Model Coherency: A Concept & Process for the Evaluation of Quality in Human Services

Errol Cocks, PhD

Introduction

The greatest challenges for modern formal human services are to be relevant to the needs of service users and effective in addressing those needs. In fact relevance and effectiveness provide a cogent definition of service quality, described by the UK Department of Health in 1997 by the phrase: "doing the right things, for the right people, at the right time, and doing them right first time" (Department of Health, 1997). Relatedly, a concept called "Model Coherency" was published in 1975, over two decades before, as an item in an evaluation instrument developed by Wolfensberger and Glenn called Program Analysis of Service Systems (PASS) (Wolfensberger & Glenn, 1975). It was expressed as a question:

Are the right people working with the right clients, who are properly grouped, doing the right thing, using the right methods, and consistently so?

At the heart of the concept of Model Coherency is the assumption that high quality is directly related to the extent of coherency or agreement between what a human service does, how it does it, and the needs of the service users.

Model Coherency was developed by Wolfensberger and colleagues into a rigorous and challenging process with a number of important purposes that are germane to determining quality in human services. Model Coherency was operationalised into both an evaluation process as part of the PASS evaluation instrument, and also as training events. The process uses a universal framework for describing and analysing all forms of human services for all types of service users. This framework, a human service model, elucidates the "building blocks" of human services consisting of the structures and processes that go together to create a human service. Three distinct purposes flow from the capacity to describe and analyse a human service.

1. The process of description and analysis lends itself to the evaluation of service quality in an existing human service (a process called Model Coherency Evaluation).
2. The framework can be used to design and plan a new human service for an identified group of service users (a process called Model Coherency Construction).
3. Model Coherency provides an effective curriculum and process in education and training for stakeholders in human services in order to deepen their understanding of how services operate and the nature of quality in services.

Model Coherency has particular relevance to many contemporary issues in human services. Through the conceptual development of a human service model, it provides a single, integrative framework that challenges the prevailing reductionism and fragmentation for which these services are well

known. The term "model" is used frequently in the human services literature with no apparent agreed meaning and even some confusion. An example was a report in 1999 entitled *Modern standards and service models*: *Mental health national service frameworks, to establish vital strategic directions for the future development of mental health services in the UK* (Department of Health, 1999b). Notably, the report contained no definition or conceptual elaboration of the central term "model." In fact in the Executive Summary, "service models" were described as objectives against each of standards in five areas of service development.

The Model Coherency approach considers systemic issues when it is applied to particular human services. In this way, a clear connection is created between the structures and processes adopted by human services and the outcomes they achieve. Model Coherency is very "client-centred," based on the major underpinning assumption that the quality of a service is directly related to the address of service users' needs. The process of Model Coherency is reflective of human needs, social problems, and the roles, functions and practices of human services. Model Coherency also draws on Social Role Valorisation (SRV) theory. SRV addresses stigma and social exclusion that incorporate the concept of social devaluation within the theory (Wolfensberger, 1983, 1998).

Modern formal human services represent, amongst other things, a major societal strategy to address issues of social devaluation. This is clearly reflected when service users experience stigma and social exclusion, or at least are vulnerable to this, because of their social, psychological, economic and/or physical conditions and also through the manner in which people and human services respond to these conditions. Human services can help redress these damaging dynamics. They can, and do, also inflict further harm, however unintentionally. In fact "unintended outcomes" or "untoward events" result in part from the lack of awareness or consciousness of the impacts of the structures and processes that are adopted in human services. In addition to being a technical process, Model Coherency incorporates the exploration of a values foundation for human services.

The purposes of this paper are to describe the key assumptions that underpin Model Coherency and the framework of a human service model, and discuss the way in which various elements of a model reflect its coherency. Finally, an illustrative case study of an actual Model Coherency analysis and evaluation of a service for people with intellectual and developmental disabilities and very high support needs in Australia will be described. More broadly, this paper focuses particularly on services for people with enduring needs who are in health or social care (e.g., elderly people, people with disabilities, chronic illness, mental health problems, etc.) since this is the context within which Model Coherency emerged and is largely applied.

The Key Elements of Model Coherency

This section of the paper describes the set of four key concepts that underpin Model Coherency.

1. Universality

It is self-evident that there is considerable value and utility in having a framework that can be applied in the description and analysis of all types of human services. There is particular value to be gained from the insights that a universal framework can provide that incorporates the common and different elements of human service models, the way in which the characteristics of models influence outcomes for service users, and the nature of "new" forms of human services. The concept of "hospital" provides an example.

A universal Western human service expression is represented by the "hospital." We are accustomed to the hospital as an appropriate service for the treatment of acute illnesses and also long-term care. Even in this role, its effectiveness is open to scrutiny in the light of various deficiencies reflected in evidence of iatrogenic effects that go back many years, and also in issues as-

sociated with the risks emanating from a number of factors including the complexity and technical nature of modern hospitals (Race, 1999; Illich, 1976). Many groups of service users with diverse needs are served within hospital, or hospital-like settings. These include people who actually live in hospitals and have lived in hospitals perhaps for much of their lives. Such groups include people with disabilities, people with mental illnesses, people with physical impairments, elderly people and some categories of offenders. The modern version of expressions of "hospital" has a long history over many centuries. These include the early versions of the hospice, through the development of the "general hospital" which catered for a very diverse group of clients, to the 19th century expressions of large institutions that still exist in many countries. In fact the very historical "embededness" of this service model makes it very difficult to reform. For the people served, hospital is not only a place of "treatment," such as that may be, but it also represents their "home." However, few people would recognise much correspondence between the lives people lead in institutional settings and the lives led in more valued or normative expressions of "home," reflecting the crucial issue of quality.

This is hardly news to human service users, planners and providers. In fact, in the disability area for example, internationally there has been a community-living reform movement in progress since the 1950s. Reforms have been guided by social policy expressed in the 1960s and 1970s by normalisation, in the 1980s by the concepts of Social Role Valorisation and an "ordinary life," and in the 1990s by "care in the community" (Brennan *et al*, 1991; Wolfensberger, 1972; Nirje, 1992; King's Fund Centre, 1980). It is not easy to judge the results of these reforms in disability or, indeed, in other areas such as mental health and ageing where similar reforms have been occurring. However, some reports and a substantial body of research literature attest to two realities (HMSO, 1989; Emerson *et al*, 1999; Department of Health, 1999a). A large proportion of people with disabilities still live in hospitals or hospital-like settings of comparatively poor quality. Many community-based service forms have retained significant characteristics of hospital service settings with clear implications for quality. Perhaps the most common expression is the congregation in service settings of unrelated people who are connected primarily by their perceived shared deviant characteristics. In some countries, the ubiquitous "group home" places people with disabilities in congregate settings where they may live with strangers.

There is obvious value in applying a systematic framework to the description and analysis of hospital-like, congregate settings that would clarify the essential characteristics of this service model. Having identified these characteristics, the task of addressing two key questions about service quality should be facilitated. What is the relationship of service model characteristics to the needs of service users? What is the nature of "new" or changed service models–are they indeed "new"?

2. Programmatic and Non-Programmatic Issues in Human Services

The theory of Model Coherency requires a distinction to be made between issues that are programmatic and those that are non-programmatic. Programmatic issues are those that are directly connected to addressing the needs of service users. These issues are determined by who are the intended beneficiaries of a human service program and the hierarchy of their needs. It includes the key assumptions about those people, the nature of their needs, and how those needs should be addressed. It also includes the things services do that impact directly on service users such as the physical characteristics of the programme, how the programme groups service users, and the methods and processes (including "treatments") utilised by the programme. Programmatic issues are those that have high relevance to the needs of service users.

Non-programmatic issues are those that primarily address the needs of other individuals, groups, and/or systems. They include activities that are designed to benefit managers, staff, funders, organisations, regulators, etc. Examples include: the career needs of staff; the demands of financial interests; historical commitments to using particular service settings or service models; and addressing personal or political agendas. Although these issues may be important and legitimate, and may also be consistent with the needs of service users, they are viewed within Model Coherency as possibly providing constraints and limiting opportunities. Non-programmatic issues are crucial because in spite of the contemporary rhetoric of needs-based and client-centred planning, human services generally are planned primarily from the standpoint of non-programmatic issues. In fact, perceived lack of resources will often prevent the development of some service models and may even prevent the consideration of any alternatives to congregation. The history of institutions was well-described by Wolfensberger in 1968 in a publication entitled "Changing patterns in residential services for the mentally retarded," and subsequently published as "The origin and nature of our institutional models" by Human Policy Press in 1975.

The logic of Model Coherency requires that services be planned and evaluated from the programmatic standpoint. Thus service quality will be measured against the ideal way/s to address service users' needs–a needs-based and client-centred level of "excellence." Anything less than this would be viewed clearly as a compromise, unavoidable perhaps, but a compromise nevertheless. Maintaining consciousness that a particular service option is less than ideal may prevent the defence of the option as the "best" which often emerges with the passage of time.

This approach to planning and evaluating human services will be difficult to achieve in services with the following characteristics that are influential determinants of organisational culture. Each of these characteristics can be described and exemplified in much more detail than is possible here.

a. Where services and service models are deeply historically "embedded," e.g., through physical locations and buildings, and other historical commitments.

b. Where the service culture is driven primarily by the needs or interests other than those of service users.

c. Where the "bottom line" drives the service.

d. Where the service is preoccupied with short-term imperatives and crises, allowing only limited consideration of issues that may be perceived to be important, but are not urgent.

e. Where there is a reluctance to take a critical look at existing service models.

f. Where there is little incentive and motivation to change.

3. Social Role Valorisation

Human perception is inherently evaluative, all the more so when the focus is other human beings. A major consequence of this is that individuals and groups of people are accorded more or less social value and some are socially devalued. This occurs at the level of individuals. It can also occur on a much broader scale whereby groups of people (e.g., people from particular racial or ethnic groups, people with impairments, elderly people, poor people, people with particular forms of communicable diseases, etc.) can be collectively and systematically socially devalued by a large segment of society or even by the entire society. Social devaluation is built into social customs and social institutions. Broadly speaking, social devaluation is relative across cultures and across eras. For example, elderly people may be respected in one culture but rejected in another. Similarly, there have been times in history when people with certain impairments have been accorded high social value. The relativity of social devaluation provides evidence that it is largely determined by social factors, including human perceptions, and does not

primarily derive from the devalued person/people. Individuals may have little influence on processes of collective devaluation. The consequences of social devaluation are that people will be treated badly. This may include stigmatisation and exclusion from the "good things in life." The relevance of this concept, as mentioned earlier, is that many groups of clients of human services either experience, or are vulnerable to, social devaluation.

Social Role Valorisation (SRV) is a social theory that was developed by Professor Wolf Wolfensberger and colleagues alongside the principle of normalisation. SRV addresses the phenomena of social devaluation. It does this by describing the consequences of social devaluation to people who experience social devaluation (called "wounds" in the theory), and by drawing together a number of concepts and theories, sociological, psychological and historical, to explain the dynamics of social devaluation. Examples of wounds include experiences of rejection, being accorded devalued roles, and loss of autonomy. Drawing heavily on social role theory, SRV theory establishes that the principal counter to social devaluation is to enable people to achieve and maintain valued social roles (e.g., as family members, students, workers, friends, etc.) and to have those roles defended. This entails, amongst other things, protecting vulnerable people from devalued roles such as when elderly people or people with disabilities are cast into the roles of children, or people with some forms of mental illness being cast into the roles of menace or object of dread. The theory argues that there are two main strategies by which this can be achieved. The first is to promote and enhance the social image of vulnerable people and to avoid associating them with negative imagery and symbols. The second is to enhance the competencies of vulnerable people. These strategies need to be developed through action at a number of levels including the individual, the primary and secondary social systems (e.g., the family and the school), and the society and culture. Action is especially called for within human services.

Because of the central role of human services in relation to social devaluation, SRV theory particularly focuses on what it is that human services do that influences social devaluation by either ameliorating or intensifying the harmful impacts on vulnerable people. Particular aspects of human service structures and practices have major impacts on the social image of service users, on the development of their competencies, and on the social roles that they are accorded. SRV theory articulates six principal means by which human services influence these outcomes.

a. Through the physical environments in which human services are delivered, e.g., by locating service users in large, physically and/or socially isolated service settings.

b. Through grouping practices, e.g., congregating all service users who have a significant deviant characteristic, such as challenging behaviour, in one setting or activity.

c. Through the way in which services structure the activities and time of service users, e.g., elderly people or people with chronic mental illness being engaged in childish activities or long periods of inactivity.

d. Through the use of language that conveys clearly negative messages about service users, e.g., calling people who are not sick "patients."

e. Through the way in which human services influence the manner in which service users are presented to observers, e.g., service users who are perceived to have few possessions or limited privacy.

f. Through the manner in which human services attach various images and symbols to service users, e.g., by attaching imagery of charity in fund raising practices.

Note also that human service structures and practices in effect "teach" the community about the service users. They also inculcate attitudes and concepts service users develop about themselves (self-attributions) through psychological processes of internalisation.

Various SRV principles are applied in a Model Coherency process. For example, it is a basic

requirement of coherency that a human service should not inflict further harm (wounds) on service users ("do no harm!"). In this regard, human service programmes should not associate service users with negative imagery that might impose or reinforce damaging stereotypes and roles. Nor should they limit the development of service users' competencies.

4. The Concept of Culturally Valued Analogues (CVAs)

Human services are commonly modelled on other human services for similar groups of service users. In fact the power of many historical human service models is such that they may be "imported" into countries where the practices may be culturally alien. This is a reflection on what has been called "the serviced society," the "post primary economy" and the "human service super system" (Emerson & Hatton, 1996; McKnight, 1995). For example, nursing homes and hospitals for the long-term care of elderly people are now common in countries where a relatively short time ago, it was the custom for elderly people to remain with the extended family. It can be argued that there is a combination of economic and social conditions in some countries that may challenge traditional forms of care and this may lead to the adoption of Western human service models. However, innovative and effective models have emerged from developing countries, community based rehabilitation being a good example (Wolfensberger, 1989).

As a principle of planning and evaluating human services, the concept of culturally valued analogues (CVAs) proposes that human services should be modelled on culturally valued and normative approaches to meeting similar needs in the valued population (Wolfensberger & Thomas, 1983). If practices are culturally valued and historically embedded positively in a culture, then a human service closely based on such practices is more likely to be accepted, along with the people who are associated with the practice. For example, although culturally-valued notions of a home are diverse in a pluralistic society, it is obvious that for the vast majority of people, living with a large group of unrelated people who are perceived to share certain deviant characteristics in a physical location that looks like a hospital would be perceived as alien. At the same time, it is possible to evoke a concept of what "home" means that is shared widely within a culture and there is much empirical evidence of this (Cooper, 1995; Despres, 1991; Sixsmith, 1986). Similarly, it is possible to describe a range of culturally valued practices by which the full scope of human needs can be addressed, e.g., education, work, health. In the context of Model Coherency, coherency is related to the extent to which service structures and practices reflect the CVAs that correspond to the needs the services are addressing.

An important related principle for planning and evaluating human services is the notion of "separation of life functions." This refers to the fact that the needs of the vast majority of citizens are met in diverse locations and with diverse groups of people. Typically, we live in one place, go to others for education and training, have health needs met in different locations, etc. This very diversity promotes opportunities and development. This principle has implications for service models that attempt to provide for most if not all service users' needs within one location.

An Illustrative Case Study

In order to illustrate the model coherency process, a brief description is provided of a Model Coherency analysis carried out with a small, non-government agency in Australia that provided residential services for adults with developmental disabilities.

1. The Background to the Case Study

The service was established as a large nursing home in the 1950s by parents of young children with severe and profound intellectual and developmental disabilities, many of whom also had

significant physical impairments. In the 1980s, following considerable developmental activity, the agency began a process of relocating the 42 service users, now middle-aged, from what had become a "hostel" into small, community-based housing. The change from a nursing home to a hostel was challenging and in itself provides an interesting account of attempts to develop from one service model to another. This was partly successful, although some elements of the nursing home model were sustained in the hostel.

The process of community relocation was completed by the mid-1990s, by which time service users were living in 13 group homes with between two and six service users in each. The agency decided to initiate the "Safeguards Project" in order to address issues about maintaining service quality in the new, dispersed service model. The author was contracted to provide an evaluation of the new service as part of that project. The evaluation had three components.

1. A participatory action research project through which major agency stakeholders identified what they considered to be quality practices in the service and how they thought these practices were, or could be safeguarded (Cocks, 1997).
2. A formal evaluation of the 13 homes using two normalisation and SRV-based evaluation instruments–the administration ratings from Program Analysis of Service Systems (PASS) and all 42 ratings from the successor to PASS, Program Analysis of Service Systems' Implementation of Normalisation Goals (PASSING). The results of this evaluation, carried out by small teams of members with experience in the content and methods of the evaluation, showed a close, positive relationship between quality of outcomes and small size of residences. This was highly significant in the two-person residences (Cocks, 1998).
3. A Model Coherency analysis.

The Model Coherency analysis took place immediately following the SRV evaluations over a period of two days and evenings within a workshop format. It utilised the detailed information gathered on the service from the SRV evaluation processes which had taken place over five days. Participants included the members of the four SRV evaluation teams, senior staff from the agency, some agency Board members, and two representatives from funding agencies. Note that the brief description that follows focuses on the Model Coherency analysis for illustrative purposes only and does not describe the complete evaluation.

2. The Framework of a Human Service Model

A central concept within Model Coherency is the human service model. The framework of a human service model consists of four elements:

a. The assumptions held about important, relevant aspects of a human service.

b. The people who are intended to be the beneficiaries of the service.

c. The service content/s–what the service is giving to the service users.

d. The processes by which the service provides the service content/s.

Each of these four elements is described below and followed by the outcomes of the case study.

A. Assumptions

Assumptions powerfully shape human services even (or especially) when they remain unexplicated or unconscious. Model Coherency processes require that key assumptions are "laid bare." In an evaluation process, the assumptions would be derived from systematic observation of the human service program. In a Model Coherency construction process, the assumptions would be established as the initial step in the planning process.

Clearly, there is the potential for a vast number of assumptions to be explored, however, some assumptions are likely to be more influential and important. These might include assumptions held about:

- Human beings (since these are "human" services).
- The parameters of social problems, particularly the problem/s about which the service is concerned. Such parameters include the nature of the problem/s, possible causes/ contributors, possible ways to address the problem/s, and desired outcomes.
- The roles, functions and possibilities of human services.
- The social and cultural context of the problem/s.
- The groups of service users for whom the service is provided or planned.

In a Model Coherency process, explicating assumptions is carried out as exhaustively as possible and involves lengthy, clarifying discussions. Reaching consensus may be particularly difficult in pluralistic, heterogeneous cultures and requires a degree of rigour and discipline to achieve. In a process aimed at education, this part of Model Coherency provides considerable opportunities for insights into social problems and human services.

Outcomes

The workshop participants identified a total of 51 assumptions that were considered to be important to the service model. These were discussed in varying degrees of detail and served to lay out and clarify the key foundations of the service. Some examples of assumptions organised into categories follow.

Assumptions about human beings.

- All people have the capacity to grow and develop.
- Small steps are valuable–all human development is worthwhile.
- Capacity to love or be loved is unrelated to intelligence or other capacities.
- All human beings show the core set of fundamental needs.

Assumptions about the parameters of the social problem.

- Society rejects people with disabilities.
- It is dangerous to be slow in a fast world.
- Society will change if we put in enough effort at the grass roots level.
- Community building that may benefit people with disabilities may benefit the whole of society.

Assumptions about the roles, functions and possibilities of human services.

- Modern human services are very materialistic and governed by materialistic assumptions.
- Modern human services exist to keep people employed, are provided to service staff, and to meet the needs of many groups apart from clients.
- Human services cannot meet all needs.
- Human services should respect and encourage choice and preference unless it violates higher order principles.

Assumptions about the social and cultural context of the problem/s.

- There is a significant difference between paid and unpaid relationships.
- We live in a materialistic society.
- Society has a responsibility to all its members.
- Human life should be preserved at all costs.

B. The People Served

The second stage of a Model Coherency process required a detailed consideration of the needs of the people to be served by the programme. This usually occurs at two levels. The first is a "factual" level that describes the service users in terms that are usually relatively clear cut and objective, e.g., their number, genders, ages, impairments, etc. This may be the level within which formal human services are confined. The second level requires a much deeper consideration of the identities of

the service users which means understanding the way in which their life experiences and conditions have shaped their needs, including the influence of social institutions, and is much more difficult to do. This level of description and analysis incorporates an existential and phenomenological view that will draw on different conceptualisations including SRV (for example, by contemplating vulnerability and aspects of social devaluation such as wounds and negative social roles).

The purpose of this important stage in the process is to gain a deep understanding of the needs of service users against which the relevance and effectiveness of the actual or planned service will be assessed. This requires some important distinctions including acknowledgment of universal needs (sometimes overlooked once a limiting label has been applied), and recognition of needs that are fundamental and urgent. Urgent needs such as the need for security and stability may require attention before others can be addressed. In addition, the needs schema includes special needs that may arise from the particular impairments or life experiences of service users.

Recognition and acknowledgement of needs is a challenging objective within formal human services for a number of reasons. Some of these include the following.

1. Service planners and providers may not actually know service users personally and may have very limited contact with them.
2. The systems and process of needs identification may be confined and limited so as to overlook or ignore needs that do not easily fit or are particularly challenging, especially basic needs such as for love, friendship and affiliation. Assumptions may be made about needs in human services solely on the basis of a diagnostic label.
3. Needs may become confused with what services do about them. For example, need for social activity may be redefined as a need for therapy and in this manner, many ordinary, everyday needs and activities have been reinterpreted as therapies and then possibly denied because of lack of therapists. In a related phenomenon that is very common in human services, needs may be redefined into what it is that a programme believes it can provide, often leading to services that are largely irrelevant when judged against service users' urgent or fundamental needs.

Outcomes: The People Served

1. The nature of the problem

The service users were described as adults with severe and multiple disabilities, the majority of whom had been institutionalised for a long time. They had experienced considerable rejection, had lived apart from the community, and lacked meaningful activities, roles and relationships. They could not live as adults in the community without physical support.

2. Factual description

A very detailed factual description of the service users was developed. In summary:

- 26 men and 16 women of average age 39 years and age range 20-69;
- all had severe or profound levels of intellectual/developmental disabilities and 37 had significant physical and sensory impairments;
- one third had limited mobility, two could communicate verbally in a limited way, six could sign, but all could communicate in various ways;
- 80-90% required substantial physical supports in activities of daily living and the remainder needed some help;
- the majority of service users participated in household activities and all participated in leisure activities;
- all had limited but extremely important social networks, especially within their families.

3. What it meant to have severe disabilities

Because disability was so central to their identities, some time was devoted in the workshop to describing in ordinary language what it meant to have severe disabilities.

4. The identities of the service users

This was a lengthy stage of the workshop and addressed the following questions.

- What had their lives been like?
- What was the impact on the service users of the recent major changes that occurred through relocation?
- What are the major assumptions and theories held by ordinary people about this group of service users?

5. The needs of the service users

There was a wide-ranging discussion that identified many fundamental and specific needs. In summary, the following service users' needs were agreed as most important. Achieving:

- A fuller, more complete life.
- Their individuality acknowledged and developed.
- Their vulnerabilities safeguarded.
- More relationships.
- Stability and predictability in their lives.
- Developmental challenge in their lives.
- Enhanced social image.
- Necessary health and physical supports.
- People who will stand by them.

This list was further refined and prioritised into six needs.

a) People to "stand by" service users in a friendship and advocacy sense.

b) A secure place to live.

c) Meaningful, productive activity.

d) Opportunities for individual growth and development.

e) Health and bodily integrity.

f) Participation in community life.

C. The Service Content

The content of a service is what is done to, or for, the people served and is distinguished from processes that are the ways in which the content is provided. From the perspective of Model Coherency, the service content should derive directly from the identified needs of service users and conscious decisions on the part of the service provider about which needs it considers are appropriate and legitimate for it to address. Services may address a number of service users' needs and may also contain a number of contents. Two of the most common service contents in human services, especially for people with enduring needs, are prevention or reversal of service users' impairments or health problems, and promoting the development (e.g., skills and capacities) of service users.

Outcomes: Service Contents/Forms

In the next stage of the workshop, each of the six prioritised needs was translated into a large number of possible service contents or service forms. Each content was then ranked on two dimensions: how closely each content reflected the culturally valued analogue (CVA) for the way in which that need was addressed for ordinary people, and how relevant that content was to the identified need. The list below describes the top ranking content for each of the six needs.

a) Someone to stand by you: spouse, family member and friend.

b) A secure place to live: one's own home.

c) Meaningful, productive activity: paid work.

d) Opportunities for individual growth and development: work, home, and family roles.

e) Health and bodily integrity: love and sexual relationships, a comfortable environment, and good physical care.

f) Participation in community life: adult education.

Following the ranking process, the workshop participants reflected on issues regarding the ideal

contents. They acknowledged that the most relevant service form may not necessarily be the most culturally valued. The Model Coherency process was oriented in this particular application towards a service form that was grouped rather than individual. The most relevant service form might be an informal one that a formal human service may not be able to provide directly, although it may be able to facilitate it. The participants agreed that having high expectations was very important for this group of service users and it would be preferable to err on the side of over-, rather than underestimation. Finally, "home" was considered to be necessary, but not sufficient in itself, to the address of the identified needs of service users and also consistent with the agency's brief.

D. Service Processes

Service processes are the means by which human services deliver the content and in Model Coherency, they fall into four categories.

1. Methods and technologies

The physical characteristics of a service (e.g., where it is located, what it resembles); and the procedures and tools used by the programme (e.g., treatments, equipment, social structures).

2. Language

Language used about key features of the service including the service users, providers, service activities and locations.

3. Groupings

The many ways in which human services group service users, including age and gender, developmental characteristics, assumed commonalities such as conditions or diagnoses, etc.

4. Server Identities

The characteristics and identities of people who provide services, including their training, personal characteristics, work roles, life experiences, attitudes, etc.

Outcomes: Characteristics of the Optimal Service Forms

The case study identified and combined service processes into "optimal service forms" for the service users.

- Each service user lives in their own home (house, apartment, villa, etc.) in which they have a financial interest.
- They have a range of relationships including intimate relationships and relationships with family, friends and neighbours.
- They have the support of guardians, advocates and organisations as required.
- Family, friends and service providers encourage the provision of independent advocacy and the possibility of more freely-given relationships for service users.
- In conjunction with others such as family members, friends and advocates, the service facilitates meaningful activities for service users including some paid employment and membership of community groups such as clubs or other interest groups.
- The service encourages service users in meaningful activities that are appropriate to one's home, e.g., looking after the home.
- The service facilitates service users' recreational and leisure pursuits both in and out of their homes.
- The service facilitates educational activities in and out of the home that are appropriate to the needs of the service users.
- The service provides necessary health and physical support to service users and ensures these needs are met in the long term and by appropriate external agencies such as local GPs and other health professionals.
- The service has high expectations for service users.
- The service facilitates and supports close relationships that service users may have or may develop.

- The service facilitates service users' spiritual development including, where appropriate, church membership.

The essential components of the service were identified as:

- Primary physical care and support in daily living.
- Someone independent from the service to stand by the service user.
- A home in the true meaning of the word.
- Acknowledgment and address of service users' developmental needs.
- Protection and enhancement of service users' social image.
- Minimised formal, paid roles in the lives of service users and maximised informal relationships.

The Coherency of a Human Service Model

Depending upon whether the purpose is evaluation or construction, the Model Coherency process gathers and generates detailed information to allow a full description and analysis that follows the framework described above. An ideally coherent service would be one in which:

- All components of the service model (i.e., assumptions, content and processes) address the needs of service users.
- Service users are appropriately selected and their needs fully understood.
- All components of the service are congruent with one another.
- All components of the service are consistent with their culturally valued analogues.

The concept of Model Coherency and its processes are complex and challenging with many implications and corollaries. There are a number of potential sources of incoherencies that will be identified in a Model Coherency analysis including:

1. mismatches between key, influential assumptions and the identities and needs of service users;
2. service contents that do not match identities and needs;
3. service processes that do not match identities and needs;
4. service processes that are not congruent with intended service content;
5. service processes that are inconsistent with one another.

The theory of Model Coherency asserts that the more coherent the service model, the more likely it is that the service is of high quality, and relevant and effective in addressing service user needs. To illustrate these sources of incoherency, five major sources of incoherency are described below.

Evaluation Conclusions: Some Major Sources of Incoherency

1. The match between key assumptions and service users' identities and needs.

The process of relocating people into community houses focussed more on assumptions about the importance of physical aspects than on a deeper appreciation of what constituted both community living and a home. Service users' developmental needs, including acknowledgment of their socio-sexual identity, needed greater emphasis. A related issue is the assumption that this relocation would be the last for service users and that their needs would not change substantially. Many implicit assumptions about the value of practices in the old service models (the nursing home and the hostel) prevailed and, as outlined below, strongly influenced aspects of the new service model. This illustrated the resilience of the old service models.

2. The match between service users' needs and service content.

The service provided a secure home for service users and this was coherent with one of the most important identified needs for all service users. Some incoherency resulted from the "whole of life" purview of the service in which the service accepted major responsibility for all service contents.

3. The match between service users' needs and service processes.

The major source of incoherency here resulted from the size and composition of groupings within the homes which exacerbated negative images associated with service users and also made it more difficult for the service to address their developmental needs.

4. The match between service content and service processes.

The size and composition of service user groupings again contributed significantly to incoherencies. This applied to both the overall size of the agency and to the number of residents sharing each house. Service processes achieved good physical integration of service users but did not achieve sufficient community participation. Although the identities of staff were largely appropriate, there was limited appreciation of the concept and ideal form of what constitutes a home. This reflected the need to examine and develop more "home forming" practices in the houses. The smaller houses used a staffing arrangement with a small core of live-in staff supported by additional staff. This had a number of advantages in terms of continuity and consistency of relationships, and also promoted a more individualised approach to addressing service users' needs.

5. The match between service processes.

Most service processes were coherent with each other. For example, physically, the houses were appropriately located in residential neighbourhoods and reflected normative appearance. Appropriate language "of the home" was used and staff were employed as carers. Again, the major source of incoherency was the groupings of service users, particularly in the larger homes.

It is uncommon to find systematic and deep analysis of human services that lead to rational and effective decision-making. It is more common, given the nature of modern formal human services, that in spite of the rhetoric of a rational and evidence-based approach, in the final analysis, non-programmatic issues and incoherency may strongly influence decision-making. Model Coherency and related concepts provide a rich and challenging source of concepts and processes with the potential to enhance the coherency of human services and thereby benefit people who use and/or provide human services. ∽

References

Brennan, T., Leape, L., Laird, N., Herbert, L., Localio, A., Lawthers, A., *et al.* (1991). Incidence of adverse events and negligence in hospitalised patients: Results of the Harvard medical practice study I. *New England Journal of Medicine; 324*: 370-376.

Cocks, E. (1997). Agency change–A case study. In P. O'Brien & R. Murray (Eds.), *Human services: Towards partnership and support.* Palmerston North, NZ: The Dunmore Press Ltd, 165-180.

Cocks, E. (1998). Evaluating the quality of residential services for people with disabilities using Program Analysis of Service Systems' Implementation of Normalisation Goals (PASSING). *Asia & Pacific Journal on Disability, 1*: 29-42.

Cooper, M. (1995). *House as a mirror of self: Exploring the deeper meaning of home.* Berkeley, CA: Conari Press.

Department of Health. (1997). *The new NHS: Modern and dependable.* London, UK: DOH.

Department of Health. (1999a). *Facing the facts. Services for people with learning disabilities: A policy impact study of social care and health services.* London, UK: DOH.

Department of Health. (1999b). *Modern standards and service models. Mental health national service frameworks.* London, UK: DOH.

Despres, C. (1991). The meaning of home: Literature review and directions for future research and theoretical development. *Journal of Architectural Planning Research, 8*: 96-115.

Emerson, E. & Hatton, C. (1996). Deinstitutionalisation in the UK and Ireland: Outcomes for service users. *Journal of Intellectual and Developmental Disability, 21*: 17-37.

Emerson, E., Robertson, J., Gregory, N., Hatton, C., Kessissoglou, S., Hallam, A., Knapp, M., Jarbrink, K., Netten,

A. & Walsh, P. (1999). *Quality and costs of residential supports for people with learning disabilities. Summary and implications.* Manchester, UK: Hester Adrian Research Centre (The University of Manchester).

HMSO. (1989). *Caring for people: Community care in the next decade and beyond.* London, UK: HMSO.

Illich, I. (1976). *Limits to medicine.* London: Marion Boyars.

King's Fund Centre. (1980). *An ordinary life*. London, UK: King's Fund.

McKnight, J. (1995). *The careless society. Community and its counterfeits.* New York: Basic Books.

Nirje, B. (1992). *The normalisation principle papers.* Uppsala, Sweden: Centre for Handicap Research (Uppsala University).

Race, D. (1999). *Social Role Valorization and the English experience*. London: Whiting & Birch Ltd.

Sixsmith, J. (1986). The meaning of home: An exploratory study of environmental experience. *Journal of Environmental Psychology, 6*: 281-298.

Wolfensberger, W. (1972). *The principle of normalization in human services.* Toronto: National Institute on Mental Retardation.

Wolfensberger, W. (1983). Social Role Valorization: A proposed new term for the principle of normalization. *Mental Retardation, 21*(6), 234-239.

Wolfensberger, W. (1998). *A brief introduction to Social Role Valorization: A high-order concept for addressing the plight of societally devalued people, and for structuring human services* (3rd ed.). Syracuse, NY: Syracuse University Training Institute for Human Service Planning, Leadership & Change Agentry.

Wolfensberger, W. (1989). Human service policies: The rhetoric versus the reality. In L. Barton, *Disability & dependency.* London, UK: Falmer Press.

Wolfensberger, W. & Glenn, L. (1975, reprinted 1978). *PASS (Program Analysis of Service Systems): A method for the quantitative evaluation of human services: Vol. 1. Handbook: Vol. 2. Field manual* (3rd ed.). Toronto: National Institute on Mental Retardation.

Wolfensberger, W. & Thomas, S. (1983). *PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals): Normalization criteria and ratings manual* (2nd ed.). Toronto: National Institute on Mental Retardation.

Errol Cocks, PhD is an emeritus professor recently retired from Curtin University in Western Australia. He can be reached at e.cocks@curtin.edu.au.

The citation for this article is

Cocks, E. (2018). Model coherency: A concept & process for the evaluation of quality in human services. *The SRV Journal, 12*(2), 55-68.