. Charlene indicated how umbrella organizations can have a positive impact on client service:

> *We should be working together, especially in a small community where resources are limited and so you should be working from a team perspective. I think it's more beneficial for the client, when they come to a multi-service agency. We know what the services are, we know what we can provide and we can give that information to the client rather than saying we can't help you, you go to the building over there, or you go down the street. Also intervention is quicker and case management is more efficient. Communication is good because you're all housed together. You can talk to one another. (372-385)*

Another benefit of an umbrella organization, particularly if the funding is flexible, is that resources can be reallocated to meet changing needs in the community. As Irma said, *"if we're under-loaded on one program, another program can help out. We shift resources between funders too"* (176-189). As agencies have more staff, an interesting shift in perception occurs. As Ethel, one of the clients said:

> *To me, having an office where there is more than one person that specializes in different things will help someone. (265-267)*

Ethel's quote shows that in multi-service agencies staff are perceived as having areas of specialization. In terms of consumer perception, specialists are afforded enhanced status, which in turn elevates the position of the agency in the small community. An alternative interpretation of this quote is that having more than one worker ensures that the client will be able to find someone who they can connect with, and receive help from. Either way, the goals of providing quality services are met, either through increased choice, or psychologically, because the services are perceived as being better.

Another important aspect of quality service delivery is stability. In a multi-service agency counsellors can provide coverage for each other. Norman tells us about the differences:

> *For example, we have the mental health counsellor here. One day she was not in the office, one of these individuals came in. But instead of them coming to an office where there isn't anyone, I knew I could handle the situation and so took the person to the hospital in order for them to be medicated, and calmed down. This was much better than them reaching the office and being told, well I'm sorry there's nothing we can do for you, or where there's a note on the door. (406-414)*

A multi-service structure in a small community can be effective in a number of ways: it can provide more consistent services to the client, counsellors can cover for each other, it

can provide better training and networking for staff as well as the important mentoring and support, and it can reallocate resources to meet changing needs. A predominant requirement in small communities for quality services delivery is for clients to have access to services. Can a multi-service enhance that accessibility?.

Accessible

The collocation of offices increases the visibility of the agency, and the programs it provides. It also decreases the chances of people going to the wrong service and being rerouted to other offices and agencies. Irma had some thoughts on accessibility:

> *I think that in an umbrella organization such as this, the access to different programs is a lot quicker, and easier in that when you go to some places in a city, you go into one building and they deal with one thing and they may not know anyone in the other building where you may have to go....I think the cities could actually take some lessons from the small communities who have been forced to manage to run everything together and make it more personal. (144-154)*

Irma notes that providing a variety of services under one umbrella organization provides enhanced accessibility. However in small communities there is also a problem with psychological accessibility due to the high visibility everybody experiences. Do clients feel anonymous going into umbrella organizations? Anonymity is a complex issue in small communities, and that question can not be answered fully here. One way of looking at it is that some programs such as parenting, child support, homemaker services, education and prevention programs are less stigmatizing than perhaps alcohol and drug or mental health. Therefore if entering the counselling office may mean the person is simply getting information for their child's school project, or some parenting tips there may be less embarrassment associated with that.

Openness

Openness was shown to be very important to consumers in Chapter 5. Pfeffer & Coote (1991) suggest that organizations will only be able to make their processes public when there is a close relationship between the organization and the consumers. In order for that to happen restructuring from "large and vertically integrated, bureaucratically controlled, rule bound organizations to small scale units, has to occur" (Pfeffer & Coote, 1991, p. 26). Privatization has provided an opportunity for that movement to smaller organizations which are closer to the consumers.

The model of the multi-service agency proposes that the very small units (single person offices) would be better integrated. A concern was raised by Harry, who is very familiar with the gossip problem and perception issues in small communities. He wondered whether having the service providers work together would increase the negative perception that service providers are talking about the clients inappropriately. This is a dilemma. Harry, who had advocated for services to be integrated came to the conclusions that:

> *If you can put that on the table when you first come in the door, in terms of these people work together, then clients enter counselling with that mindset. (354-356)*

Harry's conclusion is that if agencies can be open about their procedures, when client issues will be discussed, how case conferencing occurs etc., then clients can feel some assurances that the agency is behaving ethically. As standards in a multi-service agency are implemented, and the qualifications of the people working in the agency increase, the confidence the organization has in itself builds. I suggest that as confidence builds, the staff are more willing to be open about their systems, policies and counselling processes, which, in

turn, provides clients with confidence that ethical practice is occurring. That openness helps make the services more acceptable to the client. But would multi-service organizations be acceptable to funders?

Acceptable

The cost of service provision is an important consideration for government, even though that is not a priority for service providers. Cost efficiencies have to be carefully considered within the context of maintaining quality. Often budget cutting is the rationale for the implementation of dehumanizing procedures and scrimping on quality (Moore 1995). Frank points out multi-service agencies can provide some cost-efficiencies.

> *It's more cost effective to have everybody under one roof. You wouldn't be paying several rents and this way you're at least all together. (50-52)*

Another issue related to government funding is that contracts are often at the whim of political forces and can be canceled easily. When this occurs in small agencies there is a major impact, however if one program in a multi-service agency is cancelled, the agency continues to operate with its other existing services. This then provides a more reliable and stable service within the community which is a component of quality service delivery. Tucker, Baum, and Singh (1992) in their study of voluntary social service organizations in Toronto found that larger organizations had significantly lower disbanding rates than smaller ones. This is linked to the larger organizations having a greater capacity to attract and retain resources, and more contact with the larger system.

Cautions

While it seems that multi-service agencies provide a number of advantages to the consumer, the service provider and the funder; there are, of course, disadvantages. As the

agency becomes more bureaucratic there is the danger of losing grassroots appeal and not reaching out to the community for input. In addition there are extra demands with more services, and still a shortage of funds to provide the range of services.

Growth can lead to bureaucracy

A disadvantage in a multi-service agency is that it can become too large and bureaucratic just like a government service. As Pat points out:

> *There can be a danger of becoming more bureaucratic, and losing the grassroots appeal. If they all come under one roof and the agency has a bad board, or a bad administrator then the agency is in BIG trouble. But I think the bigger an agency gets, the more important, and the more emphasis it has to put on keeping its pulse on the community. (516-524)*

It is important to maintain the balance between growth, which often means distancing from the constituent group, and community contact. One advantage of having services together is the ability to attract and pay qualified people. As Pat explained later in her interview, in the small offices when a clinician is responsible for administration, but would rather spend his or her time in client sessions, he or she has difficulty prioritizing time in order to write proposals and find grants. In a multi-service agency with multiple contracts positions such as an executive director or an administrator can be implemented. Part of their administration role is to help the agency plan to meet the needs of the community. The danger is that as the non-profit organization becomes more adept at grantsmanship and contract negotiation, and procuring government funding they may end up essentially becoming mini-government services (Rekart, 1995). This is a danger not to be taken lightly. As Pat said, community agencies do not want to lose their grassroots appeal, and a multi-service may have to take steps to ensure they stay in contact with the community.

Growth can lead to over-integration

Clague et al. (1984) noted in their review of the Community Resource Boards and Community Health and Human Resource Centres that in terms of quality, "both clients and staff favor small and informal service structures" (p. 279). During this research, concern was raised about the impact of over integrating services, for example counselling services with hospitals[21]. The discussion of which health services are best under one organization, if one is concerned primarily about quality, is beyond the scope of this research, but is an area that warrants some study. This research, and the discussion of umbrella organizations is restricted to the out-patient counselling, support and information services which have been termed personal and community services.

Not reaching out to community

The experience of the Health Centres (CHRHCs) in the mid 70s was that although team work occurred inside the physical walls of the centres, there was less coordination and working together with other community groups and organizations such as school boards, unions, native groups, and municipal and regional boards. Working in the Centre often meant isolation from peers and support systems outside the CHRHC (Clague et al. 1984, p. 168). This type of isolation was a concern for people in this research as well. As Norman pointed out in his small, three person agency:

---

[21] Although this concern was not explained, I think it relates to the fact that out-patient counselling services are a very small component of the overall responsibility of a Hospital Board and therefore often receive little attention. Also the traditionally different approaches to health care (medical model vs. psycho-social model) and thirdly, Norman raised as issue of unionization which he felt deskilled him, and reduced his flexibility - even though it gave him higher wages.

It's easier to do it here than it is to make all those phone calls, when we can connect here at a staff meeting or just walk down the hallway, whatever. That is advantageous at times but can also be a drawback at times. (397-402)

As people start working together, it is easy to become insular. While there are numerous advantages to working among a staff team, the potential consequence may be loss of contact with organizations not under the umbrella, as well as the community itself.

Multiple contracts, multiple demands

Although it was not raised directly in this research, a potential difficulty for multi-service agencies is that even though the agency may be integrated at the community level, the funding and accountability requirements are not amalgamated. As Coulton (1982) noted, agencies with multiple funding "may have to meet multiple and overlapping evaluation requirements." If different Ministries have different view points on how quality should be assured, the agency could find itself in conflict.

Chronic under-funding

The shift to privatization has sometimes been referred to as government off-loading, partly because the non-profit sector is prudently funded. The participants in this research were not alone in their distress over lack of funding. Gove (1995) identified that non-profit societies often had no financial resources to provide quality assurance programs, and Korbin (1993a), prior to Gove, said that contracts with non-profit organizations made inadequate provision for the costs of staff, management, volunteer and board training (p. 2). One of the consequences of limited funding, is that capital costs are rarely, if ever provided. This, in turn, means that services are often housed in poorer quality buildings. Many of the buildings that agencies are in, have not been renovated for handicap access, despite government's

commitment to ensure access for all British Columbians. Pat raised other important consequences of under-funding:

> *The lack of quality equipment, and little things like the lack of soundproof offices. In our office all the radios play, all the time, so that clients can't hear each other. (559-562)*

Wilding (1994) recognized how ambiance affected acceptability. And while radios playing may create a pleasing atmosphere, the lack of client confidentiality is unlikely to be acceptable to clients. Quality service delivery can be compromized by some cost-cutting measures.

The Regional Picture: Linkages to the Vertical

One goal of contracting to non-profit societies was to enable small communities to develop models that were consistent with their social context. However "rural areas cannot be understood in isolation from their relationship with urban areas" (Berger, 1987, p. 5). In what Berger (1987) terms 'core-periphery' theory, the 'periphery' is not undeveloped, but is underdeveloped compared to the 'core'. The core-periphery relationship is extremely important in small communities, and needs to be considered within the 'how' of delivering quality services in small communities. The small community is tied to the regional city, at the core, in many different ways.

The present system recognizes that small communities cannot provide for all the needs of consumers. Specialized organizations and services are designated 'regional' in order to meet the needs of consumers in outlying communities. When the services required by consumers are beyond the capacity, or the expertise, of the service providers in the small communities they can refer into the regional core. However the linkages between the small

community and the regional city, or the core and the periphery are at the same time both fragile and authoritative. John had expressed in the opening quote of Chapter 5 that he is "*just a small part of the system,...[and because I am] tied into a bigger system, I can only do so much for my clients.*" This feeling of only being able to do so much, or powerlessness in the larger system occurs because it is the regional service which develops the criteria for admissions, and maintains the decision making regarding acceptance of clients into their facility. This leaves the service providers in the small communities relegated to a lower level operation in the vertical connections in the bigger system. In order to receive assistance for their clients they must negotiate the admissions procedures which are usually based on urban criteria, and not always hospitable to the limitations and needs of the small communities. Katherine describes her frustration with the authority at the 'core': *"the biggest problem, [in service delivery] has been actually getting people into the other community" (469-471),* meaning getting people from the peripheral small community, into the core regional service. Others told me that the specialist services are fraught with "*long waiting lists"* (10:388), *"backlogs"* (436), and *"lack of coordination"* (449). The difficulty accessing regional centres is an interesting issue in relationship to quality service delivery. Specialized services are perceived as more effective, and regional, urban centres are perceived as having more services, both of which are important to quality. But if they are not accessible, or if they have long waitlists are they, in fact, quality services?

The Provincial Health Officer, in his 1994 annual report, noted the disparities in health care in the remote and rural areas of the province (Ministry of Health & Ministry Responsible for Seniors: Report of the Northern & Rural Health Task Force, 1995). Until

these disparities cease, small communities will remain reliant on the regional resources. This is particularly problematic in northern British Columbia because of its geography. The harsh climatic conditions and the long distances affect accessibility to the regional centres. Some people take this in their stride. After all, people regularly travel to the Centre for shopping and entertainment. But there is another reality: many of the clients who seek assistance through human services are disadvantaged, and may not have the economic means to travel. It is important to be aware of the hardships that may be placed on people who have to travel long distances. As Pat says: "*the transportation problems effectively eliminate the poor [from receiving service], which is not fair*" (223-225) Opal, one of the clients, puts it this way:

> *That doesn't really work. I don't have kids, but at the time I was using services in the closer communities it was very inconvenient. I'm single, don't drive, and on welfare. Trying to get somebody to take me there was difficult, and then it costs so much, and Social Services doesn't give you very much. And then with the environment that we live in, the winter roads, all that kind of stuff, it's so inconvenient. It is even more difficult for the people who have children, full time jobs, or even full time school. (674-681, 696-700)*

Opal raises important issues. The driving is complicated by the northern climate which is a deterrent to travel. This is not always recognized by southern policy makers. The point was made clearly to me when I was travelling doing this research. Having left Prince George in relatively balmy weather, there was a sudden drop in weather conditions and on the way home I found myself in white-out blizzard conditions, and in -30 degree weather. When I finally passed through the storm I almost had to pry my knuckles off the steering wheel, and my shoulders ached from the anxiety and strain of driving. Less than a week previously one counsellor's vehicle had slipped off the road in the course of her work. These

are northern realities. Another deterrent to regional appointments is the time involved. For an employed person a one hour appointment may mean a day off, often without pay, or perhaps even an overnight journey.

Another reason for vertical linkages to regional centres is associated with accountability. Over the years, the contract managers in the regional centres have been responsible for monitoring the agencies, providing opportunities for networking and training, and supplying administrative support. However, as services move further away from government into models of community responsibility, many service providers in small communities are worried. As Bob said:

> *I still think there needs to be a Centre, and a way for this community to meet with other communities, as there is more chance of isolation if everything stays within the community. And I still believe there needs to be a regional person...that [provides] direction, and has some control of what's going on in the northern communities. (235-245)*

Interestingly Bob thinks the regional centres have provided some direction and accountability of services. This is despite the arms-length relationship with government that Korbin (1993c) describes as the contract mechanism; and the Gove (1995) review which noted that the Ministry of Social Services, had "no effective way to monitor the quality of services delivered by contracted agencies"[22]. Even though it may only be a perception that regional offices have some sort of control, there is a fear in small communities that if the linkage is further cut-off, services will slide, and further disparities and inequities will result.

---

[22] To be fair, in my experience the Ministry of Social Services does have the fewest mechanisms for monitoring contracts and some of the other Ministries at least attempt to monitor services through the implementation of standards.

The fear is related back to the sense of isolation and being 'cut off' that Bob described in Chapter 6.

Conclusion:

The organization of services is critical to quality service delivery. This research indicated that there are advantages in small communities to organizing services together. Having more people work within an organization provides an enhanced personal and professional support network. This leads to a more satisfying workplace, which reduces the turnover in staff. A stable service increases the ability to attract and retain qualified staff. Human service providers enjoy professional discretion and having autonomy within their work, but many also prefer to work as a team instead of in isolation. Multi-service agencies in small communities offer those benefits. As staff numbers increase, the issues of professional isolation, lack of consultation and supervision, and lack of training are all reduced. The more troublesome factors of working in a small community such as high visibility and increased sense of responsibility for the community's problems can be diffused when more staff are working together in a multi-service agency. As well, the conflict between personal and professional roles seems to decrease as colleagues become friends and personal supports. An umbrella organization provides two important features that a single person office cannot. It can offer a way of minimizing the personal impact of delivering services in small communities, and can develop an organizational structure that potentially enhances quality service delivery.

However small communities cannot rely completely on horizontal integration within the community. There also has to be a link into the larger system usually provided at the

regional level, for both clinical purposes and administrative support. At this time those linkages are, by and large, unsatisfactory. The balance between horizontal integration at the community level and the vertical linkages to the region, as well as other areas that work best if they are in balance, will be considered in the concluding remarks of the final chapter.

Chapter Eight

Balancing the Multiple Needs in order to Provide Quality Service Delivery

This aim of this thesis was to explore the concept of quality in community based agencies which provide personal and community human services in small, northern communities in British Columbia. While the ideal of 'quality' is sought after and the participants wanted to pursue it as an objective in their places of work, they found it difficult to articulate. Even with all their valuable insights, I also have found 'quality' to be difficult to pin down. It certainly is the slippery and elusive concept that Pfeffer and Coote (1991) describe. Nevertheless, the findings in this research indicate that in order to attain 'quality' in a community based agency a series of balances must occur. Development of policy in isolation from the practice environment will not produce quality in small communities. Similarly a service provider, working alone in a small community, with no parameters, and no recognition of the bigger picture is also unlikely to develop quality service delivery. Quality is most likely to occur in service delivery in small communities when the social context and the interests of multiple stakeholders are taken into consideration. This means a broad definition is necessary, which includes the political and economic perspective as well as the humanistic goals of social work.

This research aimed to connect policy and practice by examining the literature as well as doing some 'field' research. The goal was to gain insight into the conceptualization of 'quality' in community based services by understanding how social policy, definitions of quality, and small community practice intersect. The policy and quality discussion was taken from the literature and the practice understanding came from the 'field'. Sixteen people (five

service providers from non-profit agencies, four executive directors, two referral agents, three clients and two board members) from three small northern communities were interviewed about their ideas of quality services. Using a semi-structured interview format, the interviews were recorded and transcribed verbatim in order to develop some central themes. The interpretation of those themes resulted in the conclusion that policy and practice are inextricably linked, and interdependent on the social context of service provision. In an attempt to tease these linkages out three implications for policy and three implications for practice have been identified. These are by no means exhaustive but form a starting point for discussing quality service delivery in small communities.

1. At a macro level a mixed economy of welfare is preferable. If services are provided through both the private and the public sector, social policy can be responsive to both the requirement for community based, flexible services focusing on client need and the demand for uniform and consistent, statutory services.

2. For the services best delivered in the private, or non-profit sector, the balance of power between the government funders and the community board members needs to be considered. In community based agencies the power balance can occur if the horizontal coherence in the community is supplemented and supported, not superseded by the authority of the vertical linkage to government.

3. Privatization occurred as a political response to financial pressures, and then its effectiveness and efficiency was assessed by the 'yardsticks' familiar to centralized structures - standards, unit costs and outcomes. In order to measure effectiveness and efficiency in the non-profit sector the 'yardstick' needs updating to include the concepts important to the

individual community. Accountability and consistent standards of service provision are desirable, but the social context of service delivery needs to be taken into account and services need to be generalist and provide a range of interventions.

4. This research showed that at the practice level the concept of 'quality' is a balance of the everyday human values such as honesty, fairness, quickness and productivity with the effectiveness of safe and confidential services, provided under professional guidelines. Quality service delivery is influenced by social policy decisions, and evaluated by corporate ideals, however at the practice level social work, and other human service ideals such as self determination and responsiveness are essential.

5. In the small communities that were studied, service providers are highly visible. They have high expectations placed on them and often work in isolated offices, and feel distanced from the larger system. The resulting staff burn-out and high turnover rates eventually lead to instability in the provision of services in the community. As new workers enter the community each one has to learn the dynamics of the community and will provide different foci in their work. These transitions leave the community with decreased levels of service for periods of time and sometimes gaps in service during the recruitment period. For stable quality service delivery to occur in the small communities it is best when the needs of the service providers are balanced with the demands of the community.

6. One way of offsetting the high demands on the service providers is to integrate services under a multi-service umbrella. However the participants in this research stated clearly that for 'quality' to occur in an integrated agency the grassroots connection with the community is of vital importance and must be balanced with the inevitable bureaucratization

that occurs in larger organizations. The remainder of this chapter will summarize the emerging research themes in terms of the balances needed for quality service delivery in small communities.

1. Balancing the private and the public sector

Prior to the turn of the century assisting people with personal troubles was in the hands of the family and the church. However as families moved away from the social support systems in order to pursue work opportunities in the urban centres, governments came under increasing pressure to become involved in providing human services. By the late 1930s and early 1940s the federal government had assumed a greater role in the delivery on human services. By 1966, with the introduction of the Canada Assistance Plan (C.A.P.), human services were provided through a strong central government in order to best meet the social needs of the whole nation. Programs were developed in federal and provincial capitals and transferred without modification across the country or province. Little consideration was given to the social context in which services were provided.

As governments were increasingly plagued with deficits and charged with being meddlesome, and the expanding social programs were attacked as being too costly, British Columbia, along with other provinces, began devolving a wide range of human services to the community. The 1970s marked a watershed in the provision of human services. After that time government started to reduce its involvement and the strong centralized, vertical connections in social policy delivery were diminished. The community perspective emerged as essential to the delivery of personal and community services. Once again, as in earlier years, communities were taking on the responsibility for the social ills of their members.

Decentralization had occurred for primarily political and economic reasons -- lower perceived cost and less government intervention -- however, it also promoted the idea of, and opportunity for, community participation and horizontal integration.

But services cannot be provided only through the non-profit sector, there is a need for public sector services as well. An issue that emerged from the literature review was how the private and public sector served different kinds of clients. During the research phase of this thesis it was verified that indeed the private sector tends to serve volunteer clients based on 'client need'. This is different from the public sector which works with a large range of clients, including segments of the population that society, often through the court system, has deemed as requiring counselling services. These clients usually receive services involuntarily.

In the rush for governments to devolve services and 'save money' the non-profit sector has been plagued with under-funding. The lack of funding impacts on the ability to recruit staff, provide training and have adequate building facilities, which in turn impacts on the ability of the agency to provide effective service delivery. In order for the private sector to be able to provide quality services, government cannot simply off-load responsibility by cutting budgets. Rather a reallocation of public funds to equitable levels in the private, non-profit sector provides an opportunity for quality community services.

Decentralization does provide opportunities for quality service delivery. Small organizational units can provide quality management and a satisfying workplace for a social worker, or other human service workers. These are important considerations in the north where there are so many problems with recruitment. Vinokur-Kaplan, Jayaratne, and Chess

(1994), in their study on job satisfaction, noted that contextual factors such as autonomy, self-actualization, social support and supervisory relationships are all necessary considerations in the retention rates of social workers. The participants in this research cited the multiple opportunities provided in the non-profit sector for autonomy and self-actualization. On the other hand they also noted how the lack of collegiality and mentoring provided additional stressors in their work. The non-profit sector may have opportunities to provide quality workplaces, but providing opportunities for linking to other organizations in order to receive collegial support and mentoring would be preferable. Simply cutting off community based agencies from other centres of expertise only leads to fragmentation and isolation, and few accountability measures, which is not consistent with quality service delivery.

Decentralization and privatization provide opportunities for small organizational units to deliver human services based right in the community. These non-profit agencies can provide community responsive and flexible services in pleasant worksites. However, they are also plagued with underfunding, and tend to meet only some of the client needs. This research would agree that a mixed economy of welfare is preferable.

2. Balancing the vertical and the horizontal

Delivering human services through the non-profit sector in small communities is considered, by some, the ideal method of providing human services. Services are publicly funded, but the delivery is locally based and accountable to the community through a non-profit board of directors. Small communities have benefited from the new way of delivering services and in the last 15 years most small, northern communities have seen an overall

increase in locally based community agencies. After all, as Pat told us small communities do not want *"all help to originate from Victoria and have an urban flavour, an urban mandate, and an urban set up"* (718-720). The ideal of horizontal provision of services at the community level is accepted favourably.

Small communities have inherent difficulties providing all the services. Funding tends to be allocated based on population numbers and it is difficult to attract the range of specialists required. Therefore, it is not sufficient just to have access to horizontally provided services within the community, there need to be vertical linkages to expertise and specialization. But there is little connectedness between the delivery at the community level, and the access to the rigid, vertical system. Participants in this research identified problems with *"long waiting lists"* (10:388), *"backlogs"* (436), and *"lack of coordination"* (449). This research indicated that when small communities do not have enough of their own resources, at the horizontal level, and they attempt to enter the vertical system of care they have to negotiate urban admission criteria which causes difficulty. The findings also showed that the horizontal integration at the regional Centre usurps the vertical access from the smaller community to the larger one.

The other issue for accessing regional services is the associated cost and travel. The social context needs to be taken into consideration. Travelling in the north, particularly in the winter is substantively different than travelling in the south. Regional services may need to be configured differently in the north in order to recognize those differences. If people living in small communities are to have access to a continuum of quality service delivery, the

locally based system configured horizontally needs to connect, and be a part of the vertically aligned network of services.

At a decision making level there are similar tensions between the vertical and the horizontal powers. This research showed that on the one hand, decision making in B.C.s human services is still very centralized. The government as the controller of the funding dominates much the of the decision making power. But, on the other hand, participants like Bob, are afraid of further isolation, and more fragmentation without those vertical linkages "*to provide some direction and control over what is going on in the north*" (242-245). Bob has recognized the need for at least some accountability to occur through government hierarchies. This research clearly shows that vertical linkages may be necessary to maintain integrity, but the actual delivery and practice should occur at the community level.

In the aim for quality services a balance has to occur between these vertical and horizontal tensions. If the vertical bureaucracy is too forceful and rigid the services are perceived as being inflexible to the unique characteristics of the community, whether that is people or geography. However if the vertical linkage is non-existent, and only the horizontal connnectedness occurs, the community becomes isolated and dislocated from the decision making, as well as from the centres of specialization.

3. Balancing the measures of quality with the aims of privatization

During this time of shifting political ideology in the delivery of human services, other sectors are also experiencing change. The public is demanding greater accountability from business and government alike, and consumers who are benefiting from a world wide market place for goods, expect excellence in their products and services. Increasing attention is

being paid to the idea of 'quality'. Chapter 3 reviewed various models of quality. One understanding of 'quality', based on consumerism, has often been associated with the value of the product or the outcome of the service. In human services this model is consistent with a centralized government philosophy of providing the greatest amount of services, to as many citizens as possible, at the least cost (Alazewski & Manthorpe, 1993). Another model of quality utilized in the human services, is the imposition of a set of minimum standards. This focus is also consistent with strong vertical bureaucracies: government provides the expertise, and professional dictates under which services should be provided.

As services are devolved to the community the social context of service delivery becomes an essential dimension in considering quality. In small communities generalist services are considered the most effective. Even studies that promote the usage of performance measures as criteria for quality recognize the limited usefulness when outcomes are more complex or long range. When generalists provide a variety of services it is absurd to endeavour to try and routinize their work in order to measure it. Similarly contracting on the basis of unit-costs in small communities where the population base is low misses the complexity of the work that is provided. Unit-costs are based on seeing people, with the same kind of problem, in sufficient numbers to warrant a service. In small communities the numbers of any one kind of service are just not there, that doesn't mean they don't warrant service, just that it should be measured differently.

As human services have moved to community based models these traditional models of quality based solely on economic or business criteria are no longer appropriate. Services now have multiple stakeholders: the consumers, the referral agents, the service providers and

the boards of directors as well as the government. Services can no longer simply be defined by the experts who are located in urban centres, or reduced to measurable units of service. For quality to occur input from the community is necessary. The concepts of quality have to be transformed in order to embrace the service delivery system based on horizontal community interaction. No longer is quality simply a matter of externally determined social policy. It is necessary to consult with the practice community in order to gain an understanding of what they consider 'quality' service delivery to be.

4. Balancing the human values and the standards of service

Overwhelmingly the participants in this study think that people in small communities are entitled to the same standards of service as people in larger centres. But reliance solely on the bureaucratic product and management definitions in small communities negates the complexity and uniqueness of the community, and does not constitute quality service delivery. Quality, according to this research, has to be defined more broadly. Community members place a greater emphasis on the human values than the traditional quantitative, top-down approaches to quality. John tells us that "*quality service takes into account the needs of the client; it would be honest, it would be fair, it would be productive and it would be done fairly quick*" (379-403).

In these communities Wilding's (1994) conceptualization of quality is *apropos*. The notions of effectiveness, accessibility, openness and acceptability are all important. *Effectiveness* in small communities means providing generalist services including education, prevention, supportive counselling and treatment for a myriad of social problems and human conditions. Staff must be properly trained and work with the clients on their identified needs.

The services must be flexible and be able to respond to the changing needs of the community. Services must be *accessible.* Priority is for a range of services to be available locally, and when they are not, access to the bigger Centre should be relatively easy. Small community services generally maintain low waiting lists and can provide services in a timely way. The social closeness of the small communities allows for a good working knowledge of the available services for both service providers and clients. Psychologically, on the one hand social proximity and high visibility of everyone provides a sense of mutual support and neighbourliness which means clients are treated respectfully. On the other hand the high visibility also means additional attention has to be paid to ensure that confidentiality is maintained and anonymity is protected. Services must also be *open* about their processes and the credentials of the service providers. Formal, well publicized mechanisms for feedback in order to avoid the reliance on the rumour mill are beneficial to quality service delivery. If these factors can be provided, services will then be *acceptable* to the people in the community they serve. However that does not take away from the needs for the same standards of professionalism in the small communities as in the urban areas. As Charlene tells us "*people don't always believe services should be delivered the same way, but we can do the same thing, at the same level, and so there shouldn't be any differences*" (p. 84).

One can infer from this information that the concept of quality is complex and that quality assurance programs need to take into account both the political realities of cost containment and accountability, and the humanistic values of social work. In the introduction of this thesis I asked whether the social work values that Mullaly (1993) presented have a place in quality service delivery. Quite clearly the ideals of egalitarianism, self-

determination, participatory democracy and humanism, as well as the ideals of flexibility, pluralism and responsiveness are consistent with the themes that have emerged in this research. The human element is essential in service delivery, and as standards, or quality assurance programs are being developed, social workers need to be involved in the dialogue.

5. Balancing the needs of the service provider and the demands of the community

Small communities are characterized by isolation from the Centre and by close interrelationships within the community which can be both helpful and intrusive. In human services the single most important characteristic is the quality of its personnel (Ewalt 1992), but this importance becomes exaggerated in small communities. Enormous pressures are placed on the provider to be 'beyond reproach', and to function as a professional 24 hours a day. As Anne says *"I can't separate the counsellor part of me, totally from the person part of myself. I'm a representative of the agency, and whether I like it or not, those two parts of me are associated together" (766-770).* The typical provider in a small community, is a new graduate, or an individual new to the field, who is either drawn to the north to gain experience, or is in the north because of past life experience. Working in small communities means being visible, taking on additional responsibility, knowing something about a wide array of human conditions and understanding the local customs and mores. Services are strongly associated with the particular person providing the service, and change as that person moves out of the community and is replaced by a new worker.

If a part of quality service delivery is to have stable, well trained staff, then issues of retention and service provider support are important considerations. Understanding how the context of the community is experienced by the service providers is essential. If the

professional needs of service providers are not met, and the community demands are too strong, burnout and staff turnover result which can lead to gaps in service. Therefore the 'how' of providing quality services in small communities is important.

6. Balancing integration with community contact

For quality services to occur in small communities there has to be a balance between the political and economic realities, the social 'fishbowl' context and the individual needs of the service provider. In order to do that the organizational system of services has to be considered. The organization of services at the community level is where the practice and policy really meet.

At the practice level the multi-service agency emerged, in this study, as being able to balance some of the professional and personal needs for the service provider. A larger number of programs can provide more staff, which then offers collegial support and supervisory opportunities for the workers. The heightened responsibility and pressure service providers experience in small communities can be diffused when there are people working together to share the load.

The dimensions of quality that emerged in this research as being essential to service delivery can be provided in a multi-service agency. They myriad stipulations of accreditation are more easily complied with in a larger organization. When thoughtful, planned integration occurs in a small community it provides opportunities for quality delivery in much more important ways than just economic efficiency - although sharing of reception, rent and other facilities can be cost effective. A larger organization is more likely to withstand the 'wear and tear' of accreditation. It provides a more suitable organization for the recruitment of

qualified workers, it reduces the isolation of service providers, provides collegial support and opportunities for specialization. Accessibility is enhanced by increased visibility and an ability to provide choice and alternatives in program offerings. As the agency stabilizes and staff build confidence in their abilities, it is more likely they will be open about their policies and procedures in the community.

Integration of services in the small communities will work best if it is a goal of policy makers and practitioners alike. There are agencies in small communities who have many services under one roof and provide one stop shopping for the consumers. But that integration is occurring only at the practice level. If one looks closer it is not occurring at the policy level. The agency provides multiple programs through multiple contracts. Essentially what is occurring is that government is continuing to contract through the vertical linkages leaving it up to the agency to integrate at the horizontal community level, if they choose. What this means in practice is that a service provider receives a pay cheque from ABC community agency, but in fact identifies more with the government program that provides the contract for service. For quality community based services to be truly integrated at the community level, integration also needs to occur at, at least the next level in the hierarchical government bureaucracy.

But integration, even horizontal integration should not be done just for the sake of it. Although this research concludes that providing personal and community services under a single umbrella organization is the model of choice in small communities, there is a danger if the resulting organization becomes too large. Increased size generally necessitates bureaucratization which has the inherent danger of increasing the gap between the service

providers and the community. As well, it is noteworthy that just because an organization is large doesn't mean it is immune to poor administration. In small communities where ruling elites can dominate management this may be more detrimental for the community than a poorly run small organization. So umbrella organizations, in of themselves, just like decentralization, in of itself, will not provide quality service.

Conclusion:

Decentralization and privatization offer opportunities for quality service delivery, but there are drawbacks and not all social needs can be met through this mechanism. One conclusion of this study is that both public sector and private sector delivery should exist. Another finding is that integration of services at the community level can benefit the service provider by reducing the isolation and visibility, while still offering community responsiveness. However, integrating all services and developing large bureaucracies within a community can result in a loss of the humanness that is so necessary in quality services.

Quality service delivery in the personal and community services can occur in small communities. As the emphasis shifts from government services to community services it is essential to consider different models of quality. For quality to occur in community based models, services have to be delivered with multiple interests in mind. The traditional conservative, product and management driven models of quality do not ensure quality services. When quality is defined more broadly, and service providers and consumers are included in the discussion, a higher value is placed on the humanistic perspective. According to this research the social context is a critical component in the organization of service delivery. While the horizontal linkages are vital, and need to be taken into account, the

vertical connections are also important. Services must be accessible, open and effective, in order to be considered acceptable to consumers. They must show accountability to professional standards and fiscal responsibility in order to be acceptable to government.

Quality services can be delivered in community based agencies when the needs of governments, consumers and the service providers are in balance. It is achieving this balance that will continue to challenge social worker and service providers in work in the non-profit sector in small communities in northern British Columbia.

References

Abramson, J. A. (1979). Identifying the Particular Nature of Rural Communities As the Content for Social Work Practice. In W. Shera (Ed.), The Rural Community (pp. 35-56). Victoria, B.C.: University of Victoria, School of Social Work.

Addison, R. B. (1992). Grounded Hermeneutic Research. In B. F. Crabtree & W. L. Miller (Eds.), Doing Qualitative Research (pp. 110-124). Newbury Park: Sage.

Alaszewski, A. & Manthorpe, J. (1993). Quality and the Welfare Services: A Literature Review. The British Journal of Social Work, 23, 653-665.

Anderson, J. (1981). Social Work Methods and Processes. Belmont, California: Wadsworth.

Arches, J. (1991). Social Structures, Burnout and Job Satisfaction. Social Work, 36(3), 202-206.

Armitage, A. (1988). Social Welfare in Canada. Ideals, Realities, and Future Paths (2nd ed.). Toronto: McClelland & Stewart Inc.

Azim, A. N. (1987). Privatization of Social Services: Potential Implications and Consequences. In J. Ismael & R. J. Thomlinson (Eds.), Perspectives on Social Services and Social Issues (pp. 39-65). Ottawa: Canadian Council on Social Development.

Banting, K. (1987). The Welfare State and Canadian Federalism (2nd ed.). McGill-Queens: University Press.

Barbour, R. S. (1985). Dealing with the transsituational demands of professional socialization. The Sociological Review, 33, 495-531.

Battle, K. & Torjman, S. (1993). Opening the Books on Social Spending. Ottawa, Ont.: Caledon Institute of Social Policy.

Bauman, Z. (1992). Hermeneutics and social science: approaches to understanding. Aldershot, England: Gregg Revivals.

Berger, Stephen D. (1987). The Contribution of Periphery Theory to a Theory of Rural Community. In The Future of Rural Social Work - Toward the Year 2000. Proceedings of the 12th Annual Institute on Social Work and Human Services in the Rural Environment (pp. 5-12). Pensacola, Florida: The University of West Florida, Department of Social Work.

Blunden, R. (1990). Safeguarding Quality. In S. Sharkey & S. Barna (Eds.), Community Care - People leaving long-stay hospitals (pp. 24-37). London: Routledge.

Brawley, E. A. & Martinez-Brawley. E. E. (1988). Social Program Evaluation in the USA: Trends and Issues. In The British Journal of Social Work, 18(4), 391-413.

British Columbia Royal Commission on Health Care and Costs. (1991). Closer To Home: The report of the British Columbia Royal Commission on Health Care and Costs. (Vol. 2). Victoria: Crown Publications.

Buxton, Edward B. (1974). Delivering Social Services in Rural Areas. In L. I.. Levin (Ed.) Educating Social Workers for Practice in Rural Settings: Perspectives and Programs (pp. 52-63). Atlanta, Georgia: Faculty Development for Undergraduate Social Work Education. Southern Regional Education Board.

Callahan, M. & McNiven, C. (1988). British Columbia. In J. Ismael & Y. Vaillancourt (Eds.) Privatization and Provincial Social Services in Canada - Policy, Administration and Service Delivery (pp. 13-40). Edmonton: University of Alberta Press.

Carniol, B. (1990). Case Critical: Challenging Social Work in Canada (2nd ed.). Toronto: Between The Lines.

Clague, M., Dill, R., Seebaran, R., Wharf, B. (1984). Reforming Human Services - The Experience of the Community Resource Boards in B.C. Vancouver: University of British Columbia Press.

Coates, K. & Morrison, W. (1992). The Forgotten North: A History of Canada's Provincial Norths. Toronto: James Lorimer & Company.

Collier, K. (1993). Social Work with Rural Peoples - Theory and Practice (2nd ed.). Vancouver: New Star Books Ltd.,

Collins, P. (1994). Does Mentorship among Social Workers Make a Difference? An Empirical Investigation of Career Outcomes. Social Work, 39(4), 413-19.

Coulton, C. J. (1982). Quality assurance for social service programs: lessons from health care. In Social Work, 27(5), 397-402.

Crabtree, B. F. & Miller, W. L. (1992). A Template Approach to Text Analysis: Developing and Using Codebooks. In B. F. Crabtree & W. L. Miller (Eds.), Doing Qualitative Research (pp. 3-28). Newbury Park: Sage.

Crane, J. A. (1994). Directions for Social Welfare in Canada. The Public's View. Vancouver: University of British Columbia.

D'aunno, T. (1992). The Effectiveness of Human Service Organizations - A Comparison of Models. In Y. Hasenfeld (Ed.), Human Services as Complex Organizations (pp. 341-361). Newbury Park: Sage Publications.

Dey I. (1993). Qualitative Data Analysis: A user-friendly guide for social scientists. London: Routledge.

Drover, G. (1984). Social Work in Canada: Policy and Legislative Perspectives. The Social Worker, 52(1), 6-10.

Epstein, W. M. (1992). Professionalization of Social Work: The American Experience. The Social Science Journal, 29(2), 153-66.

Ewalt, P. (1992). Trends affecting recruitment and retention of social work staff in human service agencies. Social Work, 36(3), 214-17.

Farley, O. W., Griffiths, K. A., Skidmore, R. A., Thackeray, M. G. (1982). Rural Social Work Practice. New York: The Free Press.

Flavelle, L. (1989). Social and Economic Issues in non-metropolitan communities in B.C. Vancouver, B.C.: Social Planning & Research Council of British Columbia.

Gaster, L. (1991). Quality and Decentralisation: are they connected? Policy and Politics, 19(4), 257-267.

Gelman, S. R. (1983). The Board of Directors And Agency Accountability. Social Casework, 64, 83-91.

Gilchrist, V. J. (1992). Key Informant Interviews. In B. F. Crabtree & W. L. Miller (Eds.), Doing Qualitative Research (pp. 70-89). Newbury Park: Sage.

Ginsberg, L. H. (1974). Observations on Preparing Students for the Practice of Social Work in Rural Communities. In L. I. Levin (Ed.), Educating Social Workers for Practice in Rural Settings; Perspectives and Programs (pp. 24-35). Atlanta, Georgia: Faculty Development for Undergraduate Social Work Education, Southern Regional Education Board.

Ginsberg, L. H. (1977). Social Work in Rural Areas. In R. K. Green & S. A. Webster (Eds.), Social Work in Rural Areas, Preparation and Practice (pp. 3-17). Knoxville: University of Tennessee, School of Social Work.

Glasser, W. (1990). The Quality School: Managing Students Without Coercion. New York: Harper & Row.

Gove, T. J. (1995). Report of the Gove Inquiry into Child Protection in British Columbia. Vancouver, B.C. : Government Publications.

Green R. S. & Attkisson, C. C. (1984). Quality Assurance and Program Evaluation. American Behavioural Scientist, 27(5), 552-583.

Guba, E. G. & Lincoln, Y. S. (1981). Effective Evaluation. San Fransisco: Jassey Bass.

Guest, D. (1980). The Emergence of Social Security in Canada. Vancouver: University of B.C.

Hadley, R. (1993). Decentralization, Integration, and the Search for Responsive Human Services. In E. E. Martinez-Brawley & S. M. Delevan (Eds.), Transferring Technology in the Personal Social Services (pp. 31-46). Pennsylvania: NASW Press.

Hamelin, L. E. (1989). Images of the North. In K. S. Coates & W. R. Morrison (Eds.), Interpreting Canada's North: Selected Readings (pp. 7-17). Mississauga, Ontario: Copp Clark Pitman.

Hardina, D. (1990). The Effect of Funding Sources on Client Access to Services. Administration in Social Work 14(3). 33-46

Heginbotham, C. (1990). Community Care: In pursuit of quality and excellence. In S. Sharkey & S. Barna (Eds.), Community Care - People leaving long-stay hospitals (pp. 37-48). London: Routledge.

Hoekstra, G. (1996, Mar 5). To live and die in P.G. Prince George Citizen, p. 1.

Hookey, P. (1979). Preparing Social Workers for Effective Practice in Integrated Human Service Agencies. In F. C. Clark & L. M. Arkava & Associates (Eds.), The Pursuit of Competence in Social Work - Contemporary Issues in the Definition, Assessment, and Improvement of Effectiveness in the Human Services (pp. 261-276). San Fransisco: Jossey-Bass.

Hosie, P. (1986). Some Theoretical and Methodological Issues to Consider When Using Interviews for Naturalistic Research. Australian Journal of Education, 30(2), 200-211.

Hurley, J., Lomas, J., & Bhatia, V. (1994). When tinkering is not enough: provincial reform to manage health care resources. Canadian Public Administration, 37(3), 490-514.

Ingebrigston, K. A. (1992). Rural and Remote Social Work Settings - Characteristics and Implications for Practice. In M. Tobin & C. Walmsley (Eds.), Northern Perspectives: Practice and Education in Social Work (pp. 7-15). Manitoba: University of Manitoba.

Irving, A. (1995). Canadian Fabians: The Work and Thought of Harry Cassidy and Leonard Marsh, 1930-1945. In R. B. Blake & J. Keshen (Eds.), Social Welfare Policy in Canada (pp. 201-220). Mississauga, Ontario: Copp Clark Ltd.

Ismael, J. S. (Ed.). (1987). Canadian Social Welfare Policy - Federal and Provincial Dimensions. Kingston: McGill-Queens University Press.

Ismael, J. (1988). Conclusion. In J. Ismael & Y. Vaillancourt (Eds.), Privatization and Provincial Social Services in Canada - Policy, Administration and Service Delivery (pp. 219-226). Edmonton: University of Alberta Press.

Ismael, J. S. & Vaillancourt, Y. (1988). Privatization in Comparative Provincial Perspective. In J. S. Ismael & Y. Vaillancourt (Eds.), Privatization and Provincial Social Services in Canada - Policy, Administration and Service Delivery (pp. 219-226). Edmonton: University of Alberta Press.

Jackson, R. W. (1983). Delivering Services to Families in Rural America: An Analysis of the Logistics and Uniquenesses. In R. T. Coward & W. M. Smith, Jr. (Eds.), Family Services: Issues and Opportunities in Contemporary Rural America (pp. 69-86). Lincoln: University of Nebraska Press.

Jansson, Bruce S. (1979). Public Monitoring of Contracts with Nonprofit Organizations: Organizational Mission in Two Sectors. Journal of Sociology and Social Welfare, 6(3), 362-74.

Kagan, R. M. (1984). Organizational Change and Quality Assurance in a Psychiatric Setting. Quality Review Bulletin, 10(9), 269-277.

Kamerman, S. B., & Kahn, A. J. (1989). Privatization and the Welfare State. Princeton: Princeton University Press.

Kagle, J. D. & Giebelhausen, P. N. (1994). Dual Relationships and Professional Boundaries. Social Work, 39(2), 213-218).

Kelle, U. (1995). Introduction: An Overview of Computer-aided Methods in Qualitative Research. In U. Kelle (Ed.) with G. Prein & K. Bird, Computer-Aided Qualitative Data Analysis: Theory, Methods and Practice (pp. 1-17). London: Sage Publications

Kettner, Peter M. & Martin, Lawrence L. (1993). Purchase of Service Contracting In the 1990s: Have Expectations Been Met? Journal of Sociology and Social Welfare, XX(2), 89-103.

Korbin, J. (1993a). Commission of Inquiry into the Public Service and Public Sector - Background Paper: Contracted Community Social Services. Victoria: Government Publications.

Korbin, J. (1993b). Commission of Inquiry into the Public Service and Public Sector - Social Service Project: Summary of Initial Findings. Victoria: Government Publications.

Korbin, J. (1993c). Commission of Inquiry into the Public Service and Public Sector. Volume 2. Victoria: Government Publications.

Lightman, E.; Freiler, C.; and Gandy, J. (1990). A Transatlantic View: Privatisation, Canadian-Style. In R. Parry (Ed.), Privatisation - Research Highlight in Social Work 18 (pp. 105-116). Aberdeen: University of Aberdeen, Department of Social Work.

Lincoln, Y. S., & Guba, E.G. (1985). Naturalistic Inquiry. Newbury Park: Sage.

Lockhart, E. (1986). The Social Effects on Hinterland Communities of Professionalized Human Services. Unpublished doctoral dissertation, University of Regina, Saskatchewan.

Mackenzie Counselling Services. (1995). [Audited financial statements 1980-1995]. Unpublished Raw Data.

Martin, C. (1992). Advantages in Amalgamation For Two Small Non-Profit Health Care Agencies. The Social Worker, 60(4), 213-215.

Martin, L. L. (1993). Total Quality Management: The New Managerial Wave. Administration in Social Work, 17(2), 1-16.

Martinez-Brawley, E. (1986). Beyond cracker-barrel images: the rural social work specialty. Social Casework: The Journal of Contemporary Social Work, 67, 101-7.

Maxwell, J. (1995). The Social Role of the State in a Knowledge-Based Economy. In P. Grady, R. Howse & J. Maxwell (Eds.), Redefining Social Security (pp. 1-48). Queens University: School of Policy Studies.

McFarland, B. H., Smith, J. C., Bigelow, D. A., & Mofidi, A. (1995). Unit Costs of Community Mental Health Services. Administration and Policy in Mental Health, 23(1), 27-42.

McKay, S. (1987). Social Work in Canada's North: Survival and development issues affecting aboriginal and industry-based communities. International Social Work, 30, 259-278.

McQuaig, L. (1993). The Wealthy Banker's Wife - the Assault on Equality in Canada. Toronto: Penguin Books

Mermelstein, J. & Sundet, P. (1974). Social Work Education for Rural Program Development. In L. I. Levin (Ed.), Educating Social Workers for Practice in Rural Settings: Perspectives and Programs (pp. 36-50). Atlanta, Georgia: Faculty Development for Undergraduate Social Work Education. Southern Regional Education Board.

Miles, M. B. & Huberman, A. M. (1994). An Expanded Sourcebook: Qualitative Data Analysis (2nd ed.). Thousand Oaks: Sage.

Millar, K. (1976). Canadian Rural Social Work. In R. K. Green & S. A. Webster (Eds.), Social Work in Rural Areas (pp. 148-155). Knoxville: University of Tennessee School of Social Work

Miller, W. L. & Crabtree, B. F. (1992). Primary Care Research: A Multimethod Typology and Qualitative Road Map. In B. F. Crabtree & W. L. Miller (Eds.), Doing Qualitative Research (pp. 3-28). Newbury Park: Sage.

Ministry of Health & Ministry Responsible for Seniors. (1993). New Directions for a Healthy British Columbia - A guide for developing Community Health Councils and Regional Health Boards. Victoria: Author

Ministry of Health & Ministry Responsible for Seniors. (1994). Core Services Report. Victoria: Author.

Ministry of Health & Ministry Responsible for Seniors (1995). [New Directions in Health: Funding Data for Northern Interior Health Area]. Unpublished Raw Data.

Ministry of Health and Ministry Responsible for Seniors. (1995). Report of the Northern and Rural Health Task Force. Victoria: Author.

Ministry of Health and Ministry Responsible for Seniors. (1995). Policy Framework on the Health of Children and Youth. Victoria: Author.

Moore, S. T. (1995). Efficiency in Social Work Practice and Administration. Social Work, 40(5), 602-608.

Mullaly, R. (1993). Structural Social Work - Ideology, Theory, and Practice. Toronto: McClelland & Stewart Inc.

Myers-Walls, J. A. & Coward, R. T. (1983). Natural Helping Networks: Their Role in Community Services for Rural Families. In R. T. Coward & W. M. Smith, Jr. (Eds.), Family Services: Issues and Opportunities in Contemporary Rural America (pp. 118-132). Lincoln: University of Nebraska Press.

Nelson, B. O., McRae, J., Baldwin, G. J. (1988). Using Working Agreements to Promote Interorganizational Cooperation in Rural Communities. Human Services in the Rural Environment, 12(2), 5-10.

Nichols, A. W. & Schilit, R. (1992). Accreditation of Human Service Agencies: Costs, Benefits, and Issues. Administration in Social Work, 16(1), 11-23.

Osborne, S. P. (1992). The Quality Dimension. Evaluating Quality of Service and Quality of Life in Human Services. The British Journal of Social Work, 22(4), 437-453.

Palmer, R. E. (1969). Hermeneutics: Interpretation Theory in Schleiermacher, Dilthey, Heidegger, and Gadamer. Evanston: Northwestern University Press.

Patton, M. Q. (1987). How to Use Qualitative Methods in Evaluation. Newbury Park, California: Sage.

Perez, E. (1991). Quality Assurance Activities in a Canadian General Hospital Department of Psychiatry. In Administration and Policy in Mental Health 18(3), 183-185.

Pfeffer, N., & Coote, A. (1991). Is Quality Good for You? A Critical Review of Quality Assurance in Welfare Services. London: Institute for Public Policy Research-Social Policy Paper No. 5.

Pollak, N. (1994). Critical Choices, Turbulent Times: A community workbook on social programs. University of B.C.: School of Social Work.

Poole, D & Daley, J. M. (1985). Problems of Innovation in Rural Social Services. Social Work, 30, 338-44.

Pruger, R. & Miller L. (1991). Efficiency and the Social Services: Part A. Administration in Social Work, 15(1), 5-23.

Pulkingham, J. & Ternowetsky, G. (1995). The Changing Landscape of Social Policy and the Canadian Welfare State. In J. Pulkingham & G. Ternowetsky (Eds.), Remaking Canadian Social Policy. Publication Pending.

Q.S.R. Nud.ist 3.0. [Computer software]. (1995). London, U.K.: Sage.

Ramsdell, P. S. & Ramsdell, E. R. (1993). Dual Relationships: Client Perceptions of the Effect of Client-Counselor Relationship on the Therapeutic Process. Clinical Social Work Journal, 21(2), 195-211.

Rekart, J. (1988). Voluntary Sector Social Services in the 1980s. Vancouver, B.C.: Social Planning and Research Council of British Columbia.

Rekart, J. (1993). Public Funds, Private Provision: The Role of the Voluntary Sector. U.B.C. Press.

Rekart, J. (1995). Social Services and the Market Place: Preliminary Findings and Implications. Vancouver, B.C.: Social Planning and Research Council of British Columbia.

Roeher Institute. (1993). Social Well-Being - A Paradigm for Reform. North York, Ontario: Roeher Institute.

Rothe, J. P. (1993). Qualitative Research: A Practical Guide. Heidelberg, Ont.: RCI/PDE Publications.

Russell, M. (1990). Consumer Satisfaction: An Investigation of Contributing Factors. Journal of Social Service Research, 13(4), 43-56.

Rutherdale, R. (1994). Approaches to Community Formation and the Family in the Provincial North: Prince George and British Columbia's Central Interior. B.C. Studies, 104, 103-126.

Shulman, L. (1979). The Skills of Helping Individuals and Groups. Itasca, Illinois: F. E. Peacock.

Segal, J. (1973). The Mental Health of Rural America: The rural programs of the National Institute of Mental Health. Rockville, Md.: Alcohol, Drug Abuse and Mental Health Administration.

Segal, S. P. and Hwang S. (1994). Licensure of Sheltered-Care Facilities: Does It Assure Quality? Social Work, 39(1), 124-131.

Smith, S. R., & Lipsky, M. (1993). Nonprofits for Hire - The Welfare State in the Age of Contracting. Cambridge, Massachusetts: Harvard University Press.

Soderfeldt, M., Soderfeldt, B., and Warg, L. (1995). Burnout in Social Work. Social Work, 40(5), 638-645.

Spiegelberg, H. (1982). The Phenomenological Movement: A historical movement (3rd ed.). The Hague: Martinoff Nijhoff.

Spradley, J. P. (1979). The Ethnographic Interview. Fort Worth: Harcourt Brace Jovanovich College Publishers.

Starr, P. (1989). The Meaning of Privatization. In S. B. Kamerman & A. J. Kahn (Eds.), Privatization and the Welfare State (pp. 15-48). Princeton: Princeton University Press.

Taylor, S. J. & Bogdan, R. (1984). Introduction to Qualitative Research Methods: The Search for Meanings (2nd ed.). New York: John Wiley & Sons.

Torjman, S. (1995). Milestone or Millstone? The Legacy of the Social Security Review. Paper presented to the Seventh Social Welfare Policy Conference, Vancouver B.C. Caldedon Institute of Social Policy.

Trolley, G. (1993). Small Community Initiative Program Review, Evaluation and Planning Project. Ministry of Health, Mental Health Services, Northern Region. (Unpublished).

Tsui, A. S. (1990). A Multiple-Constituency Model of Effectiveness: An Empirical Examination at the Human Resource Subunit Level. Administrative Science Quarterly, 35(3), 458-483.

Tucker, D. J., Baum, J. A. C. & Singh, J. V. (1992). The Institutional Ecology of Human Service Organizations. In Y. Hasenfeld (Ed.), Human Services as Complex Organizations (pp. 47-70). Newbury Park: Sage.

van Manen, M. (1990). Researching Lived Experience. London, Ont.: Althouse Press.

Vaillancourt, Y. (1996). Remaking Canadian Social Policy: A Quebec Viewpoint. In J. Pulkingham & G. Ternowetsky (Eds.), Remaking Canadian Social Policy (pp. 81-99). Halifax: Fernwood Publishing.

Vinokur-Kaplan, D., Jayaratne, S., & Chess, W. A. (1994). Job Satisfaction and Retention of Social Workers in Public Agencies, Non-Profit Agencies, and Private Practice: The Impact of Workplace Conditions and Motivators. Administration in Social Work, 18(3), 93-121.

Wallace, E. (1995). The Origin of the Social Welfare State In Canada, 1867-1900. In R. B. Blake & J. Keshen (Eds.), Social Welfare Policy in Canada. (pp. 1-22). Mississauga, Ontario: Copp Clark Ltd.

Walsh, K. (1991). Quality and Public Services. Public Administration, 69, 503-514.

Walsh, M. E. (1981). Rural Social Work Practice: Clinical Quality. Social Casework, 62(8), 458-464.

Waltman, G. H. (1989). Social Work Consultation Services in Rural Areas. Human Services in the Rural Environment, 12(3), 17-21.

Warren, R. L. (1972). The Community in America (2nd ed.). Chicago: Rand McNally & Company.

Webster, S. A. & Campbell, P. M. (1977). The 1970s and Changing Dimensions in Rural Life - Is a New Practice Model Needed? In R. K. Green & S. A. Webster (Eds.), Social Work in Rural Areas: Preparation and Practice (pp. 75-94). Knoxville: The University of Tennessee, School of Social Work.

Weitzman, E. & Miles, M. B. (1995). Computer programs for qualitative data analysis. Thousand Oaks, Calif.: Sage.

Wharf, B. (1985). Toward a Leadership in Human Services: The Case for Rural Communities. The Social Worker, 53(1), 14-20.

Wharf, B. (1990). Introduction. In B. Wharf (Ed.), Social Work and Social Change in Canada (pp. 9-30). Toronto, Ont.: McClelland & Stewart Inc. Publishers.

Whittington, B. (1985). Challenge of family work in a rural community. The Social Worker, 53(3), 104-7.

Wilding, P. (1990). Privatisation: An Introduction and a Critique. In R. Parry (Ed.), Privatisation: Research Highlights in Social Work 18, (pp. 18-32). London, U.K.: Jessica Kingsley Publishers Ltd.

Wilding, P. (1994). Maintaining Quality in Human Services. Social Policy and Administration, 28(1), 57-71.

Williams, A. S. (1983). Changing Patterns of Horizontal and Vertical Linkage. In R. T. Coward & W. Smith (Eds.), Family Services: Issues and Opportunities in Contemporary Rural America (pp. 87-101). Lincoln: University of Nebraska Press.

Wright, C. A., & Wright, S. D. (1987). The Role of Mentors in the Career Development of Young Professionals. Family Relations, 36(2), 204-208.

Yin, R. K. (1994). Case Study Research - Design and Methods (2nd ed.). Thousand Oaks: Sage.

Zapf, M. K. (1985). Rural Social Work and its application to the Canadian North as a Practice Setting. (Working Papers on Social Welfare #15). Toronto: University of Toronto.

APPENDIX A

APPROVAL FROM ETHICS COMMITTEE

UNBC Research Ethics Committee
Certificate of Ethics Approval

Name of Researcher: Jackie Stokes

Title of Research Project: Quality From a Social Work Perspective, in Multi-service, Remote Community Agencies

I certify that this project was given ethics approval by the UNBC Research Ethics Committee

Signed: _____ **Date:** 2 Apr 96

Dean of Research and Graduate Studies

APPENDIX B

LETTERS OF INVITATION

TO THE

EXECUTIVE DIRECTORS

Jackie Stokes, R.S.W.
7032 O'Grady Road,
Prince George, B.C.
V2N 4Y6

July 17, 1995

***Name,
Executive Director,
****Address

Dear *******:

After working for almost 10 years in Mackenzie as an Alcohol and Drug Counsellor and then Executive Director I am currently studying at U.N.B.C. in the Master's of Social Work program. The research that I have chosen to undertake, as part of my course requirement, is to explore the concept of quality in multi-service agencies in small communities. In order to do that I would like to interview a number of people who have different relationships with the agencies in the Northern Interior Health Area.

I have chosen to interview agencies who have multiple funding sources, of which one is either Mental Health or Alcohol or Drug. I have received permission from Dr. Betsy Lockhart, Acting Regional Manager for Mental Health and Mr. Peter Cunningham Regional Manager for Alcohol and Drug Programs as well as the U.N.B.C. ethics committee in order to pursue this research. If you are interested in participating I would like to interview the Contract Manager, the Executive Director, a Board Member, a Clinician (Alcohol and Drug, or Mental Health), a Client and a Referral Agent.

The research is completely voluntary, and no one, particularly clients, should be placed under any pressure to participate. In particularly I do not want this research in any way to interfere in the therapeutic relationship between your agency and your clients. If your agency agrees to participate in the research an interview time will be set at a mutually agreed upon time. The interviews will each take approximately one hour and will involve questioning to ascertain that person's beliefs about the essential components of quality in agencies like yours. The interviews will be audio-taped and then transcribed, ensuring there is no identifying information on the transcription. The audio tape and transcription will be kept in a locked, filing cabinet in my home until successful defense of my thesis, at which time it will be destroyed. The final report will group each constituent group together, so that no individual will be identifiable. For example a response may be compared between the Clinicians, as a group, and the Executive Directors, as a group. But the report would <u>not</u> identify that the Clinician in Mackenzie, for example, said "x."
If you are interested in your agency participating in this research could you please review the information with your Board and Clinician. Between yourself and the clinician you will be asked to give a "brochure of introduction" to Clients and Referral Agents who may be

interested in being involved. The Clients and Referral Agents can then contact me directly if they are interested in participating.

If the Board and Clinician agree to participate, and you are comfortable with giving the information to Clients and Referral Agents could you please contact me by phone, 964-2515, or return the enclosed mail back form. After I hear from you, and I have made a selection of three agencies, I will contact you to pursue the research further.

I have enclosed a mail back form, a copy of an introductory letter to the Board of Directors, and your Clinician, as well as the brochure (to be given out at a later date) for Referral Agents and Clinicians. If you would like to see a copy of the full thesis proposal, or if you have any questions please do not hesitate to contact either myself at 964-2515, or my academic supervisors, Dr. Gordon Ternowetsky at 960-6620 or Mr. Glen Schmidt at 960-6519. I hope that you will assist me in this research area.

Yours sincerely,

Jackie Stokes, R.S.W.

encl.: Mail back form,
Letter to Board Members & Clinicians,
Brochure of Introduction for Clients & Referral Agents.

Letter of Introduction to Clinicians

I am a student in the graduate program at U.N.B.C. in the Master's of Social Work program, who is interested in exploring and understanding your perception of quality in human service organizations. This interest developed from working in Mackenzie for 10 years and more recently being involved in quality assurance programs. To try and understand quality as it relates to small community agencies I would like to interview one Counselor, one Client and one Referral Agent, as well as an Executive Director, a Board Member and a Contract Manager in three community agencies.

The research consists of an interview which would take approximately 1 hour to complete and will consist of questions to find out about your beliefs about the essential components of quality in agencies like yours. The research is completely voluntary. If your agency agrees to participate, an interview will take place at a mutually agreeable time. The interviews will be audio-taped and then transcribed, ensuring there is no identifying information on the transcription. The audio tape and transcription will be kept in a locked, filing cabinet in my home until successful defense of my thesis, at which time it will be destroyed. The final report will group each constituent group together, so that no individual will be identifiable. For example a response may be compared between the Clinicians, as a group, and the Executive Directors, as a group. But the report would not identify that the Clinician in Mackenzie, for example, said "x." None of the information you disclose for the purposes of this research will be given to anyone else in your community, including the agency you currently have involvement with.

I am requesting that Clinicians invite their Clients to participate in this research by handing them a brochure of introduction. If a Client is interested they can contact me directly. Of course it is important that this research does not interfere with the therapeutic relationship, and remains completely voluntary for the Client.

If your agency is interested, the Executive Director will be contacting me and advising me. If you are personally interested in being interviewed could you also contact me by phone, at 964-2515 (collect), or by returning the enclosed Mail back form. If you would like to see a copy of the full thesis proposal, or if you have any questions please do not hesitate to contact either myself at 964-2515, or my academic supervisors, Dr. Gordon Ternowetsky at 960-6620 or Mr. Glen Schmidt at 960-6519. I hope that you will assist me in this research area.

Yours sincerely,

Jackie Stokes, R.S.W.
encl: Mail back form

Letter of Introduction for Board of Directors

To Chair person:

I am a student in the graduate program at U.N.B.C. in the Master's of Social Work program, who is interested in exploring and understanding your perception of quality in human service organizations. This interest developed from working in Mackenzie for 10 years and more recently being involved in quality assurance programs. To try and understand quality as it relates to small community agencies I would like to interview a Counselor, a Client and a Referral Agent, as well as an Executive Director, a Board Member and a Contract Manager in three community agencies.

The research consists of an interview which would take approximately 1 hour to complete and will consist of questions to find out about your beliefs about the essential components of quality in agencies like yours. The research is completely voluntary. If your agency agrees to participate an interview will take place at a mutually agreeable time. The interviews will be audio-taped and then transcribed, ensuring there is no identifying information on the transcription. The audio tape and transcription will be kept in a locked, filing cabinet in my home until successful defense of my thesis, at which time it will be destroyed. The final report will group each constituent group together, so that no individual will be identifiable. For example a response may be compared between the Clinicians, as a group, and the Board members, as a group. But the report would not identify that the Board Member in Mackenzie, for example, said "x." None of the information you disclose for the purposes of this research will be given to anyone else in your community, including the agency you currently have involvement with.

If your agency is interested, the Executive Director will be contacting me and advising me. If you are personally interested in being interviewed could you also contact me by phone, at 964-2515 (collect), or by returning the enclosed Mail back form. If you would like to see a copy of the full thesis proposal, or if you have any questions please do not hesitate to contact either myself at 964-2515, or my academic supervisor, Dr. Gordon Ternowetsky at 960-6620 or Mr. Glen Schmidt at 960-6519. I hope that you will assist me in this research area.

Yours sincerely,

Jackie Stokes, R.S.W.
encl: Mail back form

Mail Back Form

If you have any questions about this form or the research please contact Jackie Stokes at 964-2515 (collect if necessary) or Dr. Gordon Ternowetsky at U.N.B.C. 960-6620 or Mr. Glen Schmidt at 960-6519.

To: Jackie Stokes,
7032 O'Grady Road,
Prince George, B.C.
V2N 4Y6

Your Name: _____

YourAddress: _____

_____

Your Phone No: _____

_____ I would like to participate in the research being undertaken by Jackie Stokes which is to understand the essential components of quality in small community agencies.

(Please check one)
Are you interested in being interviewed for your perspective on quality in human services agencies in small, northern communities from a

_____ Client's point of view

_____ Board Member's point of view

_____ Executive Director's point of view

_____ Referral Agent's point of view

_____ Clinician's point of view

Jackie Stokes, R.S.W.

APPENDIX C

BROCHURE OUTLINING RESEARCH

WHAT IS THIS RESEARCH ABOUT?

Small, northern communities have special characteristics that you are likely aware of: feelings that the south dictates to the north, a sense of isolation, a strong belief in working together, to name a few - not to mention long, cold winters and a yearn for more shopping.

The purpose of this research is to find out from the people living in small communities how it would be best to provide human services in their communities, as well as the factors that make for a quality service.

In order to do that I need to interview Clients, Referral Agents, Counsellors, as well as Board Members, Executive Directors and Contract Managers in three small community agencies.

WHAT DO I HAVE TO DO?

If you are interested in participating you will be interviewed, in person, for about an hour, about what you think quality service in small communities should be.

The interview will be audio-taped, and then transcribed to ensure there is no identifying information on the written copy. (Your name and community will be coded so no-one else will know who you are.)

Is It Confidential?

This brochure has been given to you by your counsellor. Your name will not be given to me by your counsellor.

The audio tape of the interview will be stored in a locked filing cabinet in my home, until I have successfully finished this research. At that time you can choose to have it destroyed or returned to you.

If you agree to participate, your counsellor will not know that you are being interviewed.

THE REPORT

You will have an opportunity to see the written transcription of the tape. Once all the transcribing has occurred a report will be written analysing the information. In that report no individual will be identified, although groups of individuals may. For example "the clients interviewed agreed that ..... was important." A copy of the draft report will be available for your input, and if you feel anything said identifies you, you may delete it. The final report will be my Master's Thesis and will be available to the public.

WHAT NEXT?

If you are interested please call me at 964-2515 (collect) or mail back the form on the back cover of this brochure. I will then contact those who are interested and interview some people from each community.

WHO IS JACKIE STOKES?

I worked in Mackenzie for almost 10 years as a counsellor and Executive Director. I am now living in Prince George completing my Master's of Social Work at the University of Northern British Columbia.

I am very interested in quality service in small communities and ensuring that services are accountable to the community they are in. I think the people who use the service are the best people to say how they should be provided and what quality services are. That is why I am interested in interviewing you.

Thank you

Jackie Stokes

If you have any questions about this form, or the research please contact Jackie Stokes - 964-2515 (collect), or Dr. Gordon Ternowetsky at U.N.B.C. 960-6620 (collect).

Your Name: _____

Your Address: _____

_____

Your Phone No: _____

____ I would like to participate in the research being undertaken by Jackie Stokes which is to understand the essential components of quality in small community agencies.

(Please check one)

I am interested in being interviewed for my perspective on quality from a

____ Client's point of view

____ Referral Agent's point of view

____ Board Member's point of view

____ Executive Director's point of view

____ Clinician's point of view

____ Contract Manager's point of view

WHAT DO YOU THINK ABOUT

Counselling Services in Small Communities?

Quality in Counselling Services?

How services should be provided in small communities?

IF YOU ARE INTERESTED IN GIVING YOUR THOUGHTS AND OPINIONS

YOU MAY BE INTERESTED IN PARTICIPATING IN THIS RESEARCH

APPENDIX D

EXPLANATION OF RESEARCH

AND

OVERVIEW OF QUESTIONS

Dear ******:

Thank you for agreeing to participate in this research on essential components of quality in small community, northern agencies. I have enclosed an Agreement of Participation for you to review, which will need to be completed prior to the interview. Also attached is a listing of the areas that will be covered during the interview. If you would like to take some time prior to the interview to prepare your thoughts on some of these areas it may focus our discussion.

As mentioned earlier this is not an evaluation of the agency in your community, and your remarks will not be identified in any written material that develops from this research. I am interested in your beliefs and ideals on how to provide quality services in small, northern communities.

The interview has been arranged for ***Date & Place & Time*** If you have any questions prior to my arriving in Mackenzie please contact me at 964-2515.

Areas that will be covered include:

Your impressions of the advantages and constraints of working, and providing services in a small, northern community.

Your thoughts about how services could be provided in small, remote communities compared to urban centers.

Your experience with agencies providing a number of different human services. Your impressions of the benefits, as well as draw backs, of providing a variety of services under one umbrella organization.

Your beliefs about how agencies can connect with other community organizations, as well as what you see as being the ideal way of connecting with the larger regional and provincial centers.

What you believe to be essential concepts of quality in a multi-service agency.

How these concepts may be different in small community centers compared to urban centers.

How you think agencies could demonstrate that they are providing quality services.

Who you think should be involved in setting and maintaining standards for quality service.

Thank you for your participation in this research. Jackie Stokes

APPENDIX E

AGREEMENT OF PARTICIPATION

QUALITY
FROM A SOCIAL WORK PERSPECTIVE
IN MULTI-SERVICE, REMOTE COMMUNITY AGENCIES

AGREEMENT OF PARTICIPATION

This purpose of this research is to understand and explore the essential components of quality when providing human services in small communities. This will be done by interviewing Clinicians, Clients, Executive Directors, Board Members, Contract Managers, and Referral Agents in multi-service agencies located in small, northern communities.

The research forms a component of my Masters of Social Work curriculum at the University of Northern British Columbia. If you agree to participate in an interview it will be held at a time and place chosen for your convenience. It will take approximately one hour and will be audio taped. The tapes will be transcribed and coded to ensure there is no identifying information on the transcript. The transcript will then be sent to you for any comments or clarification.

The tape will be stored in a locked filing cabinet, in my home, until successful defense of my thesis, at which time it will be destroyed. The written transcripts will be maintained but will be kept strictly confidential, and will not be available to anyone except myself and my academic supervisors. Your name will never be used on written material, and you will not be identified by any means in any publications as a result of this research.

If you choose to participate in this study, you may withdraw at any time. If you have any questions please contact me at 964-2515.
****

Your signature below indicates that you understand and agree to the terms of participation in the study. Please sign two copies and keep one.

Thank you for your assistance

Name _____ Signature _____

Date _____ Witness _____

Jackie Stokes, B.S.W., R.S.W