

Social Work Practice: A look at Competency Assessments with Older Adults in Healthcare  
Settings

by

Krystal Kaposi

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfilment of the requirements of the degree of

MASTER OF SOCIAL WORK

Faculty of Social Work

University of Manitoba

Winnipeg

Copyright © 2014 by Krystal Kaposi

## Abstract

This research contributes to the social work understanding of mental competency assessments with older adults in healthcare settings. Utilizing a narrative research methodology, this qualitative research study analysed nine face-to-face interviews with social workers with experience assessing competency of older adults in the following Winnipeg, Manitoba healthcare settings: hospitals, personal care homes, and a number of community settings (home care, geriatric specialty programs, and private practice). Drawing from systems and ecological theories, as well as the social determinants of health, the results of this study revealed several key concerns such as the motivation behind what triggers an assessment, the specific tests and methods used to determine competency, inequitable treatment of the patient throughout the assessment depending on their cultural or socioeconomic background, and depending on the setting whether the social worker felt their role on the assessment team was valued or dismissed. Recommendations outlined implications for: enhancing the quality of the competency assessment process; expanding the role of social work in interdisciplinary settings; examining the use of methods and tests for assessment; and exploring opportunities for change in legislation, education and early detection. Potential areas of further study are discussed.

## Acknowledgements

I would like to thank my family and friends for their support during this challenging journey. Thank you to my best friend and partner in life Don Kaposi for understanding and supporting me as I pursue my life goals and dreams. Thank you to my father Paul Yanor for always pushing me to strive for more and be the best person I can be.

Thank you to my nine participants. I appreciate that each of you took time of your busy days to share your experiences. I truly enjoyed all of the time we spent together.

I would like to acknowledge my thesis advisor Lyn Ferguson, and thesis committee Tuula Heinonen, and Kerstin Roger. Thank you Lyn for all of the time you have spent reading and editing this multi-year project. And thank you to my committee for all of your advice and support thorough this process. Thank you to my first thesis advisor Silvia Straka for the many hours spent discussing this topic.

I want to thank Gisele Aviles for inviting me to join her thesis group as I got to meet a wonderful bunch of women who provided me with support during the ups and downs of this process. Thank you to Kimberley Hart (a fellow MSW student and now MSW graduate), your support and friendship has meant a lot through this stressful and isolating experience.

A huge thank you to my aunt Fran Yanor and her partner Grant Cool your support and time spent reviewing and editing suggestions my hundreds of versions, it has meant more than I can put into words!

## Dedication

To my husband Don Kaposi. I feel so lucky to have such a special person in my life. I look forward to our life and what we can accomplish together.

To my dad and family, thank you for always being my cheering squad, pushing me to achieve more than I thought possible and always backing me 100%.

To social workers working every day to improve the lives of others, you are making a difference and your role is important.

In memory of my mother and grandfather.

## Table of Contents

Abstract .....	i
Acknowledgements .....	i
Dedication .....	iii
Chapter One: Introduction .....	1
Purpose of the Study .....	1
Research Question .....	1
Rationale for Study .....	1
Summary .....	2
Chapter Two: Literature Review .....	4
Competency .....	6
Provincial Legislation .....	8
Assessment Tools .....	10
Biopsychosocial Assessment Model .....	14
Social Work Ethics in Healthcare .....	18
Conclusion .....	23
Chapter Three: Theoretical Framework .....	26
Theory .....	26
Social Determinants of Health .....	26
Systems Theory .....	29
The Ecological Model .....	30
Summary .....	32
Chapter Four: Research Methodology .....	33
Qualitative Research .....	33
Strengths of Qualitative Research .....	33
Limitations of Qualitative Research .....	34
What is Narrative Research? .....	35
Narrative and Social Work Practice .....	36
Methods .....	38
Sample .....	38

Number of participants .....	39
Recruitment Process .....	39
Interviews .....	40
Data Management.....	41
Data Analysis.....	41
Coding the Data .....	42
Summary .....	43
Chapter Five: Participants.....	44
Demographic information .....	44
Participant stories .....	45
Participant 1: Gina .....	45
Participant 2: Mary .....	47
Participant 3: Hebert.....	49
Participant 4: Tara .....	51
Participant 5: Greg.....	53
Participant 6: Lorraine .....	55
Participant 7: Bonnie .....	57
Participant 8: Tina .....	58
Participant 9: Jessica.....	60
Summary .....	61
Chapter Six: Findings and Discussion .....	63
Competency.....	64
Legal/legislative description.....	64
Defining Competency.....	67
Competency: All or nothing (The Competency Continuum) .....	67
Varying Standards of Competency.....	70
Last Resort.....	70
Monumental outcome for client .....	71
What triggers a mental competency assessment? .....	72
Institutional and Organizational factors .....	73
Facilitating discharge.....	73
Disagreement with a healthcare professional. ....	74
The relationship between paternalism and risk.....	75
Reducing institutional liability.....	77
Impact of Social Determinants of Health .....	79
The Money Motivator.....	79
Request from Family.....	80
Greater likelihood of intervention if person is impoverished. ....	82
Cultural differences complicate the process. ....	85
Ethnic minority cultures have higher tolerance for incompetencies.....	87

Methods and Tests.....	88
MMSE (Mini-Mental Status Exam) .....	89
The MoCA (The Montreal Cognitive Assessment).....	90
Biopsychosocial Assessment.....	91
Organizational Contexts.....	92
Hospital Settings.....	92
Home Care.....	93
Geriatric Program Assessment Team (GPAT) or Geriatric Mental Health Team (GMHT) .	94
Personal care home.....	95
Well-Functioning Approaches to Competency Assessments.....	95
Team Dysfunction.....	96
Professional Role of the Social Worker.....	98
Advocacy Roles.....	99
Protecting clients' rights.....	100
Informing clients.....	101
Holistic Ecological Perspective.....	101
Recommendations for Change.....	105
Further education and training.....	105
Further training for Social Workers.....	105
Further education for all healthcare professionals including physicians.....	106
Further education is needed for the general public.....	107
Pre-planning and early interventions.....	108
Expansion of the Social Work role with competency assessments.....	109
Summary of Results.....	111
Chapter Seven: Conclusions.....	113
Original research question and objectives.....	114
Limitations of this study.....	115
Recommendations and Implications.....	116
Recommendations for the Competency Assessment Process.....	117
Implications for Role of Social Worker.....	120
Implications for Methods and Tests.....	122
Implications of Education and Early Detection.....	123
Opportunities for Legislative Change.....	124
Opportunities and Areas of Further Study.....	125
Concluding Statements.....	127
On a Personal Note.....	127
References.....	128
Appendices.....	138

Appendix A: Email Script Introduction - (Sent to MIRSW and the Social Work Alumni) ...	139
Appendix B: Email Recruitment Script - (Sent to MIRSW and the Social Work Alumni)....	140
Appendix C: Telephone Script with Potential Participants.....	141
Appendix D: Interview Guide.....	144
Appendix E: Informed consent for participation.....	145
Appendix F: Counseling Resources .....	149
Appendix G: Letter of Invitation to Participant .....	151
Appendix H: Advertisement Poster.....	153
Appendix I: Human Research Ethics Board Approval .....	155



## **Chapter One: Introduction**

### **Purpose of the Study**

This study focuses on social workers who have experience working in one area of social work practice in healthcare settings: competency assessments with older adults. It aims, through a narrative methodology, to explore and better understand the lived experiences of social workers in Winnipeg who have worked in a this form of social work practice. I explore what it is like to be such a social worker, discuss what it is like to be involved in assessing an older adult's mental competency and elucidate social workers' recommendations about changes to the system.

### **Research Question**

What are social workers' experiences with competency assessments with older adults in healthcare settings?

### **Rationale for Study**

This topic and approach to the study were chosen because there is a need for more understanding of this important area of social work practice. Over fifty-five social workers contacted me indicating interest in participating in this study. A further ten social workers who did not fit the criteria requested the final report as they were interested in the results. This suggests there is significant interest in this topic among social workers in Manitoba.

The Canadian population is rapidly aging with nearly 5, 379,600 million people or 15.3% of the population over the age of 65 in 2013 (Statistics Canada, 2013). Newfoundland and Labrador have the highest proportion of seniors at 17.7%. Manitoba's population over 65 years in 2013 was slightly less at 14.4% of the population (Statistics Canada, 2013). It is estimated that

by 2036 the percentage of people over the age of 65 will almost double to 23.7% and Manitoba will remain closely in line with this growth at 21.4% (Statistics Canada, 2011).

Because individuals over the age of 65 are already the leading users of healthcare services in Canada (45%), the demand on healthcare services will only increase and healthcare professionals will need to adapt to meet the needs of this population (Canadian Institute for Health Information, 2011, p. 1). In 2009-2010, patients over the age of 65 accounted for 40% of acute hospital stays (CIHI, 2011, p. 28) and their length of stay was 1.5 times longer than any other age group (CIHI, 2011, p. 30). Social workers employed in healthcare, especially in hospitals, will need to adapt to on-going societal changes by participating in training and competency building in order to meet the needs of their clients now and into the future (CIHI, 2011, p. xi).

### **Summary**

In chapter two I begin by reviewing the current literature on competency. The concept of competency and decision-making capacity is discussed followed by a review of provincial legislation and current assessment tools to determine competency. The chapter concludes with a discussion of the biopsychosocial assessment model used by social workers and social work perspectives on delivering healthcare services. The literature review outlines how social workers contribute to patient care and demonstrates that ethical issues inherent in competency assessments need to be examined more fully to better ensure the protection of older adults' rights when receiving care in any healthcare setting.

Chapter three discusses the theoretical frameworks chosen for this study. These include: social determinants of health as the guiding framework along with a combination of systems and ecological theories. Together these theories help us to understand the findings.

Chapter four outlines the research methodology for this study. I begin by presenting the rationale for choosing a qualitative research approach and a narrative methodology for this research question. Lastly, the chapter covers the research methods including: selection criteria, number of participants, the recruitment and interview processes. The methods used for data collection and analysis are also discussed.

Chapter five presents the demographics and background information of the participants of this study. The participants' stories are presented individually to provide the reader with an in-depth look at the different experiences and perspectives each participant brings to the results of the study.

Chapter six discusses the collective stories of the participants including how I relate them to the empirical and theoretical literature chosen to understand the findings. Chapter seven closes with implications and conclusions.

## Chapter Two: Literature Review

“Hospital social workers constantly face ethical dilemmas in their everyday work,” (Landau, 2000, p. 76). While the moral and ethical obligations of physicians and nurses are understood as vital to quality patient care, the dilemmas faced by social workers and the ethical impact of their decisions are not as widely recognized (Cummings & Cockerham, 1997). This includes social workers struggling with multiple competing priorities such as whether or not to intervene in the first place, as well as, “the patients’ right to know and the potential negative consequences of unwelcome knowledge” (Landau, 2000, p. 76). Social workers are also juggling increasing demands with limited resources; all while being under immense pressure to make decisions quickly (Landau, 2000). Cummings and Cockerham (1997) found that, “social workers often deal with the most complex situations, in which ethical dilemmas occur” (p. 102). Since the introduction of hospital social workers in 1905, social work has taken on a major role and function in discharge planning (Cummings & Cockerham, 1997; Gregorian, 2005). Social workers involved in discharge planning for older adults in particular, often face ethical dilemmas related to principles of beneficence and autonomy (Strang, Molloy, and Harrison, 1998; Cummings & Cockerham, 1997; Landau, 2000). Beneficence can be defined as, “the act of doing ‘good’ for another” (Kane, 1998, p. 181), which in practice is essentially someone acting in the ‘best interest’ of another even if it violates the individual’s rights. Autonomy is “freedom of choice” (Kane, 1998, p. 181), and the, “right to exercise free will; to be free from constraint and coercion in order to act according to his or her intentions, preferences, and values” (Manitoba Law Reform Commission, 1999, p. 10). Self-determination is defined as, “the right to make decisions that affect one’s self” (Manitoba Law Reform Commission, 1999, p. 10). This

is especially the case if the older adult has been diagnosed with a dementia. In the early stages of the disease ethical issues are more prevalent as there can be disagreement among healthcare professionals as to the degree of impairment and the extent to which it is affecting the individual's ability to participate in their discharge plan(s) (Cummings & Cockerham, 1997). It is often these complex situations that may lead to the assessment of the individual's mental competency.

When determining mental competency, a role of social work in a hospital setting is one of advocacy and representation of the individual's voice on the healthcare team (Landau, 2000; Gregorian, 2005). The removal of an individual's legal mental competence is "one of the most significant mechanisms in our society for removal of a person's fundamental rights and freedoms" (Pachet, Newberry & Erskine, 2007, p. 178). According to the CASW Code of Ethics, social workers are committed to the principle of individual rights, such as the right to autonomy and self-determination (CASW, 2005). This commitment of advocating for individual rights can be challenging when working within the medical model in a healthcare setting (Gregorian, 2005). The ethical dilemma for social work is determining the purpose of the competency assessment and whether or not it respects or devalues the individual's rights to autonomy and self-determination.

I will begin by exploring what is known about the competency assessment process. Next, Manitoba's provincial legislation governing the legal and clinical components of competency assessments is reviewed, followed by a look at the various assessment tools and practices currently used in the field, as well as their research underpinnings. This review concludes with the role of social work in competency assessments and the ethical implications of this practice.

## Competency

In order for a social worker to determine whether a competency assessment is warranted, the concepts of competency and decision-making capacity need to be understood. The terms competency and capacity are often used interchangeably but they are substantively different. Competency is defined as having legal connotations as determined through a clinical process with legal implications established and governed by the courts (Kane, 1998; Moberg & Rick, 2008). Decision-making capacity is defined as the ability to understand information relevant to a decision and to appreciate the consequences of the decision (Moberg & Rick, 2008; Kane, 1998; Marson, 2002).

Assessing competency involves evaluating the individual's decision-making abilities (Moberg & Rick, 2008). A clinical judgment of incapacity may protect patients from perceived harm but could also prematurely remove autonomy and independence (Widera, et al., 2011). From a legal point of view an assessment of an individual's competency only becomes important or necessary if it is meaningful to the decision at hand (Tuokko, 2001). Kane (1998) acknowledges that competency is rarely all or nothing and one definition and accurate testing applicable to all individuals is impossible.

Strang, Molloy, and Harrison (1998) suggest the optimal pathway when determining 'acceptable' risk taking is to establish whether the current choices seem congruent with the individual's past beliefs and values which can be determined through the completion of a social history. The only way to resolve a conflict or disagreement about an individual's choice to 'live at risk' in healthcare is to assess their competency according to Strang, Molloy, and Harrison (1998). Multiple articles indicate that competency is often not questioned until or unless an

individual does not agree with the recommendations of the physician or other healthcare providers (Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012; Kane, 2008; Strang, Molloy, & Harrison, 1998). Guzman-Clark, Reinhardt, Wilkins Schantz & Castle (2012) point out that agreement with the treatment plan should also not presume capacity. Importantly, an individual is always considered competent (once age of majority is reached) unless otherwise determined through a clinical and/or legal process (Moberg & Rick, 2008; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). The onus is on the clinician or practitioner to prove incompetence; the individual does not have to prove anything (Moberg & Rick, 2008), and a bad choice does not necessarily mean the individual lacks capacity (Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012).

Competency is no longer seen as a global condition but rather viewed on a continuum ranging from totally competent to totally incompetent (Kane, 1998; Pachet, Newberry, & Erskine, 2007). On this continuum competency is seen as domain-specific (Pachet, Newberry, & Erskine, 2007). Under the concept of domain-specific abilities or deficits, an individual may be competent to decide where to live but not able to handle more complex decisions such as financial or medical decisions (Pachet, Newberry, & Erskine, 2007; Moberg & Rick, 2008). Decision-making requires a number of cognitive domains, such as executive functioning, which supports the need for more comprehensive competence examinations (Mayo & Walhagen, 2009). Therefore a competency assessment should be multi-factorial when determining decision-making abilities (Strang, Molloy, & Harrison, 1998; Pachet, Newberry, & Erskine, 2007; Moberg & Rick, 2008).

An individual may have multiple deficits but still be 'functional' or capable to make

decisions about their life (Moberg & Rick, 2008). Decision-making may be diminished in older adults due to different neuropsychological or medical conditions that interfere with cognitive functioning such as dementia or delirium (Horning, et al., 2013). Judgment of decision-making capacity involves evaluating whether the individual has the mental and physical abilities to meet the demands of a given situation, appreciates the risks and has the ability to make choices (Horning et al., 2013). With appropriate supports (such as home care, family, friends, adaptive devices) people can become more capable or able (Pachet, Newberry, & Erskine, 2007). Since there is so much discrepancy, a competency assessment should only be used as a last resort as the process can be humiliating, demeaning, and the outcome could be life altering (Cattarinach, Gibson, & Cave, 2001).

### **Provincial Legislation**

The legal process of assessing competency is provincially legislated and the laws vary from province to province. Since there are differences in legislative policies across Canada, it is important to understand how they are administered. In the province of Manitoba, the Mental Health Act of 2005, “is a provincial law that provides the legal framework by which individuals may be assessed and treated in a general hospital psychiatric unit, a psychiatric hospital or a mental health clinic” (Canadian Mental Health Association[CMHA], n.d., para. 1). The intent of the Act is to, “balance an individual’s need and right to treatment, the individual’s civil rights not to be arbitrarily detained, and the need of society to prevent people from harming themselves or others when they are mentally ill” (CMHA, n.d., para. 1).

The Mental Health Act is administered by the Office of the Chief Provincial Psychiatrist and only allows a physician to assess and determine mental competency. The act aims to strike a



balance between two principles (“Manitoba’s Mental Health Act”, n.d.):

1. The rights given to all citizens under The Canadian Charter of Rights and Freedoms;
2. Society’s obligation to provide care and treatment to those individuals who, at times, may not appreciate their need for treatment due to mental illness.

Criticism of the Manitoba Mental Health Act is that it is seen as an “all or nothing approach to competence...which...is problematic” (Manitoba Law Reform Commission, 1999, p.19).

As compared to Manitoba, other provinces have taken different approaches. The Maritimes (Nova Scotia, New Brunswick, Newfoundland, and Prince Edward Island), have Adult Protection Laws which are seen as fairly invasive and an infringement on one’s autonomy with due process potentially being compromised (Manitoba Law Reform Commission, 1999, 39). British Columbia, Yukon, and Ontario have forms of Adult Protection Laws perceived by the Manitoba Law Reform Commission as less comprehensive than the Maritimes. B.C. is similar to Manitoba in its governance of the Adult Guardianship Act, because through the Adult Guardianship Office competency can only be assessed by a physician. Québec has the Charte des droits et Libertés de la Personne, 1975, Article 48 (which translated means Québec Charter of Human Rights and Freedoms, 1975). Article 48 states, “every aged person and every handicapped person has a right to protection against any form of exploitation” and , “such a person also has a right to the protection and security that must be provided to him by his family or the persons acting in their stead” (1975, c. 6, s. 48; 1978, c. 7, s. 113).

Ontario and Alberta are different from all other provinces in that they have legislation that allows specially trained assessors to perform capacity assessments. In Ontario this

legislation is under the Substitute Decision Act, 1992, governed under the Minister of Attorney General – Capacity Assessment Office. Eligible professionals are registered psychologists, registered nurses, registered psychiatric nurses, registered occupational therapists, and registered social workers (Ontario Ministry of Attorney General, 2011).

In Alberta the Adult Guardianship and Trusteeship Act, 2009 allows registered nurses, registered psychiatric nurses, registered occupational therapists and registered social workers to complete specialized training to become capacity assessors under the auspices of the Minister of Alberta Seniors and Community Supports. For example they have developed a Regional Capacity Assessment Team (RCAT) for the Calgary Health Authority (Pachet, Newberry, & Erskine, 2007). This team is the only one of its kind in Canada; its sole function is assessing and addressing capacity issues (Pachet, Newberry, & Erskine, 2007). The team is made up of a registered neuropsychologist, registered occupational therapist and a registered social worker. Its mandate is to become involved only in the most complicated cases, to address gaps in service, or as a second opinion. This means only the cases that pass a risk threshold high enough to warrant involvement from the RCAT are assessed.

### **Assessment Tools**

Determining competency is complicated by the fact that there is no one definition, nor is there one accepted standardized measurement tool or widespread training in competence assessments (Cummings & Cockerham, 1997). Clinical interviews or impressions, such as personal judgments by various clinicians to assess decision-making capacity may result in variable criteria measures (Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). Provider agreement about a patient's decision-making capacity improved when an instrument

with specific criteria or standards was used to guide judgments of decision-making capacity (Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). Given that a competency assessment should be done as a last resort option, pre-screening is a critical step in the process (Pachet, Newberry, & Erskine, 2007). Pre-screening can aid in determining if there is a less intrusive method to solve the problem before proceeding with a competency assessment (Pachet, Newberry, & Erskine, 2007). Incapacity can be short term (such as a delirium) and can fluctuate depending on the individual's medical conditions, mental health and wellness, and physical conditions all which can affect people's abilities (Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). The assessor should also be looking to rule out any reversible conditions that could be impacting the individual's ability to make decisions (Pachet, Newberry, & Erskine, 2007). It is important to go ahead with a competency assessment only in situations where there will be some benefit to the individual. Individuals whose competency is under question need to be informed of the nature, purpose and potential consequences of the outcome (Pachet, Newberry, & Erskine, 2007). This allows the individual an opportunity to participate or decline their involvement in any cognitive assessments. Subsequent to the clinician deciding that the competency assessment is necessary, there are a wide multitude of cognitive assessments that can be utilized to reveal the individual's strengths and weaknesses (Pachet, Newberry, & Erskine, 2007).

Cognitive assessments should only be seen as screening tools and not the only basis for deciding whether someone is competent or incompetent (Tuokko, 2001; Pachet, Newberry, & Erskine, 2007; Pachet, Astner, & Brown, 2010; Strang, Molloy, & Harrison, 1998). Standardized assessment tools can provide support but they are not sufficient on their own as

judgments are made beyond the instruments (Tuokko, 2001; Pachet, Newberry, & Erskine, 2007; Pachet, Astner, & Brown, 2010; Strang, Molloy, & Harrison, 1998). A recent review found standardized cognitive tests often do not correlate well with decision-making capacity evaluations (Guzman-Clark, Reinhardt, & Wilkins, 2012). The Mini Mental Status Exam (MMSE), also often referred to as the Folstein, is one such standardized tool tested for validity and reliability and is the most utilized screening tool within healthcare (Pachet, Astner, & Brown, 2010; Tuokko, 2001). The MMSE is intended to measure a person's basic cognitive skills, such as short term memory, long term memory, orientation, writing and language skills (Pachet, Astner & Brown, 2010; Tuokko, 2001) and should be used as part of a comprehensive assessment. It is often used in making determinations regarding a patient's decision-making capacity, with proposed cut-off scores used to indicate the degree of cognitive impairment (mild, moderate, severe) (Pachet, Astner, & Brown, 2010). There is little literature regarding the use of the MMSE with different cultural groups, such as with Aboriginal people. Cattarinich, Gibson, & Cave (2001) found, "the administration of the MMSE to the Aboriginal seniors was inappropriate," (p. 1469) and highlighted the need to develop a more culturally appropriate tool. This issue needs attention as the outcome of a poor MMSE score can have major implications for the individual's subsequent assessments and overall view of their capacity and competence (Cattarinich, Gibson, & Cave, 2001).

Even though the MMSE is a standardized tool, tested for validity and reliability there is still variability in how the results are interpreted by the assessor, based upon their training and background (Pachet, Astner, & Brown, 2010). As Pachet, Astner, and Brown's (2010) study found, "the Mini-Mental Status Exam (MMSE) had extremely poor sensitivity across all

diagnostic groups and the total sample” (p. 6), because they found that the MMSE is not sensitive or sophisticated enough to differentiate between individual complexities such as executive functioning, values, or belief systems. The findings from this study imply that this is simply a screening tool and should be used with caution (Pachet, Astner, & Brown, 2010).

The Montreal Cognitive Assessment (MoCA) is another popular screening tool used in Manitoba to assess for cognitive impairment with older adults. It was created by Dr. Ziad Nasreddine in Montreal, Canada in 1996 to assess several cognitive domains. The short-term memory recall task (5 points) involves two learning trials of five nouns and delayed recall after approximately 5 minutes.

Visual spatial abilities are assessed using a clock-drawing task (3 points) and a three-dimensional cube copy (1 point). Multiple aspects of executive functions are assessed using an alternation task adapted from the trail-making B task (1 point), a phonemic fluency task (1 point), and a two-item verbal abstraction task (2 points). Attention, concentration and working memory are evaluated using a sustained attention task (target detection using tapping; 1 point), a serial subtraction task (3 points), and digits forward and backward (1 point each). Language is assessed using a three-item confrontation naming task with low-familiarity animals (lion, camel, rhinoceros; 3 points), repetition of two syntactically complex sentences (2 points), and the aforementioned fluency task. Finally, orientation to time and place is evaluated (6 points). The MoCA has proven to be a much more sensitive screening tool than the MMSE as it assesses several cognitive domains and is superior to the MMSE in detecting mild cognitive impairment (Nasreddine et al., 2005).

Even though the MoCA is a more sensitive screening tool, Pachet, Newberry, & Erskine

(2007) refer to the importance of using multiple assessment tools to determine an individual's competency. Multiple assessments can include such tools as standardized assessment tools (MMSE), a social history, medical examination or work-up and functional assessments. The use of multiple assessments will ensure an individual's competency is assessed as a whole and not based upon one test or assessment, but rather an interpretation based upon the results of multiple assessments.

Pachet, Newberry and Erskine's (2007) study supports the use of multiple assessments, as they claim it provides the individual being assessed and the assessors with some protection as to the outcome of the results. They report that this approach also helps to ensure that, "the final determination is accurate, impartial and based on a comprehensive understanding of the adult," regarding their abilities and circumstances (Pachet, Newberry, & Erskine, 2007, p. 176).

### **Biopsychosocial Assessment Model**

Often part of multiple assessment tools, a social history or a biopsychosocial assessment, is social work's primary assessment tool (Newberry & Pachet, 2008, Craig, 2008; Gray & Zide, 2008; McInnis-Dittrich, 2005). In the context of geriatric services, the purpose of a biopsychosocial assessment is to identify supports or rehabilitative services that can help elderly individuals to maintain independent and satisfying lifestyles (McInnis-Dittrich, 2005). George Engel is considered the pioneer of the biopsychosocial assessment (1977, 1980, 1997). He believed that in order to develop a complete picture of an individual the social worker needs to consider the biological, psychological and social aspects of the individual when assessing behavior (Gray & Zide, 2008).

Biological refers to the individual's medical status and its effect on the individual. Psychological refers to thoughts, feelings and ability to cope with illness. Social refers to family, culture and environmental influences. It is a comprehensive assessment evaluating, "physical, psychosocial, social, and environmental factors that lead to problems in living as well as the adult's strengths and capacities that could alleviate or prevent problems" (Newberry & Pachet, 2008, p. 440). Social workers' knowledge of the biopsychosocial meanings of disease, as well as their knowledge of individual and family life course (Landau, 2000; Gray & Zide, 2008; McInnis-Dittrich, 2005) facilitates the patient's voice to be heard at the level of their healthcare team. Understanding that each part affects the client's behavior, coping, and functioning allows the social worker to identify client strengths and areas with which he/she may be struggling. As well, seeing the client as a whole and not just a disease, a mental problem or social issue the biopsychosocial assessment allows the social worker to represent the client as a whole person to their team (Gray & Zide, 2008).

The assessment can alert both the older adult and the social worker to high-risk areas of the client's life that may be affecting the individual's ability to function to their fullest potential (McInnis-Dittrich, 2005). A thorough assessment should identify areas of the individual's life where they are functioning well and the challenges they may be facing (McInnis-Dittrich, 2005). By identifying competencies the older adult maintains and has at their disposal to address current challenges this model assists the social worker to empower the client when facing a crisis (McInnis-Dittrich, 2005). Applying a strengths perspective ensures the social worker is focused on discovering and encouraging client strengths and available resources during the assessment process (McInnis-Dittrich, 2005).

The most important principle of the biopsychosocial assessment is maximizing independence and promoting dignity at end of life, which can be done by focusing on maintaining current supports and abilities (McInnis-Dittrich, 2005). Identifying therapies, resources and/or services that can alleviate or restore mental, emotional, physical or spiritual functioning should be the primary focus of the social work assessment with clients (McInnis-Dittrich, 2005). Assessment of activities of daily living (ADL) to determine what function an individual still possesses and areas that may be compromised, allows the social worker to identify required assistance to compensate for the loss of a certain physical function to enable the client to live as independently as possible (McInnis-Dittrich, 2005).

Components of a biopsychosocial assessment are:

- Basic demographic information
- Physical health
- Psychological Functioning
  - Personality
  - Intelligence
  - Memory
  - Dementia
  - Delirium
- Emotional Well-being
  - Depression
  - Suicidal ideation
  - Anxiety and worry



- Self-esteem
- Self-respect
- Hope
- Motivation
- Sexual functioning
- Social functioning
  - Lifestyle
  - Social networks, communities
  - Social isolation
  - Instrumental and emotional supports
- Spirituality
- Activities of daily living (ADL)
- Instrumental activities of daily living (IADL)
- Financial resources
- Environmental issues
  - General repair
  - Hazard-free living space
  - Security precautions (McInnis-Dittrich, 2005, p. 93-109)

Biopsychosocial assessments are meant to provide information to the social worker regarding the client's functioning in both successful and compromised areas of their lives. The biopsychosocial assessment should be seen as a partnership between the social worker and the client to reveal the client's story and a current picture of their overall functional abilities

(McInnis-Dittrich, 2005). The social worker should work collaboratively with the client in developing an intervention plan to assist the client to improve functioning in the areas identified by the assessment that may be compromised (McInnis-Dittrich, 2005). If the client is no longer able to participate the social worker may need to work with the family or loved ones in respecting what the client would have wanted (McInnis-Dittrich, 2005). Providing support to the patient and their family is a major and on-going role for social workers in hospitals (Landau, 2000; Gray & Zide, 2008; McInnis-Dittrich, 2005). A social work biopsychosocial assessment is indispensable and could, “reduce the need for more intense and expensive services” (Newberry & Pachet, 2008, p.440), making social work a valuable resource.

The biopsychosocial framework helps to provide a complete picture describing the patient’s functioning at all levels. It also helps the social worker to look beyond the disease or social issue that brought the patient to their attention to see them as an individual with a life beyond the hospital walls. Overall these frameworks allow social workers to assess whether the client still maintains the capability to be an active participant, if given the appropriate access to family, community, societal and environmental resources and supports.

### **Social Work Ethics in Healthcare**

The Canadian Social Work Code of Ethics (CASW, 2005) is the guiding framework for all social work practice in Canada regardless of the setting. The code of ethics is meant to provide an ethical framework for professional behaviour and decision-making (CASW, 2005). The code of ethics is a set of core values, principles, and the standards developed on the basis of those values designed to inform ethical decision-making (CASW, 2005). It, however, does not provide a hierarchy of values, principles or standards due to the complex, context-bound nature

of the process of ethical decision-making.

The social work profession is dedicated to the rights of the individual and the promotion of self-determination and autonomy (CASW, 2005). Social workers are committed to upholding human rights (CASW, 2005). Social work is particularly interested in the needs and promotion of self-empowerment of discriminated, oppressed and vulnerable individuals and groups (CASW, 2005). Core social work values and principles in the Canadian Code of Ethics are (CASW, 2005):

Value 1: Respect for Inherent Dignity and Worth of Persons

Value 2: Pursuit of Social Justice

Value 3: Service to Humanity

Value 4: Integrity of Professional Practice

Value 5: Confidentiality in Professional Practice

Value 6: Competence in Professional Practice

There are very few studies available on how social workers make informed ethical decisions, but the literature is growing (Landau, 2000). Rossiter et al (as cited in Banks, 2008, p. 1241) found that many Canadian social workers are not using any ethical decision-making models or are even familiar with their professional code of ethics. This finding is not surprising given the reports that there is increased pressure for social workers to make decisions quickly, therefore leaving little time to consult a step-by-step model for decision-making (Banks, 2008; Landau, 2000).

Healthcare professionals in positions of authority over others may be conservative in their opinions versus a more autonomous perspective (Strang, Molloy, & Harrison, 1998). When

there is intolerance for risk-taking by healthcare professionals, beneficence can occur.

Beneficence is seen as justifying one's actions because of the "good" that is seen as being done (Cummings & Cockerham, 1997). An action taken that violates the rights of another is often done under the premise that the assessor felt that harm would come to the individual or others if action was not taken. Under this principle, autonomy can be compromised in order to 'protect' the individual from harm, even if the harm is only perceived (Cummings & Cockerham, 1997). This concept is dangerous if used with little to no reasoning behind the decisions of the assessor because, "to violate another's autonomy is generally perceived as difficult to justify" (Kane, 1998, p. 18).

Paternalism is a form of beneficence in which respect for individual rights to self-determination are overridden by the healthcare professional based upon the desire to protect them from harm (Cummings & Cockerham, 1997). If a healthcare professional does not fully disclose all the information or choices available to the individual in order to make an informed choice, this can be labeled as paternalistic behaviour (Cummings & Cockerham, 1997). In healthcare some believe that paternalism is justified when an individual is incompetent and their right to autonomy is no longer present (Cummings & Cockerham, 1997). However, problems arise when trying to determine true incompetence versus making decisions based upon values that are incongruent with those of the healthcare professionals (Cummings & Cockerham, 1997). The social work role in these situations is to ensure individual values and rights are not compromised in order to protect them from perceived harm (Cummings & Cockerham, 1997). The intervention chosen by the professional should be the least restrictive option in relation to the individual's autonomy (Kane, 1998).

The Social Work Code of Ethics promotes the principle of autonomy, emphasizing that social workers advocate for the client's right to self-determination (Cummings & Cockerham, 1997). These principles are often challenged within the medical model (Gregorian, 2005, p. 10). The primary objective of healthcare professionals, especially social workers, should be to protect and maintain an individual's basic rights and choices before removing them (Landau, 2000). Essentially the onus is on the relatively powerful to behave in ways that acknowledge and respect other's rights (Lloyd, 2006).

Conflict can arise when the social worker aims to simultaneously respect the individual's wishes while trying to protect them from harm (Cummings & Cockerham, 1997). As highlighted in studies conducted by Healy (2003) and Landau (2000), social workers struggle with advocating for individual rights as part of inter-professional teams, especially when their professional values are in direct conflict with the individual's wishes. The dynamics of the inter-professional team will dictate both the influence of the social work perspective and the stress and tension felt by the social worker.

Healy (2003) conducted a study with social workers who worked for home care in the community and examined their ethical tensions when evaluating the decision-making capacity of their elderly clients who were experiencing some degree of cognitive impairment. Three themes emerged in relation to ethical decisions: clinical uncertainty, pressure from other professionals and a combination of clinical uncertainty and pressure from other professionals (p. 293). Healy's study also found that the dynamics within inter-professional collaborations can cause conflict and tension due to varying perspectives on self-determination, risk and safety and autonomy.

Landau (2000) completed a study that explored fourteen directors of social work and

eighteen direct hospital social worker practitioners' perceptions of their contributions to the identification and resolution of ethical dilemmas. Landau (2000) found that participants agreed that ethical decision-making is an interdisciplinary process, but felt that, "social workers rarely make the final decision" (p. 81). Social workers' impact on the outcome of an ethical dilemma included their relationship with their inter-professional team and the value placed on the social work perspective (Landau, 2000). Some participants believed that out of all of the members of an inter-professional team, social workers are the most concerned with quality of life and autonomy (Landau, 2000). Social workers were also identified as being the most sensitive to an individual's self-respect (Landau, 2000).

Gregorian (2005) also found that the social work profession is poorly understood, especially in healthcare and therefore underutilized. One criticism Gregorian (2005) found of the profession is that it has had difficulty articulating what social work does and what it can contribute to healthcare. Two important factors that emerged from Landau's (2000) study supporting the claims made by Gregorian (2005) argue that social workers need to educate others about their role and spend more time and effort relationship building with their inter-professional team members to increase their impact on the ethical decision-making process in hospitals.

Social work often stands alone in a team of healthcare professionals when it comes to competency assessments due to our adherence to the protection of individual rights to autonomy and self-determination (Healy, 2003; Landau, 2000). What this has meant to social work in healthcare has been increased conflict and tension when working with other healthcare professionals, especially when assessing risk (Healy, 2003). As Healy (2003) found, most professionals tend to lean towards beneficence. Social workers working within highly restrictive

environments reported greater issues with stress and tension due to managing or balancing their role and simultaneously protecting the individual's autonomy and rights (Gray, 2010; Landau, 2000; Gregorian, 2005).

Naik et al.'s (2013) study presented perspectives of 45 social services and health professionals who assessed vulnerability among older clients living in the community. The participants were made up of 22% social workers, 18% geriatric physicians, 13% lawyers, 9% primary care physicians, 7% nurses and 7% psychologists. Four themes emerged: 1) clients' inability to perform activities of daily living, 2) lack of social supports, 3) socio demographic factors, and 4) neuro-psychotic conditions. Professional time spent with the vulnerable adult: Social worker 52%, geriatric physician 44%, lawyer 35%, primary care physician 15%, nurse 13%, and psychologist 15%. Participants agreed screening is best performed by an interdisciplinary team in the home setting and with more than one visit (Naik et al. 2013). They also agreed that vulnerability exists on a continuum, and that interdisciplinary dialogue and collaboration are paramount to assessing vulnerable older adults in the community (Naik et al. 2013).

### **Conclusion**

In healthcare social workers contribute to patient care by looking beyond the medical model and emphasizing the systems-ecological perspective of the person-in-environment (Landau, 2000). The systems-ecological perspective is a feature of social work that largely contributes to the process of ethical decision-making in hospitals (Landau, 2000). This holistic perspective allows individuals to be seen as part of their family and the larger environment. If the individual is able to utilize their natural support systems effectively, it could aid in protecting

their autonomy (Pachet, Newberry, & Erskine, 2007).

Social workers can offer healthcare a great deal in the area of the ethics of competency assessments. Social work does have an integral role within the area of competency both at the micro level with individual patients and the macro level, as advocates for individual rights and social change. The profession of social work can offer advocacy, experience, ethical guidelines, tools to complete a comprehensive assessment, research material based upon clinical practice and professional skills.

Even though it is recognized that social workers face ethical dilemmas the literature is still growing around what decision-making processes social workers use to make ethical decisions and determinations. Currently the Social Work Code of Ethics is the primary framework social workers have as a guide to ensure they are following practice standards laid out by their profession.

There are multiple tools to determine an individual's decision-making capacity but there still remains no 'gold standard' format for the assessment of competency. But recent studies, (Pachet, Astner, & Brown, 2010; Pachet, Newberry, & Erskine, 2007) have provided proposals for preferred considerations when undertaking a competency assessment. The way in which an individual's basic human rights are honoured and protected based upon governing legislation exists, however there are few safeguards in place. Provinces such as Alberta are reporting success in their use of more comprehensive legislation and assessments.

As the population continues to age and economic times become more difficult, more individuals with cognitive impairment will come in contact with health and social services. Competency assessment practices and research with older adults requires attention to develop



more encompassing laws and policies to protect the individual.

### **Chapter Three: Theoretical Framework**

In this chapter I present the literature pertinent to the theoretical framework chosen for this study.

#### **Theory**

The foundational theoretical frameworks for this study include: social determinants of health and a combination of systems and ecological theories. Social determinants of health was chosen because of its ability to address social and economic factors that lead to adverse medical outcomes for individuals of all ages. This framework also addresses issues raised by participants regarding oppression and power differentials faced by both social workers and their clients. Systems and ecological theories examine how individuals are part of multiple systems and provide explanations as to how these systems affect individuals' ability to function and cope in their environments.

#### **Social Determinants of Health**

The social determinants of health refers to the effects of economic and social conditions in which people are born, grow, live, work and age; the distribution of these factors influences and contributes to measurable differences in health within a population. They also help explain perpetuating inequalities in health (Mikkonen & Raphael, 2010; Raphael, 2011). Social determinants of health (McGibbon, Etowa, & McPherson, 2008) consider the following factors:

- Employment, unemployment and working conditions – access to safe, secure and meaningful employment means steady income for housing, food, healthcare, security for dependents and an increased sense of well-being and self-esteem.
- Income and its equitable distribution – access to adequate income allows individuals to

secure housing, provide security for their family, food, and healthcare.

- Food insecurity – consistent access to food allows individuals to manage the other parts of their life when they are not worried about meeting a basic need.
- Housing – access to safe and secure housing allows individuals to feel physically and mentally settled.
- Early childhood development – if a child is raised in a safe, secure and loving home it can allow the child to develop a well-rounded sense of self and grow to their potential without the burden of worrying about where they will live, when they will eat again or receive adequate care.
- Education – access to education is proven to increase employment opportunities, raise income potential and increase overall well-being and self-esteem.
- Healthcare (primary, secondary and tertiary) – access to healthcare allows the individual the ability to have their needs met when the need arises whether it's medical, physical or mental health.
- Social exclusion – occurs when certain individuals or groups are not granted the same access to resources and rights as the rest of the population.
- Social safety nets – are meant to protect the poor or vulnerable from falling below a poverty line and access to resources to meet the necessities of life; includes programs such as Social Assistance.
- Identity (gender, race, social class, dis (ability) and sexual orientation – our identities within a greater population may increase our access to food, housing, employment, education, social inclusion, income, and healthcare, or our identities may lead to

discrimination, stereotyping, or prejudice, limiting access to the social determinants of health.

From the examples provided, it is easy to see how all of these factors intersect and can maintain the inequities of access to care within a population (McGibbon, Etowa, & McPherson, 2008).

This framework speaks to how sensitive health is to social and economic factors (Wilkinson & Marmot, 2003) and helps explain how social structures and power relationships affect an individual's overall health and wellness (Mikkonen & Raphael, 2010; Raphael, 2011). In Canada poverty is the strongest determinant of health, and "poverty rates have not improved over the past two decades" (McGibbon, Etowa, & McPherson, 2008, p.25).

Major inequities exist among Canadians in their access to appropriate housing, food, nutrition, and healthcare (Raphael, 2011). These inequities can be measured by the higher incidences of chronic disease and mortality within impoverished communities (Raphael, 2011). The social determinants of health can be seen as, "the social gradient of health" (Wilkinson & Marmot, 2003, p.25) which enables researchers and policy makers to identify the determinants of health among any population (Wilkinson & Marmot, 2003).

This approach is a good fit with my research question as I am looking for a framework that looks beyond the medical model to explain discrepancies in health among clients social workers encounter (Raphael, 2004). The medical model sees the individual either as a diagnosis or disease without any consideration of economic and social aspects of client care (Raphael, 2004). Another dominant perspective of health is the lifestyle approach which focuses on lifestyle choices made by an individual as a means to determine the cause of their ailments (Raphael, 2004). This approach seeks to point out if the individual had made 'healthier' choices

they would have improved health (Raphael, 2004). However the major critique of this approach is that it fails to consider the unequal distribution of access to housing, food, employment or healthcare and looks to blame the victim as the cause of their illness (Raphael, 2004).

### **Systems Theory**

Systems theory was developed in the 1940's and 50's by Ludwig von Bertalanffy in an attempt to explain the interdependent network of relationships that exist within each person's life (Gray & Zide, 2008). Ludwig von Bertalanffy is credited as being the originator of systems theory used by social work (Friedman & Neuman-Allen, 2011). Systems theory provides a way to present a holistic perspective of the complex systems individuals occupy (Friedman & Neuman-Allen, 2011) by looking at boundaries of subsystems with systems and the maintenance of homeostasis or equilibrium within a model (Kirst-Ashman & Hull, 2006). Understanding subsystems and boundaries allows social workers to understand the dynamics of a system such as a family (Kirst-Ashman & Hull, 2006) as well as solutions for how to identify areas needing improvement.

(Kirst-Ashman & Hull) 2006 highlight key concepts to understand:

1. Microsystems: Small size social systems (i.e., family)
2. Mezzo systems: Intermediate size social systems, groups, extended family.
3. Macro systems: Large social systems such as communities and organizations

Important definitions:

Boundary is defined as what gives a unique social system its definition (Friedman & Neuman-Allen, 2011). Boundaries can be clearly defined or permeable (Friedman & Neuman-Allen, 2011). Boundaries can be formal through social customs and norms and each system has a

way of defining itself (Friedman & Neuman-Allen, 2011). Systems can only grow if energy is exchanged and if the boundaries are permeable. Von Bertalanffy defined the difference between open and closed systems (Kirst-Ashman & Hull, 2006). An open system means energy can be exchanged between the individual and their systems (Friedman & Neuman-Allen, 2011). Closed systems are not able to exchange energy (Friedman & Neuman-Allen, 2011). Openness is critical to the functioning of a system. Exchanging information between system and environment is known as feedback, this allows the systems to measure responses of output and input between individual and their systems (Friedman & Neuman-Allen, 2011). Equilibrium or homeostasis refers to maintaining a state of balance, because when the balance is disrupted the individuals within the system will work towards regaining the state of balance because of the stress caused when the balance is disturbed (Friedman & Neuman-Allen, 2011).

### **The Ecological Model**

The ecological model evolved based upon research completed as far back as 1870 by Schwabe and Bartholomai (Bronfenbrenner, 1994). Bronfenbrenner was the first to introduce an ecological model (1970) to help explain the relationship between individuals and their environments (Bronfenbrenner, 1994). Bronfenbrenner took the works of Von Bertalanffy further from a one dimensional cause-and-effect model that only saw relationships between social units within the environment to a model that captured the complex dynamics of social systems that take into account all of the factors affecting the development of each individual (Friedman & Neuman-Allen, 2011).

The ecological model focuses on living, dynamic interactions. Humans are seen as having active involvement with each other and their environments (Kirst-Ashman & Hull, 2006; Gray &

Zide, 2008). The ecological model takes into account both internal and external factors involved in each transaction we have (Gray & Zide, 2008). People are seen as being involved in reciprocal relationships with others within their environment. They are not passive participants (Gray & Zide, 2008).

The ecological model considers five major concepts (Gray & Zide, 2008, p.12):

1. Person-Environment Fit: In social work practice, this means assessing the “fit” between the person and their environment and the dynamics of their interaction.
2. Adaptations: How people change in order to maintain the equilibrium between themselves and their environment.
3. Life Stressors: Seen as any event that upsets the equilibrium of “fit” between the individual and their environment.
4. Stress: The emotional, mental, and physiological responses to life stressors that is observable by the social worker such as depression and anxiety.
5. Coping Measures: How the individual draws upon internal and external resources to cope with internal or external changes.

The ecological model sees individuals as constantly adapting and coping with life changes and if there isn't a goodness of fit between the individual and their environment during any of the life transitions then stress will occur (Kirst-Ashman & Hull, 2006). Social workers often encounter individuals when they are experiencing life stressors and are having difficulty coping (Gray & Zide, 2008). Social workers use their knowledge of the interaction between an individual and their environment to assist the individual by providing resources or assisting the

individual in recognizing the internal strengths they possess in dealing with the life stressor (Gray & Zide, 2008).

### **Summary**

By considering these theoretical frameworks the study provides a familiar format known by social work practitioners. The particular strength of the social determinants of health is how it will help to explain differences in client experiences and power dynamics faced by clients accessing health services and social workers working within a hierarchy. The social determinants of health may help to explain conditions in which the client came into contact with a social worker and why their mental competency was questioned. It may help explain differences in social and economic status and if it made a difference in whether the client was found mentally competent.

The combination of systems and ecological theories can help the social worker find patient strengths and resources that she or he already possesses as well as how these strengths can be developed and supported. Critical to social work is how this framework is client-centered and how it values the unique strengths and perspectives of clients who may be struggling with cognitive impairment. An important social work value is to appreciate differences and meet people where they are at in their journey. Social workers often see people when they're in crisis and this should be seen as an opportunity by the social worker to help show the client the strengths they possess to meet the current challenges they are facing.



## **Chapter Four: Research Methodology**

I have chosen a qualitative research design utilizing a narrative inquiry to address the research question. I will begin by explaining the overarching paradigm of qualitative research and then move to the specific lens of narrative methodology.

### **Qualitative Research**

Qualitative research is used to explore a research problem from the perspective of the individual or group to discover how they view the problem (Creswell, 2007). Qualitative researchers choose an appropriate approach to evaluate the data; the research is often done in a natural setting and no attempt is made to manipulate the situation under study. An inductive approach to data analysis is used to establish themes and patterns (Creswell, 2007). The final research often presents the voices of the participants, the researcher is brought in reflexively, and an interpretation of the data is presented which then adds to the literature or calls for action (Creswell, 2007).

### **Strengths of Qualitative Research**

Qualitative research has the benefit of providing complex textual descriptions of how people experience a given research issue (Mack, Woodsong, MacQueen, Guest & Namey, 2005). It is effective in identifying intangible factors (Mack, Woodsong, MacQueen, Guest & Namey, 2005). In an interview based study open-ended questions and probing gives participants the opportunity to respond in their own words rather than forcing them to choose from a fixed response (Mack, Woodsong, MacQueen, Guest & Namey, 2005).

Data is analyzed based upon the participant's own meaning of the phenomenon (Creswell, 2007). It allows the researcher to focus on a small number of participants in order to

conduct an in-depth investigation and can be helpful when attempting to explain a complicated phenomenon (Creswell, 2007). It can provide detailed data regarding each participant and provides description and understanding from an insider's viewpoint (Creswell, 2007).

The researcher can sometimes identify with the phenomenon being studied because they may have their own lived experiences of the research question that is being explored, providing a rich analysis of the data (Hancock, 1998). Qualitative research is useful when needing to determine how participants describe particular constructs (Hancock, 1998). Researchers are usually able to collect data in a natural setting producing data as close as possible to real world reaction to the identified phenomenon (Hancock, 1998). Qualitative researchers are able to adapt to changes in the focus of study if the fieldwork suggests necessity in doing so (Hancock, 1998). Since the study often uses the participants' own words, important explanations or case examples can be used explicitly to demonstrate a particular point or meaning (Hancock, 1998).

### **Limitations of Qualitative Research**

Knowledge learned through qualitative research may not be easily generalized to other individuals or settings, due to the small sample size and the sampling processes (Mack, Woodsong, MacQueen, Guest & Namey, 2005; Creswell, 2007). It is difficult for qualitative researchers to make predictions because there is no formula to predict how individuals will describe or respond to a particular phenomenon especially if it is rare or unstudied (Mack, Woodsong, MacQueen, Guest & Namey, 2005). Qualitative research can hold less credibility than quantitative research with administrators because of the small sample size and process of data collection (Mack, Woodsong, MacQueen, Guest & Namey, 2005). Qualitative research can be intensive and time consuming (Mack, Woodsong, MacQueen, Guest & Namey, 2005).

### **What is Narrative Research?**

Narrative inquiry has as many accepted definitions as it has different meanings in addition to being used differently by disciplines (Reissman, 2004; Polkinghorne, 2007; Creswell, 2007; Larsson & Sjoblom, 2010). One accepted definition of narrative and its application to social work is as follows: “narrative is the reconstruction of a story or collective stories, made up of individual voices and identities to represent the collective” (Reissman, 2004, p. 428). Stories are seen as units of analysis with a sequential order that make meaningful connections between events (Reissman, 2004; Creswell, 2007; Polkinghorne, 2007). These stories offer insight into individual experiences of the world and social situations (Reissman, 2004). The staple of narrative research is ordering and sequencing (Reissman, 2004; Creswell, 2007). One action is seen as a consequence for the next. Researchers or narrators create plots from the stories and structure the events either temporally or spatially (Reissman, 2004). Narrators can also create themes, plots and drama (Reissman, 2004). Narrators are striving to make sense of the actors, the participants, social situations and themselves (Reissman, 2004).

Narrative also offers the ability to capture social representation processes such as feelings, images, and time (Mitchell & Egudo, 2003). It also provides the potential to address ambiguity, uncertainty, complexity and dynamism of individual, group, and organizational phenomena (Mitchell & Egudo, 2003). Narrative analysis can be used to record different viewpoints and interpret collected data to identify similarities and differences in experiences and actions (Mitchell & Egudo, 2003). Narrative approaches are seen as a way to bring forward stories of silenced or underrepresented voices such as minority and/or discriminated groups (Reissman, 2004; Creswell, 2007; Merrill & West, 2009). Since narrative can be used to provide

a voice to underrepresented individuals and groups, it has been linked to feminist practice (Reissman, 2004; Byrne, 2003). Reissman (2004) does share a caution when researchers want to give a voice to an unheard group, that as researchers, “we cannot give voice but we do hear the voice that we record and interpret” (p. 274). Narrative research methods are tools to discover meaning; not to reveal or discover truth (Reissman, 2005; Mensinga, 2009).

Researchers collaborate closely with participants rather than using indirect contact or distant observation (Creswell, 2007). Narrative research gives a voice to individuals affected by the particular phenomenon under study (Creswell, 2007). Narrative helps to bring voices of a few to a broad audience and allows researchers to capture and present research in familiar terms used by participants (Creswell, 2007).

### **Narrative and Social Work Practice**

A central area of narrative research is human interaction, the core of social work practice (Larsson & Sjoblom, 2010). Another core component of social work practice is engaging with individuals’ lived experiences (Merrill & West, 2009). In practice social workers often use pieces of their clients’ stories to inform their interventions and decision-making (Mensinga, 2009). For example, social workers engage in the stories of client experiences to make sense of events and present the client’s narrative to the larger group during case conferences in order for it to make sense to the group at large (Mensinga, 2009).

Familiar to any seasoned social worker is the creative way clients can present their narrative. The social worker is left to interpret the sequence of events, look for patterns and/or themes, and make sense of the clients’ account (Reissman & Quinney, 2005). In the same way clients might get creative with presenting their stories in order to engage an audience;

interdisciplinary team members can also present their narrative about a client in a convincing way. They can persuade a group to go a particular way, resulting in decision-making about client situations influenced by highly subjective accounts of their stories and creation of their truths in order to serve the professionals' agenda and not the clients' (Reissman & Quinney, 2005).

Social workers use narrative every day in their letters to other agencies, trying to engage other bodies or resources with the client's story (Reissman & Quinney, 2005). Narrative research is seen as an appropriate approach to social work practice as it is seen as honouring social work values and ethics because of its value on "time with others" and "diversity among people" (Larsson & Sjoblom, 2010). Narrative is seen as a relevant method when trying to understand social workers' interaction processes with their clients and their discussions about those clients with other professionals (Larsson & Sjoblom, 2010). Social work is multi-dimensional and the narrative approach complements this because of its holistic perspective on life experiences and human interaction (Larsson & Sjoblom, 2010).

Narrative inquiry for research purposes is different but its use in practice makes it a useful and familiar research approach for social workers. Narrative social work is defined as, "a conversation between theory and practice, which can lead to development in both social workers and service users" (Roscoe, Carson & Madoc-Jones, 2011, p. 47). Narrative as a conversation allows social workers and client to both share stories and to understand where the other is coming from (Roscoe, Carson & Madoc-Jones, 2011). The knowledge the social worker brings to the conversation can help to deconstruct and reveal cultural and historical assumptions that constitute each narrative (Roscoe, Carson & Madoc-Jones, 2011).

## **Methods**

The data collection method used for this thesis was nine in-depth semi-structured interviews with social workers who have experience with competency assessments in a healthcare setting with older adults.

### **Sample**

I met one-on-one with nine social workers who had experience working with older adults. Purposeful sampling, specifically a criterion sampling method was used to recruit social workers who were employed, or who had been employed in a healthcare setting in Manitoba. This type of sampling offers the best opportunity to collect rich data by ensuring the researcher recruits a sample of participants who have experienced the phenomenon based upon a set of criteria. These criteria included; social workers who at any time during their career worked with an older adult in a healthcare setting and were willing and able to discuss their involvement in a competency assessment conducted with that older adult. Healthcare settings included: hospital (including long term rehabilitation), community (home care, geriatric assessment teams) and long term care (long term care access, personal care homes). The social workers recruited were required to have at least one year of experience working in a healthcare setting and were able to speak in detail about at least one case example in which they were involved. Participants needed to be fluent in English and agree to have their interview tape-recorded and transcribed for analysis. The participants were required to have at least a Bachelor's degree in Social Work from an accredited university.

### **Number of participants**

As per Jones (2003) who recommends between 5-10 interviews, I recruited nine participants; the goal was five to seven. Narrative researchers are more likely to aim for a certain number of interviews or interviewees but remain open to modify such a goal during the research process. Narrative researchers tend to use small numbers of interviewees; this is due to the extensive nature of the interviews which require labor intensive analytical procedures (Jones, 2003). Richness of data and a thorough, meaningful analysis is required to fully explore and articulate themes; this necessitates limiting the number of interviews (Jones, 2003). According to Crouch and McKenzie (2006), when conducting in-depth interviews, a smaller sample size allows the researcher to spend more time with the participants and gain a deeper understanding of the data which enhances the depth of the findings. Only one interview was used to collect data, each lasting an average of 40 minutes.

### **Recruitment Process**

Human research ethics board approval from the University of Manitoba Psychology/Sociology Research Ethics Board was obtained on January 22, 2014 (Appendix I). Participants were then recruited by email through advertising using the Manitoba Institute of Registered Social Workers (MIRSW), and the list of alumni at the Faculty of Social Work of the University of Manitoba.

I obtained initial email contact information for MIRSW and the alumni of the Faculty of Social Work through their websites. I sent an email covering letter (Appendix A) briefly explaining the project and requesting the assistance of each organization in distributing the information to their members. Once a "yes" response was received from the organization, I sent

another email. This email requested that the following attached documents be forwarded via email to their members: an email recruitment script (Appendix B) and a letter of invitation to potential participants (Appendix G). This email also had an attached project poster (Appendix H) to be used for advertising in their newsletter and on display in their organizational establishment. A pdf copy of the ethics approval certificate (Appendix I) was also provided with this email.

### **Interviews**

Respondents were asked to contact the principal investigator/student by phone or e-mail and an interview time as well as place was set through this contact. I set-up the interview within one week at a quiet, mutually agreed upon confidential setting. The social workers who agreed to participate in this research were asked to carefully read and sign the informed consent form. After giving their consent, the participants participated in an in-person interview which averaged 40 minutes in length. An in-depth, semi-structured interview was chosen because it allowed the interviewer to have a focused two way conversation but also allowed for the interview to stray from set questions when the interviewer felt it was relevant to the discussion (Cohen, 2006). Narrative interviewing is a way to explore the meanings of phenomena that underpin people's lives (Elliot, 2005). Narrative interviewing allows stories to stay closer to actual events than methods that elicit explanations (Elliot, 2005).

The interviews were semi-structured with open-ended questions, with a particular interest in the participant reflecting and providing recollections of their experiences as a social worker assessing the competency of at least one older adult in a healthcare setting (Appendix D). Since I was using a narrative approach, I only interrupted participants if necessary to probe or clarify but not to interrupt the natural process of re-telling an event. If a participant got stuck or did not



know what to say next, I provided clarification or an example to assist with answering the interview question more fully.

The research participants were provided an opportunity to debrief at the end of the interview, but none required any debriefing. All participants expressed interest in obtaining the summary of results which would be sent by e-mail or surface mail depending on which option they chose. The participants were also informed about the opportunity to attend the final defense at the Faculty of Social Work at the University of Manitoba in the fall of 2014.

### **Data Management**

Data was recorded verbatim through an electronic recording device; permission was given by participants. All data was transcribed verbatim into Microsoft Word documents. The information was stored on a secure computer hard drive and only accessible to the principal researcher, the thesis supervisor and a professional transcriber who agreed to protect confidentiality. All participants were given pseudonyms. All data will be destroyed upon completion of the researcher project, by December 31, 2015.

To make efficient use of my time I hired a professional service to transcribe each interview as soon as it was complete. The transcriptions were completed within 24 hours of the interviews. I re-listened to each interview twice to ensure accuracy of transcription and to fully immerse myself in the data. I began data analysis as soon as each interview was transcribed; I completed this process within 3 weeks.

### **Data Analysis**

Data was analyzed through a narrative methodology guided by Catherine Reissman (2004, 2005), Thorne, (2000), Heather Fraser (2004) and Denzin & Lincoln (2000), a blended

approach was used incorporating all sources. Catherine Riessman was chosen because she is a leading figure in narrative research and she provides an accessible framework for new and experienced researchers to analyze narrative texts. Her writings focus on interviewing and the process of transcribing interviews (through the use of examples) which is helpful for a new researcher.

### **Coding the Data**

Coding the data consisted of first listening to the tapes and then reading the transcripts multiple times for accuracy. Coding was done manually on paper using line-by-line coding principles. Open coding was used to determine core concepts and categories (Thorne, 2000). The goals of the first round of coding were to note recurrent experiences and also differences in experiences. The goal of the second round of coding was to begin to organize and attach meaning to the data by writing out themes in the columns of the transcripts. I used axial coding to identify the relationships between the codes; I did this by separating the data into large themes (such as Social Work role) and also attached subthemes (for example advocacy under the larger theme of Social Work role) into separate word documents for further organization and analysis. Inductive codes were developed while I examined the data. The chosen text for each theme and subtheme was copied and pasted into its own document. For example, all stories about culture, and was again reanalyzed for relevance within each theme. Some data was relocated to different themes if they fit the essence of the data more appropriately. During the final round, selective coding was used to analyze themes further for similarities, differences and the nature of the participant's story. I analyzed the participants' stories and reported on themes in order to interpret the larger meaning of their stories to provide a broader analysis (Creswell, 2007). These

coding methods produced theoretically important themes and subthemes. Themes were developed based upon my literature review, research questions, and theoretical frameworks. To ensure validity and reliability both the principal investigator and thesis supervisor reviewed the data and coding information.

### **Summary**

Narrative research methodology was used to provide participants with opportunities to share their stories in their own words. This study was designed to bring the voices of social workers to the forefront of this analysis providing the opportunity for them to discuss their experiences. Issues of recruitment, sampling and ethical considerations were considered when developing the design of this research to increase the trustworthiness and relevance of the findings.

## **Chapter Five: Participants**

This chapter begins by providing demographic and background information about the participants; education, work experience, years of service, age range and ethnicity. Next, this chapter will discuss the individual story provided by each participant in chronological order, focusing on their narrative about their experiences as a social worker with competency assessment in a healthcare setting working with older adults. The following chapter moves into the analysis of the collective stories and explicates how the theories of social determinants of health, systems and ecological as well as the empirical literature help to explain the emerging conceptual categories and themes that arose from the data.

### **Demographic Information**

The participant social workers were from diverse ethnic and cultural backgrounds. All but two participants were Caucasian, with backgrounds including Filipino, Ukrainian, Jewish, Polish, and Aboriginal heritages. There were seven females and two males. Five had MSW degrees while the remaining 4 had BSW degrees. The sample as a whole had many years of service averaging over 20 years; half the sample had over 32 years in healthcare. Only one participant had less than 2 years of service in healthcare. Their ages ranged from 28 to 73, and the average age was 50 years old.

The sample had diverse backgrounds in social work practice. The settings represented in this study include: acute care, which refers to hospital setting(s) including long term rehabilitation; long term care, which refers to personal care homes (nursing homes) and long term care access (system for accessing supportive housing and personal care homes); and community, referring to provincially funded home care, geriatric programs, and private practice.

These settings were equally represented: three from acute care, three from community and three from long term care. However the majority had experience in two or more of these healthcare settings within their careers.

### **Participant Stories**

All participants were able to provide rich stories about their experiences with older adults with competency assessments in a healthcare setting. Most began by providing demographic information about their current positions, the length of time they had held their current position and the length of time they had practiced as a social worker. Some kept the conversation to more of a broad discussion about when and why a competency assessment would be requested and, the legislative practices in Manitoba and across Canada. Others preferred to present their story through one or more case examples to illustrate their experience with older adults and competency assessments. All participants have been given pseudonyms and their positions generalized in order to protect their identities.

#### **Participant 1: Gina**

Experience: 6 years; hospital setting and residential community care.

Education: BSW

Gina's story represents the voice of social workers new to the hospital environment.

A minority female, she has been a practicing social worker for 6 years. The majority of her experience has been in residential community care, working with young people with disabilities. She was candid about her relative inexperience (one year) in a hospital setting.

She came across as shy and a little nervous. Her nervousness may have contributed to her brief answers (the shortest interview of all nine participants at 15 minutes), although she did

relax a bit as the interview progressed. Gina described her experience as predominantly negative when asked what it was like to be a hospital social worker.

Throughout her one year in a hospital setting, Gina occupied an in-patient BSW position. The area she covered was rehabilitation and geriatrics. Patients are admitted or transferred to this ward when they require a longer hospital stay, for example, after a stroke or acute event, or post-surgery. The criteria and goal of the rehab and geriatric unit is to get an individual functioning at a level that will allow them to return home or to the community. The typical length of stay is 1-8 weeks, depending on the diagnosis and amount of rehabilitation required. During the course of a geriatric patient's stay in hospital, questions about the individual's mental competency can be raised at any point, although assessments are usually related to discharge planning. Gina was very open about her lack of confidence in her role as a social worker in hospital and about her involvement in a competency assessment, "Not really knowing very much until I started working in a hospital, as a social worker...I felt really uncomfortable...(saying to herself) 'I don't know what I'm doing' (Laughs)."

Gina had never been trained on the job or in school on how to conduct a competency assessment, nor had she been taught how to evaluate an individual's mental status. She was left with a lot of unanswered questions about the process and the role of key players, "I found it really difficult, like because, I mean, who was really the expert in competency assessment[s]?"

Gina's experience highlights the need for better preparation for social workers in school and especially on the job if they are to be productively involved in discussions about an individual's mental competency. Better training would build the confidence required for social workers to be active participants instead of passive bystanders and outsiders to the process.

A big part of Gina's story included the struggles, challenges and emotional toll she felt from what she perceived as a lack of support while working as a hospital social worker. Multiple times, she referenced breaking down and crying at the end of day (which became a daily occurrence at one point), "Oh I was crying by the end of it! (Laughs)...yeah it was, it was stressful." She said the stress she felt was due to constant pressure and blaming from hospital administration and families, with no back-up from management. She reported looking for and receiving emotional support from the social work leader, but felt that even the leader was not respected by administration, so there was no reprieve day in and day out from the negativity. After exactly one year of working in the hospital she had enough and quit. She said she hasn't looked back.

**Participant 2: Mary**

Experience: 35 years; personal care home and hospital setting.

Education: MSW

Mary's story represents the voice of the seasoned personal care home social worker.

While she has worked in a hospital setting, the majority of her 35 years of experience as a social worker has been as a personal care home social worker. She currently works as a personal care home social worker. A mature, white female, Mary appeared confident and knowledgeable about competency assessments in Manitoba. She was talkative and responsive to the interview questions. Her interview length was on the longer side at 60 minutes.

As a personal care home social worker, Mary often wears many hats. She does duty as admissions officer, coordinator of admission, discharge and quarterly reviews of each resident. Often the social worker in a personal care home is the only allied health member on staff full-

time. All other disciplines are on consult only, spending maybe one or two days per week at the home to assess residents for specific issues. Often the social worker is the ‘be all and end all’ for the residents, families, hospitals, long term care staff, and visitors.

A social worker in this position is usually second-in-command to the director of care and, as such, often wields a lot more authority and autonomy than her/his social worker peers working in other healthcare settings. Personal care home social workers are often allowed or obligated to perform cognitive assessments whereas, social workers in acute care settings are not permitted to perform cognitive assessments.

As a result, Mary has been involved in many competency assessments. She was well versed in the legal requirements and legislation governing formal competency assessments in Manitoba. Mary has participated in numerous competency assessments involving different types of legal substitute decision-making options.

Mary’s track record on competency assessments seemed extensive particularly in the case of reassessments of competency. She spoke about acting or practicing on the side of caution when initiating any process which may have allowed an individual to return to the community to live at high risk. A person previously found incompetent and placed in a personal care home subsequently could be discharged into the community if a reassessment deemed him or her competent. Part of Mary’s reasoning for *not* pushing for a reassessment seemed a response to patients’ families, particularly their pleas to keep a family member in the personal care home setting, which they deemed a safe, structured environment.

Mary’s view of her role and work setting was much more positive in comparison to other participant stories. She spoke about mutual respect and equality within her team. She did not



speaking about feelings of powerlessness, struggles or major stress. Her feelings towards her involvement and experiences with competency assessments were quite neutral with no real moral dilemmas coming to mind, she repeated a few times that: “When I placed people under an order of supervision, at that time I always believed that I was acting in the person’s best interest.”

Generally, Mary didn’t share a lot of controversial issues about competency assessments with one exception, which she brought up on three separate occasions:

I find it in general we, we assume somebody’s competent when they tend to agree with the decisions that we’re making or that we think they should be making. If they’re making decisions that we feel are inappropriate, that’s when sometimes competency is, questioned.

She brought this practice up multiple times indicating it has occurred several times in her career.

Overall, Mary presented as quite content and didn’t raise any major issues related to the current provincial legislation which designates the physician as the sole decision-maker when it comes to competency assessments. I was surprised to hear such a positive perspective towards competency assessments and her experiences as a social worker in healthcare. It made me want to hear more from the other participants to see if her experiences were unique to her alone or shared by other participants who’ve occupied the same kind of position in the healthcare system.

### **Participant 3: Hebert**

Experience: 14 years; personal care home, long term care access and legislative policy advisor.

Education: MSW

Hebert represents the voice of a diversely experienced mid-career long term care social worker. His story also includes the unusual dimension (in this sample) of legislative policy advising on Adult Protection legislation.

During his career, Hebert worked as a social worker and manager of a personal care home, a manager of long term care access (entry system into personal care home placement), and a policy and legislative advisor. He's spent much of his career in Canadian provinces outside Manitoba. His experiences provided an informed view of how the assessment of mental competency is conducted in other jurisdictions compared to Manitoba.

A lively interviewee, Hebert was succinct and analytical in his responses. His interest and passion about the topic of mental competency was apparent from the beginning of the interview. His story embodied inquisitiveness about the process of how and why someone's mental competency was being questioned and how that process changed during the course of his career. I was excited to learn what he had to share.

Hebert's curiosity about the competency assessment process began in his first social work position as a frontline personal care home social worker. During that time, he witnessed many incidents in which individuals were excluded from their own competency assessment discussions solely because they were diagnosed with dementia.

What I found was a lot of the times the residents weren't even being invited (to quarterly rounds)...when I was asking why, it was like, 'Well, you know, she has dementia, so she's not invited,' and I was like, well, that's kind of a shitty reason (laughing) to not invite somebody.

While managing a long term care access centre, he saw further injustices occurring in the hospital system. Patients would be assessed incompetent for the sake of system efficiencies and to achieve quicker patient flow, ““cause of course in the hurry to get people out of acute care, we’d get all kinds of applications with just like a scribble from the doctor or something. You know, Mr. Smith is not competent.”

These experiences led him down the path of advocating for major changes in the assessment process. Along the way, Hebert encountered interest and buy-in from physicians, administrators and the social work professional association all of whom believed changes were needed in how citizens’ mental capacity and competency were assessed. Hebert’s advocacy instigated innovative changes to practice, policy and legislation outside of Manitoba, “I had the opportunity to be part of a decision specific capacity assessment in my frontline practice.”

Hebert’s desire to question the status quo and work towards policy changes in the service sector left me feeling optimistic that improvements could be made in Manitoba to correct deficiencies in our current processes, policies and legislation. I felt invigorated after the interview, inspired that someone could start out as a frontline social worker and move into policy and management so quickly, as well as become part of a larger movement for the betterment for all those whose competency is in question (and their families too).

#### **Participant 4: Tara**

Experience: 33 years; hospital setting and Child and Family Services

Education: BSW

Tara’s story represents the experienced hospital social worker.

Tara has worked most of her career as an in-patient hospital social worker. Previous to that, she worked at Child and Family Services and an in-patient mental health facility. Her story revolves around her experiences over the last 26 years on a medical unit. Tara presented an uncensored account of the issues social workers encounter in the competency assessment process in hospitals.

The medical unit in a hospital is populated by general admissions from emergency. The majority of patients who are admitted and have prolonged length of stays are older adults. As an in-patient social worker her predominant role revolves around discharge planning. The social worker is consulted to problem solve the barriers that stand in the way of the patient's discharge back into the community.

Throughout the interview, Tara referenced multiple case examples showcasing unprofessional conduct by various healthcare professionals. Mostly, her stories indicated a lack of knowledge, and maybe unwillingness, on the part of other professionals to acknowledge the seriousness of requesting a formal competency assessment, "So it's always been a concern of mine that, people use the term 'competency' very informally when, they have a concern about a person that they might be working with."

She spoke primarily about the strength and uniqueness of the social work role. Tara said protecting an individual's right to self-determination is part of her professional duty as a social worker, "We have an obligation to question and challenge that and ensure that a person's abilities or individual rights and freedoms are not being subjugated by others and, that's a key part of our practice and our responsibility." Tara made strong arguments for social workers in hospitals to be given more authority and more credibility regarding competency assessments.

I identified with her stories as a previous hospital social worker myself, including feeling unsupported as if she had to fight a battle every day. Even though she works in an environment with little support and with other professionals with opposing values, she is unwavering in her commitment to uphold human rights and freedoms. I felt her story spoke a lot to her resiliency and character as both a social worker and an individual.

**Participant 5: Greg**

Experience: 43 years; community care, hospital setting, post-secondary and private practice.

Education: MSW

Greg's story represents the voice of a veteran clinical social worker who has filled a vast array of roles across the gamut of healthcare settings.

The participant with the longest, widest scope of experience, Greg has worked as a private practitioner, university lecturer, consultant, and advocate. During his extensive career, he has held positions in a hospital and in the community; he has developed curriculum and advised on changes to policy and provincial legislation. He has lived the role of a social worker on the frontlines and as a senior manager. His specialties are in the areas of geriatrics and advocacy for families. Greg's story encompasses all these experiences, but was spoken from the perspective of his present role as a private consultant.

Greg's wealth and breadth of experience was humbling. He was very comfortable being interviewed and did not hold back on his opinions of social work and healthcare as they pertain to competency assessments and discharge planning.

Providing an informative view of hospital social workers in particular, Greg feels the social worker role can offer much more than just collecting collateral information, "I think,

unfortunately, social workers, traditionally in health, in the hospital have always accepted the role of providing collateral information, they've been the ones to go out and get the social history, I mean that's really been a tradition.”

He prefaced this by saying, the social worker needs to make the information relevant to the present day and to the issues at hand, not just regurgitate the patient' demographics. In hospitals, Greg said, social workers and social work administrators should expand or refocus their roles to extend beyond collateral information collectors to taking the lead on being much more involved with families, “Social work is the one that can connect with the family, educate the family, and advocate.”

Greg feels the hospital social worker is the only team member who looks beyond the hospital setting to the patient's return to the community. Social workers can support the family and provide the linkage for them between the hospital and the community. All other team members are focused on assessing the patient.

Not spending the time with the family is a missed opportunity. Greg recalled a few examples of how a hospital social worker could have made a more meaningful impact by being more attentive to the family, “The social worker could have said to the family, ‘what is your wish, what do you see?’ because who else would ask that question?” An advocate for individuals and their families, Greg had a particular interest in individuals of reduced socio-economic circumstances and those with cognitive impairment. An especially sensitive time for families occurs in the later stages of a person's dementia, when the family needs to step in as substitute decision-maker and advocate.

Greg has been a major player in social work practice, policy, education and legislative changes. I took his challenge to social workers to be more proactive, educated and involved to heart. His story reminded me that as social workers we do have a lot to offer the people (and their families) we encounter in our work. Greg is proof social workers can inspire change and have long satisfying careers. Listening to his story influenced my attitude towards the work I do. His accomplishments reminded me I have knowledge and skills that can contribute to positive outcomes and that what's really important at the end of the day is responding competently to the needs of the people we serve.

**Participant 6: Lorraine**

Experience: 35 years; hospital and community care.

Education: MSW

Lorraine's voice represents the experienced community social worker operating as part of a team.

Working in community care for the last 13 years, Lorraine's position is a specialized clinical role, assessing individuals over the age of 65. More of a consultative than case management approach, the nature of her work is short term, predominantly crisis intervention and community management of the client.

A mature, white female, Lorraine spoke positively about having a team approach in competency assessments and about her place among the other healthcare professionals. Lorraine works within a small team, collaborating directly with a geriatrician, which is unlike any of the other participants' positions. Lorraine spoke to the strength of this team approach and how they have a step-by-step process when assessing mental competency.

I tend to work not in isolation but I work with, a very good healthcare team. We have a geriatrician that we consult with on a daily basis...there's a ten step protocol that we follow and it's clear, it's concise, it's very simple.

She embraced her role as advocate and spoke of the significance of competency assessment. Clearly taking her participation in a competency assessment seriously, she spoke about protecting individuals from unnecessary assessment, as well as, from undue harm. Her focus on protection seemed a direct consequence of her participation often initiated due to a crisis event. Other times, she is the first healthcare provider to be involved in the client's life, "That's the paramount goal, to protect your client whether they're younger or older...to get them out of that situation, to protect them and put them into a safer situation."

Other major parts of her story revolved around working with clients and families of diverse cultural backgrounds. She spoke at length about the need for social workers to educate themselves about cultural norms and family systems. Language is also a barrier for completing competency assessments in a timely manner. More work and time is required to assess individuals' cultural backgrounds in order to determine cultural practices and perspectives of viewing and treating elderly family members.

I felt her story really conveyed the need for social workers to be conscientious and diligent in their practice and I could hear from her examples that she carries high practice standards for herself and those around her. Working with families in crisis brings its share of stress. I felt her sadness when she spoke about uncovering terrible situations that people have been surviving in and how unfair it is that someone steps in to help them only in their final stage



of life. She spoke about the benefits of expressing your human side and developing relationships with your team in order to debrief when you encounter difficult situations.

**Participant 7: Bonnie**

Experience: 13 years; Regional Home Care program

Education: BSW

Bonnie's story represented the voice of the experienced home care case coordinator.

An aboriginal female, Bonnie has worked in home care for the past 13 years. As a home care program case coordinator, her role is largely case management with upwards of 110 clients. Her position also includes aspects of educating, counselling, resource locating, and management of chronic illness and disease. There is no limit to the duration of an individual remaining a home care client. Some clients can be recipients for 10, 20 or more years. Bonnie's job entails long term case management for both the client and their families.

Bonnie was very forthcoming and descriptive in her interview responses.

She described her position as a facilitator, "And we as coordinators facilitate a decision-making process. We facilitate clients and families receiving informed consent before they make that decision. So we're instructing them about options."

As case coordinator, Bonnie manages long term relationships and sometimes encounters difficulty managing family expectations versus what's best for the client. In particular, she referred to the challenges of working with families that want to work against you versus the families that work with you, and the conflict that can ensue from your professional involvement, "And they (the family) weren't intervening enough to protect the individual and, so you...you do

what you believe is in their best interest and, hear from them afterwards that...that was the wrong thing to do.”

What came across in her story was her genuine interest and attentiveness to her clients’ complete situation. What also shone through was her willingness to accept (while admitting that it’s difficult at times) that individuals have the right to live at risk and make bad decisions as long as they are not placing themselves or others in *imminent harm*.

As a home care case coordinator myself, her experiences were very interesting and all too familiar. Her approach was a reminder that we need to have ethical guidelines and checks in place when deciding whether to intervene in another person’s life, and to check ourselves as professionals as to why we feel an intrusive intervention is required.

### **Participant 8: Tina**

Experience: 25 years; acute care hospital.

Education: MSW

Her story represented the voice of an experienced emergency and in-patient hospital social worker.

The emergency room (ER) role of the social worker is similar to that of an in-patient social worker in that the focus is on resolving barriers to discharge. The ER social worker meets people when they are at their worst, arriving at the hospital in crisis for medical and/or social reasons. The monumental difference in the competency assessment process in acute care versus ward care is the ER social worker may have 20 minutes to complete a holistic assessment. An in-patient social worker in a hospital, on the other hand, may have days or weeks with a patient to complete an assessment.

Tina is a white female who spent the last 18 years of her career in acute care. Her story focused on her role in the emergency room as well as her other in-patient duties.

Managing the stress of the patient, their families, the ER staff and your own feelings can be overwhelming, said Tina, if you haven't developed strategies to cope with the constant stress.

It becomes a hard place to work. So then you'll see a lot of burnout or people just not happy with their jobs, or social workers who just begin to kind of go along to get along to make their workday tolerable.

She got to the heart of her story within her first two sentences of the interview. She sees major issues with how and why competency assessments are performed in hospital, "It's my perception that the majority of times or instances where competency assessments were being requested was to facilitate discharges." She had a lot of critical things to say about the hospital system and the difficulties of being a social worker in that type of environment. She described many parts of her story through the use of beautiful metaphors, such as, "We run into trouble when we just, are kind of cogs in the wheel."

Her story expressed a lot of frustration towards a hospital system that she believes problem solves difficult situations in a short sighted and conservative manner. For example, in the discharge process, if the social worker role was more valued, he or she could contribute much more meaningfully to the patient's wellbeing.

I think social work is an under-utilized resource in hospitals and if we're used to our capacity for creative thinking and creative care planning, I think a lot of those types of circumstances, there wouldn't need to be competency assessments.

It was upsetting to me to hear someone who is obviously very experienced, articulate and an innovative thinker express that she felt she didn't have a voice among the professionals she worked with after so many years. After working in a setting for 18 years, one would expect some mutual respect for each other's experience and skills. Rather, Tara's experience was that her contributions to patient care were often disregarded because they didn't always fit nicely into a box. I admire her unwavering commitment to advocacy and her courage in speaking up especially when she felt that it's neither encouraged, nor welcomed.

**Participant 9: Jessica**

Experience: 20 years; personal care home and hospital setting.

Education: BSW

Jessica's story represented the voice of an experienced personal care home social worker and long term rehabilitation in-patient hospital social worker.

Jessica has 14 years' experience in long term care and hospital settings. She currently works on a rehabilitation unit in a hospital. A white female, Jessica was talkative and spent a good portion of her interview comparing her experiences as a personal care home social worker to her current employment on a rehab unit.

Jessica had more authority as a personal care home social worker because she worked in virtual isolation with an occupational therapist assisting only at certain times. As a result, her role in assessing capacity was much greater in a personal care home than hospital acute care where occupational therapy takes the lead in performing cognitive assessments, "In the personal care home where you're the one social worker there... People like the OT are only coming and going, right?"

In her current position as a long term rehab in-patient hospital social worker, Jessica's main role involves working with families which can be frustrating at times. Much of their irritation comes from what Jessica described as a lack of understanding of their loved ones' abilities and disabilities. This leads to a feeling that there is a lack of safeguards for vulnerable individuals, "Family are allowing them to, to be totally involved in decisions on things that they can no longer understand or really participate in... families believe that they can and they'll bring lawyers in."

Jessica's interest in learning was apparent, as was her belief that not continuing to educate yourself can lead to incompetent and outdated practice approaches to issues such as competency assessments. Despite this, Jessica's experience was that upgrading wasn't something freely offered in the hospital workplace. She had to seek out opportunities to learn in order to increase her knowledge base, "But had I not sought that out for myself, it wasn't something that was available or that was encouraged."

She concluded with saying experience on the job should be seen as an on-going learning opportunity. Maintaining curiosity and a willingness to learn not only benefits the professional but everyone with whom they work. I could not agree more with her opinions about lifelong learning and the trouble we run into as healthcare professionals when we stop being curious or stop exploring new ways to improve our skills and approaches to patient/client care.

### **Summary**

The reason the individual stories were presented prior to delving into the collective stories was to represent the unique narrative of each participant. Participant stories were also presented separately to provide the reader with a sense of each participant's experiences and to

provide a context for the various healthcare settings represented in this study. The next chapter moves into the analysis and discussion of the participants' collective stories. Both theory and empirical findings help to provide a link between the participants' narratives to broad concepts and existing literature.

## Chapter Six: Findings and Discussion

This chapter presents the interview findings and relates them to empirical research and theory including social determinants of health, systems and ecological theories.

The key questions in the interview schedule were intended to facilitate dialogue and sharing of experience to better understand the competency assessment process, particularly as it is applied to older adults in a healthcare setting in Winnipeg.

In the previous chapter the individual stories of the participants were presented as each narrative reflects each person's understanding of the phenomena being explored but also reflects the broader social narrative, in which each person's narrative is embedded. This chapter presents their collective stories and its connection to the broader social narrative of competency assessments in healthcare settings.

Common themes that emerged through interviews included the recognition that social workers bring a holistic perspective of the client to the process of competency assessments. Bound by the code of ethics and standards of practice, their position as primary advocate for the client sometimes leads to the feeling that they are the 'fly in the ointment' in the competency assessment process. The majority of the study participants expressed moral conflict and professional misgivings related to their frontline experiences as part of a healthcare team involved in the competency assessment process.

The rationale for presenting the findings in the order they appear was guided by two principles. The first principle guiding the development of the major themes was the order in which a competency assessment would occur in practice, which also flowed from the order the interview questions were asked. A competency assessment begins with understanding

perspectives/definitions of competency and how a competency assessment would impact the individual; next are the triggers (or reasons) an individual's competency would come into question. Then I discuss the methods and tests used to screen to determine the extent of cognitive impairment and assess the need for formal competency evaluation. Finally the professional role of the social worker is discussed at length, concluding with participants' recommendations for improving the competency assessment process.

The second guiding principle was the theoretical frameworks chosen for this study, the social determinants of health, systems theory and ecological theory. These theories helped to organize the subthemes and explain various aspects of the findings the participants reported. Social determinants of health illuminated how social and economic factors play a major role in the risk of a competency assessment occurring. Systems and ecological theories helped to explain the perspectives and approaches social workers take to their interactions with clients, families, their own employers and the larger community and government.

## **Competency**

### **Legal/Legislative Description**

Since every question posed to the participants was about an aspect of their experiences with competency assessments, the natural starting point of this discussion is an exploration of the concept of competency.

As presented in the literature review: competency is defined as having legal connotations as determined through a clinical process with implications established and governed by legislation and the courts (Kane, 1998; Moberg & Rick, 2008). Decision-making capacity is defined as the ability to understand information relevant to a decision and to appreciate the



consequences of the decision (Moberg & Rick, 2008; Kane, 1998; Marson, 2002; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012; Widera et al, 2011).

All the participants understood the meaning of a competency assessment and what the process entailed. They easily spoke about at least a few competency assessments with which each had been involved. All participants clarified that the concerns they voiced related to the competency process pertaining to the questionable or borderline cases involving individuals seemingly competent enough to still be a part of the assessment discussion. They had fewer comments about patients or clients with obvious severe cognitive impairment.

All participants showed a sound understanding of competency legislation in Manitoba and were aware that only physicians have the legislative authority to assess mental competency, “With competency assessments it’s actually the physician if we have to assess someone for competency” (Mary).

They referred to power of attorney, private committeeship and order of committeeship to the Public Guardian and Trustee as common legal matters in which they had been involved with clients/patients and their families. All participants understood the role of power of attorney and spoke about the different types of power of attorney most commonly encountered, ranging from a family member acting as a private committeeship for a loved one, to an order of committeeship to the Public Guardian and Trustee.

Social work is commonly involved when an individual is found mentally incompetent without having made arrangements for an enduring power of attorney. The social worker advises the family or loved ones about options; the individual’s loved ones can apply for private committeeship and if the individual is in the hospital, the social worker will often assist with

arrangements for the assessments required by the courts. In the absence of anyone willing, able, or appropriate, to care for the individual the social worker can apply for private committee. In all situations, the social worker completes a social history to accompany the Certificate of Mental Incapacity (completed by a licensed physician in Manitoba) and both documents are sent to the chief provincial psychiatrist for review, “Order of committee (is) a legal form that a psychiatrist or physician that is filled out...but it's the social worker who does all the background research and investigation to support that form” (Tara).

The social worker has the lead role in assuming responsibility for facilitating communication and initiating any necessary documentation for the chief provincial psychiatrist until the order of committee is assigned to the Public Guardian and Trustee of Manitoba as the individual's committee. The order of committee to the Public Guardian and Trustee is always appointed for both personal and property matters, and these cannot be separated. “Order committee [has] the right to make all decisions for that person's financial and personal decisions” (Mary).

Sometimes the chief provincial psychiatrist may deny the request for order of committee if the individual is still competent or a loved one objects and takes legal steps towards becoming their private committee.

Two participants had experience attempting to affect policy change at the legislative level. Greg spoke of previous efforts to expand Manitoba's legislation to include partial committees that would recognize individuals who are often not *completely* incompetent:

Partial committee where the person, would not be held responsible for contracting you from financial matters really for executive level functioning, but the day to day if you

want to live in your home, yes, they could make that decision. They could not break the mechanics of how would that happen, but that never really came to pass in the legislation.

### **Defining Competency**

In the literature and as reported by participants, competency is a fluid concept and is heavily defined by the assessor. Competency is relative to who is assessing and why; there is no standard method for assessing competency in decision-making (St. Amant et al., 2012; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). In clinical practice the assessor (physician) determines competency based upon their interview and possibly collateral assessments completed by other professionals (Naik et al, 2013). As Bonnie put it, speaking about a competency assessment she observed of a community psychiatrist: “It was very fluid and unstructured and it just seemed more like a dialogue.” She said assessing a person’s competency is difficult to explain without being there to observe the assessment. Contrary to popular opinion, there are not that many kinds of tests and diagnostic assessments used to determine competency. In fact, Bonnie said, it’s often a conversation between the physician and the individual whose competency is in question.

Gina saw competency as undefined and said she felt there were no clear answers as to who defines competency, “Competency is such a grey area.” Indicating that the lack of definition and consensus made the process more difficult to understand and to communicate to patients and families. Each team member provides advice to families from their own understanding of what competency means which Gina felt only confused matters more.

### **Competency: All or Nothing (The Competency Continuum)**

The literature supports the participants’ claims that in reality competency is rarely all or

nothing, suggesting individuals should be assessed on domain-specific areas, not whether they are globally competent or incompetent (Kane, 1998; Pachet, Newberry, & Erskine, 2007; St. Amant et al., 2012; Horning, Wilkins, Dhanani & Henriques, 2013; Widera, Steenpass, Marson & Sudora, 2011; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). Simply put by Hebert is the following: “It’s not that you’re competent or not...there’s varying degrees of capacity, so we started kind of shifting the language and the thinking to less global competency and more decision specific capacity.” Jessica shares this view, “Because people are not necessarily globally incompetent...they (have) their areas of incompetency.” Both participants further added that when someone is assessed, it should be clearly stated in which area(s) they lack competency and in which they still retain competency. The goal being that they should retain decision-making power in their specific areas of retained competency.

Half of the participants referred to competency as existing on a continuum, feeling that in most situations individuals are not globally incompetent, but rather, that they retain areas of competency or capacity. Hebert used the following analogy to explain his view of competency: “My approach to it has always been...more like a dimmer switch than a light switch.” Other participants also felt strongly that decision-specific capacity should be considered in the competency assessment process, “The physician sees that ‘okay, this person is not competent to make decisions about where they live or their finances anymore’. But they are competent to say what food or medication they want to put in their body” (Bonnie).

Several participants noted that frequently the physician assessing competency does not specify in what area(s) the individual is incompetent and in which area(s) they retain competence. The inability of a competency assessment to recognize an individual’s competency

relative to a continuum was cited as a systemic weakness in the assessment process.

Mary spoke about the need to educate team members that deeming someone incompetent should not remove all their decision-making power: “[She] can still have preferences and choices and you know, make some decisions on her own behalf.” She stated that if assessors explicitly indicated the area(s) someone is incompetent, that would clarify for other healthcare professionals and families which decisions the individual is still capable of making.

Half of the participants were familiar with practice in other provinces such as Alberta and Ontario that have legislation that recognizes decision-specific capacity (Pachet, Newberry, & Erskine, 2007; Moberg & Rick, 2008). Hebert is the only participant who had experience conducting decision-specific capacity assessments because he had experience outside of Manitoba, “I had the opportunity to be part of a decision specific capacity assessment in my frontline practice.” Hebert explained that in such assessments the questions are specific to the decision at hand; he provided the example of someone being able to sell their home:

The capacity assessment asked direct questions about whether he knew he owned a house, realized its worth, knew whether he wanted to sell it, and whether he understood what it meant to sell it. The assessment only asked about the house and only determined his capacity about selling it.

Another participant noted that registered social workers in other provinces, among other professionals (registered occupational therapists, registered nurses, registered psychiatric nurses, and registered psychologists) are legally authorized to complete specialized training and education to become capacity assessors. “I know other provinces seem to have social workers as a part of the actual assessment team in some places and I think that might be something to

explore here in Winnipeg” (Tina). This option of allowing certain professionals to perform capacity assessments was presented as something to consider in Manitoba.

### **Varying Standards of Competency**

Bonnie highlighted assessors’ need to understand the patient’s typical life-long competency levels to accurately analyze changes in an individual’s competencies, “not compare them to some unrealistic standard.” The participants’ definition of decision-making capacity in the context of an individual’s life-long competency was supported by various literature sources. An individual’s capacity should be based upon the ability to understand information relevant to the decision and appreciate the consequences of the decision (Moberg & Rick, 2008; Kane, 1998; Marson, 2002; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012).

Bonnie pointed out that the first goal of the assessment process is to determine the individual’s level of functioning compared to their baseline in order to determine if there had been a change. “Any good assessor...will try to get a sense of what the person’s baseline is in terms of their functional abilities and their cognitive abilities... and not compare them to some unrealistic standard that they never had met” (Bonnie). Once the person’s baseline is determined, the assessment team can set expectations around the levels to which the patient can *realistically* return. As Mary put it, “There are a lot of people surviving in society who are not competent.”

### **Last Resort**

The consensus in the literature suggests competency assessments should be the last resort as the process can be humiliating, demeaning, and the outcome could be life altering (Cattarinach, Gibson, & Cave, 2001). Lorraine, Bonnie and Tina referred to competency assessments as “the last resort”. No one ever wants to go through a competency assessment. Yet,

sometimes a social worker's first contact with a client is during a moment of last resort. Lorraine reported many clients who lived for a long time in dire situations and finally were offered help when they were deemed to be mentally incompetent. "No matter the circumstances, a competency assessment is an invasive process. It is the most intrusive intervention that we can do...hopefully least used," ideally, said Bonnie, an ethical decision-making process is being utilized and consultation occurs prior to the request for a competency assessment. Tina spoke about competency assessments as an important, but, hopefully, rarely necessary procedure, "It's a mechanism that's essential but it should always be last resort and it should be used with an abundance of caution."

The primary purpose of an assessment is the protection of individuals who no longer have the capacity to speak up for themselves. Tina was adamant that a competency assessment should only be pursued if there is a benefit to the individual and the outcome will be life changing.

### **Monumental Outcome for Client**

A competency assessment can have monumental long term consequences for the individual. The greatest consequence is the removal of individual rights and freedoms. "Other disciplines...sometimes, I feel they don't really take seriously what they're asking for when they're making a statement about someone needing a competency assessment" (Tara). Tina spoke about the losses for individuals when deemed mentally incompetent, "It's a big deal to be found incompetent...you're denied your basic rights and someone else is going to take over... who hopefully has your best interest at heart but may or may not."

There are many variations about who may become the substitute decision-maker, it could be a family member or the state. Either way, the patient/client's life will change irrevocably.

“That’s a really major decision to make in someone’s life and, you really have to legitimize it and be sure that this is really the case” (Lorraine). Participant social workers spoke about a range of situations that triggered a mental competency assessment of an older adult.

### **What triggers a mental competency assessment?**

Which leads to the question: What is a *valid* trigger? A trigger is defined as, “anything, as an act or event, that serves as a stimulus and initiates or precipitates a reaction or series of reactions” (dictionary.com). Social workers interviewed used this term to refer to some sort of event that causes someone to question the mental competency of another. “If you’re going to do a competency assessment or capacity assessment on somebody, there needs to be a valid trigger. We’re all assumed to have capacity unless it’s documented otherwise” (Herbert).

In the literature a valid trigger appears to be tied to establishing valid thresholds that should first be met before the assessment of an individual’s mental competency should be considered. Besides meeting a threshold, it is necessary to establish there is some benefit to the patient/client in having the assessment. If no benefit is found for the individual, further discussion and consideration of other options is needed (Fish & Siberfield, 1994; Perkins, 2002). A legal view by Tuokko (2001) found a competency assessment only becomes necessary if it is meaningful to the decision at hand. Tara simply stated: “When competency assessments are coming into question, I always ask myself or ask other people, ‘What’s the purpose of it and/or whose purpose is it serving to have this competency assessment done?’” Tara indicated she has been questioning assessment triggers for years and finds that people often don’t have a valid reason for questioning competency. She echoes the literature in asserting that the purpose should be to benefit the individual in some way, not just the professional or institution.



## **Institutional and Organizational Factors**

A number of factors arose from the data indicating the trigger for a competency assessment appears to be closely linked to institutional and organizational factors. The reason for the request of competency can be seen as a method to facilitate discharge, reduce institutional liability, and provide a healthcare professional legal authority to override an individual's rights to make decisions often based upon the institution's or professional's threshold for risk taking.

**Facilitating discharge.** All of the hospital social workers and participants with long term care access experience said competency assessments are often used as a mechanism to facilitate discharge. "Competency is requested so the hospital can facilitate the discharge plan that they see as appropriate, not necessarily what the client or their family sees appropriate" (Tina). Tina felt the only reason competency assessments are used in hospitals is to facilitate discharge, otherwise, she said, a patient's competency would never be questioned.

Also a hospital social worker, Tara spoke about the hospital system that hurries to assess competency to establish the discharge plan, "There's this rush sometimes to having a person assessed for competency so that a care plan can be developed quickly and smoothly and, you get an end result in terms of a disposition plan." All the hospital social workers said competency assessment is seen as the efficient tool to quickly answer questions about where the patient can be discharged and whether or not the patient has a say.

As Hebert pointed out, rushing towards a discharge plan when patients enter the department may not always be the most appropriate plan or approach: "Particularly if they're presenting with delirium, that's the worst possible time you can do an assessment on somebody, and it's not really a true indication of what the person needs." He spoke further about the need to

slow the assessment process down a bit when people are entering the emergency department in order to determine true baseline functioning of the patient. This would allow fair time for the patient to recover before rushing to a competency assessment and personal care home placement.

**Disagreement with a healthcare professional.** One of the most disturbing findings of the study was brought forward by four participants: competency is often questioned when the patient or their family disagrees with the plan set out by a healthcare professional or the healthcare team. “The worst one I saw was, ‘As long as Mr. Smith agrees with the nursing home placement, he is competent. If he disagrees, then he is not.’ Ah, so like, well, what the heck is this?” (Herbert)

This finding is supported in the literature. Strang, Molloy and Harrison (1998) acknowledged that a way to resolve conflict regarding a disagreement about an individual’s choice to live at risk is to assess their competency. Kane (1998) also pointed out that competency is often not questioned until or unless an individual does not agree with the recommendations put forth by their physician or other healthcare providers. Guzman-Clark, Reinhardt, Wilkins Schantz & Castle (2012) also stated that evaluation of competency is usually when the patient refuses a recommendation for care.

As Tina put it:

When clients’ or their families’, intent for discharge is in conflict with [the] hospital’s... That’s often the point where competency is requested so the hospital can facilitate the discharge plan that they see as appropriate, not necessarily what the client or their family sees appropriate.

Tina was very expressive in her disappointment with the ethics of how competency assessments

are utilized in hospitals. Mary acknowledged that this bias also occurs in long term care, “We assume somebody’s competent when they tend to agree with the decisions that we’re making or that we think they should be making. If they’re making decisions [that] we feel are inappropriate, that’s when sometimes competency is questioned.” She brought this point up a few times, adding that the medical profession is quite powerful and often “strong arms” the outcome it wants, indicating that this shouldn’t occur but it does.

Tara spoke about competency assessments being requested in hospital to deal with difficult or ‘non-compliant’ individuals as a way to force them to be compliant or to be able to sign off responsibility for them.

A physician or a community service (Home Care) is asking for a competency assessment because that person might be difficult to manage in the community or hospital setting and they’re not agreeing with the plan of care...or ‘non-compliant’ is a big term that’s used. This practice is alarming. As previously presented, competency should be based upon the individual’s ability to understand the information in making a decision and appreciate the consequences of the decision. It should not be based solely upon what the healthcare professional believes to be the correct decision or lifestyle choice.

A lot of participants in this study regarded healthcare providers as genuinely concerned about the welfare of others but said, unfortunately, sometimes their care and concern is misguided or inappropriate.

**The relationship between paternalism and risk.** According to the literature paternalism is a form of beneficence in which respect for individual rights to self-determination are overridden by the healthcare professional based upon the desire to protect the vulnerable person

from harm (Cummings & Cockerham, 1997). A formal competency assessment should be sought only if it serves the person's interests and/or if there is imminent risk of harm to that person or others (Fish & Siberfield, 1994). "They don't want people to come to harm so the intent comes from a good place but, it's often not appropriate" (Tina).

Risky behavior is not proof of incompetence (Fish & Siberfield, 1994). The initial task for the practitioner is to determine tolerable versus intolerable risk (Fish & Siberfield, 1994). "And being able to separate between you know, the right to make a bad decision versus imminent harm" (Bonnie). As many participants pointed out, "A mere feeling or intuition that a person is at risk is at best a starting point for risk assessment and it is not a valid ground for challenging the person's competency," (Fish & Siberfield, p. 60, 1994). Competency assessments are only seen as appropriate if some objective evidence of intolerable risks are present when assessing an individual (Fish & Siberfield, 1994).

Most participants alluded to, or out rightly stated, that the behavior of some of the other healthcare professionals they have worked with have been paternalistic. "I'm sure they were acting in her best interest, you know, to protect her, but I know it certainly wasn't what she wanted" (Mary). Judgments can be clouded by the natural desire to protect the weak and vulnerable with the equally natural desire to avoid any personal blame or guilt should the individual actually come to harm (Fish & Siberfield, 1994). Sometimes there is confusion between the desire to avoid guilt or blame without any objective evidence of risk by both healthcare professionals and caregivers (Fish & Siberfield, 1994). "People are often quick to make assumptions...that someone might not be competent...but they don't necessarily have the ability to...back up with good evidence why they're making that statement" (Tara).

If a healthcare professional does not fully disclose all the information or choices available to the individual in order to make an informed choice, this can be labeled as paternalistic behavior (Cummings & Cockerham, 1997). As many participants stated, this concept is dangerous if used with little to no reasoning behind the decisions of the assessor (Kane, 1998).

Tina spoke a great deal about questionable assessments completed by psychiatrists she worked with at a hospital, “I know one particular psychiatrist who, in my 16 years at a hospital, never found someone competent when it was asked, ever. And that defies statistical probability.” A lack of collaboration, which inherently brings checks and balances to the assessment process (assuming the contribution of all team members is similarly weighted), allows paternalism to flourish.

Some professionals see as their duty.... to sort of bubble wrap, or eliminate risks for their clients... use the phrase ‘in my professional opinion,’ which could be very persuasive when you’re listening to it but if you actually examine what it was she was saying, she was just saying, ‘Well, I think you should do this.’ (Tina)

Tina’s story provided a cautionary warning about a professional’s need to work towards objective versus subjective assessments and interactions with patients. This includes being aware of how powerful their opinions can be perceived by the older adult population and their families.

**Reducing institutional liability.** Another major theme in relation to triggers raised by half of the participants is the trend to deem an older adult incompetent so that the patient can be institutionalized and cease being a hospital responsibility. An extreme example of intrusive intervention is placing the patient in a personal care home for reasons of efficiencies. Hospitals understand the paneling process (process of a person accessing admission to a personal care

home). Having the patient declared incompetent and placed in a care home reduces the institutional or professional liability that might arise if the patient were harmed due to risk he or she encountered after being released into the community. If something happens to a patient in a personal care home, no one will hold the hospital or its staff liable.

In this scenario, the personal care home placement is used as a tool of convenience for community agencies and hospitals when they no longer want to support their clients. “(Home Care nurse case coordinator) viewed it as too much work and that this woman should just be paneled and go to nursing home,” Tara admitted that this practice occurs almost daily and said it is something she fights against every time it comes up, as she does not want individuals seen as expendable and easily locked away for the convenience of others. Resourcing of the home care system is a crucial part of this system. If the home care system was more generously supported it would help, as services are carefully rationed on the basis of family availability.

Tina spent a lot of time talking about this issue as well. It is something she also said she encountered frequently during her time working at the hospital. She said, a lot of work has gone into ‘stream-lining’ the process of getting individuals into personal care homes from hospitals. Quite well understood by most hospital staff, the process is efficient and straightforward, with a checklist to follow for the hospital.

A personal care home is very straightforward and it’s kind of easy for hospitals to do it because it’s, A, B, C, D, E, F kind of process. So, it’s easy, so once people get to that kind of, thought in their head I think the system generally kind of likes that ‘cause it’s an easy process to follow, whereas trying to figure out how to reduce the risk (is not). (Tina)

The process of problem-solving beyond discharge, including home care or discharge to a

person's home is more difficult to plan and execute. It's seen as less efficient because it's not easily communicated, and has many variables, including how long it may take to put supports or other housing options in place to mitigate risks. It is much more efficient, by comparison, to send a patient straight to a personal care home, "They all think he belongs in a nursing home. It's like this cookie cutter, he's met these criteria, therefore, it's a nursing home, that's sad" (Greg).

The additional layer is that the hospital has authority and power over the personal care home process and can influence or expedite discharge. Whereas, in the case of other community options, the hospital has no say in the time it takes for approval and timely access to housing and other community supports. A majority of participants cited the need for more creative thinking in discharge planning. If the home care system was more generously supported it would help as 110 cases is a huge caseload and services are carefully rationed based on family availability.

### **Impact of Social Determinants of Health**

Theory highlighting the social determinants of health helps to explain the influence economic, social and cultural factors can have on the reason for initiating a competency assessment and the potential negative consequences of a competency assessment. Factors raised were economic as well as the impact of family and other social systems.

**The money motivator.** The most experienced participant, Greg, said money is the number one trigger for a competency assessment, "What do you do with the money and who's going to manage to pay the bills and where does the authority come from." Money is certainly the biggest motivator for an assessment of competency when it comes to personal care home placement. Personal care homes will not accept an individual until financial arrangements are in place to cover the home's monthly per diem. The individual may be competent but may no

longer have the physical, communicative or learned life skills to manage finances (for example: women whose husbands managed the finances and never involved their wives). The client may have unreliable or no family support willing and/or capable of assisting them to manage their finances.

Without personal competency or a designate to manage an individual's finances, the care home will force the issue of mental competency so that someone assumes responsibility to pay for the personal care home services. Mary cited a personal example of someone for whom she holds enduring power of attorney:

If you say that she can't go home, then she has to be declared incompetent because without that I can't pay the per diem and if I can't pay the per diem no nursing home's going to take her. So we have to have her declared incompetent.

**Request from family.** Families often trigger a competency assessment, usually when a loved one is suddenly in crisis or about to be discharged after a health crisis. Five of the participants spoke about different reasons families request competency assessments. Some experiences could be seen as positive, while others had much more of a negative connotation. Hebert spoke about his work in a personal care home. On several occasions, families pushed their agendas over what the resident (their relative) wanted, "The family is putting pressure...the facility would give into what the family wanted." He struggled ethically with these situations as he saw himself as the resident advocate and felt the family's rights shouldn't outweigh the resident's rights. Tara had encountered a range of reasons why a family asks for a competency assessment.

Family may be asking...they [want to] know how to manage that situation...other people



could be burnt-out or overburdened and want the competency assessment done so that they can step in and make decisions about that person that might be quick and easy to make those decisions and it's more efficient for them.

While families sometimes do have to step in and take over, the ethical dilemma for the social worker resides in how and when it's done, as well as whether the individual's rights and wishes are being honored in the process. Mary pointed out that competency assessments are necessary to establish legal authority to manage someone's affairs in a legitimate way, "I think there's you know definitely a need for competency assessment because you don't want people just taking over, you know, managing somebody's (finances)...without, you know, reasonable grounds to do that." She has seen a lot of informal arrangements and the difficulties families or facilities can face when those legal processes haven't been in place.

Bonnie saw one family request a competency assessment as a means to obtain legal permission to be involved in the patient's healthcare decision-making:

Facilitate informed consent, informed decision making. And it can be to facilitate or empower caregivers to now know when they need to take over for decision-making because they often need permission to do that, right? They need to hear the words.

She used the term empower to describe situations where families are watching someone struggle or make harmful decisions and they need to be empowered so that they can intervene and assist their loved one.

Greg spoke to two major issues. One was about establishing who to listen to when there are multiple family member decision-makers in disagreement. Second, he said, if money was involved there was always more family members motivated to gain control, "Get into difficulty

because family members didn't always agree. If there was no money involved it was much simpler. If there was money involved it became very complicated, because, really, who had the authority.” Both issues can be difficult to problem solve while also trying to include the patient/client in the picture. Legal battles can get ugly at any point, especially when someone legally incompetent is in middle of it, whether it’s a child or a parent.

Working with the family is an important part of the process for social workers. They can provide a great deal of support to the individual in question. The difficult part for the social worker is determining whether or not the family members have the client/patient’s best interest at heart and whether or not the social worker has the authority to intervene if necessary. “That’s the paramount goal, to protect your client whether they’re younger or older...to get them out of that situation, to protect them and put them into a safer situation,” (Lorraine) which is much easier said than done. It’s quite difficult to prove abuse or neglect unless the client/patient admits it. Even then, they must also be willing do something about it legally.

**Greater likelihood of intervention if person is impoverished.** Theory highlighting the social determinants of health helps to explain why all participants spoke about the disadvantaged as vulnerable and often provided with fewer options than the privileged. Social inequities in health refers to the negative impact of inequitable access to health services, helping to explain why certain portions of the Canadian population have higher rates of chronic illness and how this inequity is perpetuated (Raphael, 2004). Six participants referred to wealth as a protection against a competency assessment. Wealth is a protection allowing individuals the means to put arrangements in place to protect their assets. “The thing is that with people usually that have a lot of money, either they or family have arranged well in advance for some orderly management of

those finances” (Mary).

Wealth becomes a protection in older age. Attaining a higher education provides access to better employment opportunities, which allows for access to resources not available to poorer and less highly educated individuals.

If you are better educated or have access to more services and resources because of your financial background... I see that as an inequity that, that someone shouldn't be assessed as incompetent because they haven't had the same opportunities...decent employment or education or...access to, appropriate resources. (Tara)

Wealth affords individuals with access to choices not available to people who have to rely on government-provided services. Not having to rely on and conform to fit government rules afford people with power more ability to do what they want because they can access private services. This changes the rules particularly when it comes to hospital discharges (e.g. supportive housing's high number of beds are expensive making them inaccessible to the majority of the population. Supportive housing is a housing model in Manitoba that offers mild to moderate cognitively impaired individuals 24 hour supervision but the individual must be independent with managing their personal care).

The more vulnerable, I don't know that they are given the same range of choices and options...I don't think that they are as empowered...the more sophisticated family comes to you empowered. They've already had other experiences where they know how to talk, they know what their money will do. The less empowered family have generally not too many ideas about that, so I think they are less empowered, yeah. (Greg)

Wealth is a protection because someone with fewer resources would likely have more trust in a healthcare provider and go along with recommendations as they may believe they have no other choice, in particular if they depend on government-provided services.

If they were wealthier I think they would probably even be more suspicious. They're socially protective of what they have and they don't want people to know about that. I think with people that are less well off or have less resources, I think they're maybe be more open to help. (Lorraine)

Competency is an issue raised in relation to the working class. Tina had a very interesting point that she feels competency is “saved for the working to middle class”. She used the analogy of a doughnut to explain that competency is not bothered with for the extremely wealthy or extremely poor and marginalized. Wealthy individuals can meet their needs through their financial means. As for the poor and marginalized living on the street she felt, no one is generally unhappy to send them back out. She felt the paternalistic ‘bubble wrapping’ is saved for the working to middle class who don’t have the financial means to access private services:

People who are quite wealthy probably would never be assessed because they likely have a strong support system or access to other, avenues of support that they might be able to pay out of pocket for so you don’t have to bother with competency.

Jessica explained what she has seen is people with higher incomes likely having advocates and allowed more lenience and time before their competency would be assessed in comparison to their less wealthy cohorts whose competency is assessed at a much earlier stage:

People who are declared incompetent may be a little too early, some of their rights seemingly may be taken away a bit too early just because they don't have the backup

systems...people with very high, with higher socioeconomic, backgrounds and, better resources...there can be a resistance to, to doing that, that competency.

Wealth may be power. But wealth *and* education make the patient's competency nearly unassailable, "If they're professional, if they've always had money, if they have a higher level of social know how, they are harder to assess for incompetency, and, particularly if they've got university degrees" (Greg).

These findings suggest that the potential of a competency assessment occurring is highly correlated with a patient's personal resources and education, which is an issue of social inequity and injustice. The need to perform a competency assessment should be based upon questions of mental impairment of decision-making, not wealth. An individual should not be assessed as to their competency if the issue is actually about their wealth.

Additionally, if competency assessments are performed less on wealthy individuals because of their resources, then one could wonder how many competency assessments that area being performed could be avoided with the right resources. Clearly, for those with money, plenty of alternatives to competency assessment are available. Therefore, those with limited resources and education should also have access to a greater range of problem solving alternatives before a competency assessment is considered.

**Cultural differences complicate the process.** Research participants and many in the literature argue that any mental competency assessment tool must be culturally sensitive. In order to be culturally sensitive it must: address how an assessor's values, beliefs, and attitudes may obstruct the older adult's ability to respond to assessment questions; take cultural diversity into account and respect how language interferes with understanding; and appreciate how cultural

difference may affect answers and shape acceptance of the assessment and care plan options. All these factors ultimately impact the client's ability to access services and resources (Berkman, 2006). "Standard cognitive testing doesn't accommodate different cultural values and language barriers '...mental health is so different in different cultures and religions...competency assessments... are a Western kind of perspective'" (Gina).

Systems theory also helps to explain the need for multicultural perspectives to testing. Multicultural systems include culture and ethnicity, both seen as crucial influences on the interactional styles among family members and within the culture at large (Hepworth et al., 2009). Systems theory dictates that service providers should not make assumptions about the internal structures of a family based upon crude stereotypes and generalizations and therefore, recommends that social workers shed stereotypes, challenge assumptions and take an open-minded approach (Hepworth et al., 2009).

Language barriers prevent access to timely intervention which results in more expensive services. Under these circumstances health can deteriorate undetected (Nova Scotia Department of Health, 2002). Participants noted language was an issue for some patients, both in terms of understanding English as a second language and having poor English language comprehension due to illiteracy. All participants discussed how culture and ethnicity influence, as well as, complicate assessing competence, "Assessing competency of person with cultural differences... takes more time, takes more arranging" (Lorraine).

Social determinants of health theory helps to explain the immigrant and refugee experience brought forward by a few participants which includes, racism and discrimination, lack of access to appropriate housing and supports, difficulty accessing and lack of knowledge in

navigating the healthcare system, and professionals' lack of knowledge and sensitivity to diverse healthcare needs (Raphael, 2004).

Discussing culture and ethnicity, participants spoke about the importance of noting cultural norms, sensitivity, and awareness, as well as highlighting cultural and ethnic practices. Some participants spoke openly about disparities in client/patient treatment by other healthcare providers. Disparities in this context referred to differences in outcomes for different groups. Disparities created through socioeconomic status, culture, language, and education often determine whether or not an individual is given a fair chance for an objective assessment. Both the tools and the process place the disadvantaged in an unfair position in comparison to an advantaged individual. As Cattarinich, Gibson, & Cave (2001) found, "the administration of the MMSE to the Aboriginal seniors was inappropriate," (p. 1469) and highlighted the need to develop a more culturally appropriate tool. An intervention based upon the wrong premise would fail (Hepworth et al., 2009).

**Ethnic minority cultures have higher tolerance for incompetence.** Ethnic minority cultures in Canada often have different perspectives on what constitutes incompetency in older adults and how the patient/client should be treated.

There's a lot of suspicion and mistrust of healthcare professionals asking too many questions. There's the social worker coming and wanting to do all these assessments in a different language and they're taking their parent...away from them. Competency assessment is difficult enough in one language. (Lorraine)

An added complexity is that people from non-Western cultures with advanced 'mental deficits' may not come to the attention of a healthcare provider until the very late stages (or after death)

because of cultural beliefs that outside intervention is dishonorable.

Two participants referred to ethnic minority cultures as having different views and standards about older people's appearances and actions in comparison 'typical' Canadian perspectives. "People just tolerate (incompetency) because that's the way older people look, that's what they do. So, they wouldn't even complain to you about (it as a) concern" (Greg).

In her work with diverse ethnic and cultural groups, Lorraine has encountered families who use cultural differences as an explanation for how they deal with loved ones' incompetency, "They tend to downplay, they tend to minimize things and use ethnic and cultural reasons as, as those reasons for doing what they do and say" (Lorraine). Individuals using cultural or ethnic reasons for minimizing a potential abusive situation further complicate the competency assessment process for the social worker/assessor investigating the situation. A collective view of the family and the role of the older person may be important to consider. Cultural ideas may involve greater acceptance of incompetency in older people, not referring to it as problematic in the same manner as Western cultures.

### **Methods and Tests**

Just as cultural differences can make assessing competency more challenging, the cognitive assessment tools and methods used by healthcare providers must be culturally appropriate and sensitive when working with multicultural population. Cognitive assessments evaluate important cognitive processes such as memory, concentration, reasoning, and among many other processes. Cognitive assessments are essential in establishing a baseline or reference point as to where the individual is performing cognitively. The results of the cognitive assessment can help focus and guide the healthcare provider(s) treatment and intervention plan,



so the validity and reliability of the results is very imperative. The participants discussed the validity and appropriateness of the commonly used cognitive assessment screening tools used with older adults in Manitoba which are, the MMSE (Mini-Mental Status Exam), MoCA (Montreal Cognitive Assessment) and the biopsychosocial assessment. The participants provide a critique of the MMSE and MoCA when used in isolation. An argument is made for the use of multiple tools, including a discussion around the strength of the biopsychosocial assessment as it draws from ecological and systems theories in evaluating the overall functioning of the individual.

### **MMSE (Mini-Mental Status Exam)**

The MMSE was created in 1975 by Marshal F. Folstein, Susan Folstein, and Paul McHugh (See Appendix J for sample MMSE). The test includes five major areas: orientation, immediate recall, attention and calculation, recall, and language. The test is scored out of 30. A score of 23-30 is considered normal, 19-23 borderline impairment and less than 19 means impaired. According to every participant, the MMSE is a standard cognitive assessment screening tool used in Winnipeg. Half of the participants spoke about the limitations of this type of tool and the need to use additional assessments to inform the larger competency assessment, “I’ve often done an MMSE mini mental status evaluation which gives us an idea of how the person functions. However, it’s not definitive” (Mary).

St. Amant et al. (2012) found that the MMSE does not have a cut-off point to determine capacity; this determination is left to the practitioner’s discretion. Half the participants cautioned that assessors should use multiple tools and recognize that cognitive screening tools are not the be all and end all, “There’s too much emphasis put on the mini-mental...there’s a lot of focus on

the score...and that number can often be the determining factor that takes the care plan in one direction or another” (Tara). Participants agreed, because the outcome of a poor MMSE score can have major implications for the individual’s subsequent assessments and overall view of their capacity and competence. It should not be the sole tool for informing the competency assessment, but rather one of many, “We saw people admitted to long term care basically with... an MMSE done...” (Herbert). Assessors need to dig deeper than just an MMSE, “Isn’t there any other assessment tool that could be used?’ Or, you know, not the MMSE all the time to determine certain (kinds) of things” (Gina).

### **The MoCA (The Montreal Cognitive Assessment)**

The MoCA is another popular screening tool used in Manitoba to assess for cognitive impairment with older adults. It was created by Dr. Ziad Nasreddine in Montreal, Canada in 1996 to assess several cognitive domains. This test includes eight areas: visuospatial/executive, naming, memory, attention, language, abstraction, delayed recall, orientation. It is also scored out of 30. Normal cognitive range is 26-30. One point is added if individual has less than a grade 12 education.

The MoCA has proven to be a much more sensitive screening tool than the MMSE as it assesses several cognitive domains and is superior to the MMSE in detecting mild cognitive impairment (Nasreddine et al., 2005). It also has the ability to assess multiple neurological disorders which the MMSE is not capable of doing (Nasreddine et al., 2005). “I think doing the MoCA ought to be standard. People ought to have both the mini-mental and the MoCA” (Greg).

Empirical findings from the literature are consistent with participants warning that cognitive assessment tools such as the mini-mental status assessment (MMSE) or the Montreal

Cognitive Assessment (MoCA) should only be used as screening tools and to inform the larger assessment. They should not be used as the sole basis for determining whether someone is incompetent (Tuokko, 2001; Pachet, Newberry, & Erskine, 2007; Pachet, Astner, & Brown, 2010; Strang, Molloy, & Harrison, 1998; Guzman-Clark, Reinhardt, Wilkins Schantz & Castle, 2012). As standardized tools are not sufficient to stand on their own, clinical judgments need to be made (Tuokko, 2001; Pachet, Newberry, & Erskine, 2007; Pachet, Astner, & Brown, 2010; Strang, Molloy, & Harrison, 1998).

### **Biopsychosocial Assessment**

Biopsychosocial Assessments are more comprehensive than just cognitive testing, but are not always considered as weighty as cognitive testing. The literature and the study's participants both referred to the social work assessment as a social history or a biopsychosocial assessment.

Multiple authors spoke about the knowledge base social workers use when assessing an individual and the strength of being able to understand the biopsychosocial meanings of disease as well as the individual and the family life course (Landau, 2000; Gray & Zide, 2008; McInnis-Dittrich, 2005; Berkman, 2006). This assessment is comprehensive because it evaluates the physical, social and environmental factors that lead to problems and takes a strengths approach to highlighting what the individual is still capable of doing and how they have dealt with adversity at other times in their life (Newberry & Pachet, 2008; Berkman, 2006).

The assessment also allows the social worker to develop a therapeutic relationship with their patients/clients and better connect them with appropriate resources in order to facilitate discharge or develop appropriate care plans (Landau, 2000; Gray & Zide, 2008). The assessment should guide or inform the social worker in providing an appropriate course of action with the

older adult or their caregiver (Berkman, 2006).

Systems theory helps to explain family systems and interactive patterns of the family as well as transitional challenges throughout the life cycle (Hepworth, Rooney, Dewberry-Rooney, Strom-Gottfried & Larsen, 2009). Changes in the life cycle include changes in roles such as parent-child to child to parent dependency switching (Hepworth et al., 2009).

### **Organizational Contexts**

Systems theory also alerts us to the reality that the assessment process differs for mental competency of older adults depending on the organizational approach and the specific healthcare setting in which it is conducted. Some settings have adopted a collaborative, team approach. Others are more insular, relying on a couple of assessors or even just a single decision-maker. In some settings, assessments follow a standardized process, such as in the case of a community geriatric program, whereas hospital settings do not seem to have implemented a standardized approach to the assessment process.

### **Hospital Settings**

In a hospital setting, a lack of standardization in terms of which team members are involved in an assessment process was reported. The social worker may or may not be consulted. Despite the availability of a multi-disciplinary team which could inform the assessment, the only standardized part of the process is consultation with psychiatry to assess and provide the final competency determination. "I mean, it's very clear that a physician or a psychiatrist have the final say in terms of declaring someone competent" (Tara). Tara's comment speaks to the power hierarchy in the hospital setting. The hospital social workers reported the lowest level of autonomy and authority compared to other settings.

Social workers are kind of caught up in the same system in terms of facilitating discharges and if they are perceived to be slowing down at discharge they won't be well liked in that system and then it becomes a hard place to work. So then you'll see a lot of burnout. (Tina)

Even though social workers do not have the "final say" they do contribute to the assessment process. All hospital social workers reported feeling they have an integral role in patient care. Their primary role with competency assessments are obtaining and providing collateral and social history information to the team and physician. All hospital social workers felt they could play a leading or facilitative role with competency assessments instead of a supporting role or just providing collateral information.

### **Home Care**

In home care, the case coordinator is removed from the assessment and decision-making process. The case coordinator either makes a referral to the Geriatric Mental Health Team or the Geriatric Program Assessment Team to assess the client's mental competency. If the main question is mental competency, then the case coordinator can only refer the family to the client's general practitioner (GP) and request that the GP refer the client to St. Boniface hospital Geriatric Psychiatry. The case coordinator is often not consulted in relation to the competency assessment.

The home care case coordinator in this study reported higher levels of autonomy and authority than the hospital social workers. As home care case coordinators maintain much more of a case management role they have more autonomy and authority with patient care as they are the drivers and developers of the care plan.

We as coordinators facilitate a decision making process. We facilitate clients and families receiving informed consent before they make that decision...we're often not privy to the actual assessment. We request it and that you know...And you certainly don't get to witness it or be part of it (which used to be an option). (Bonnie)

Case coordinators work with external partners to problem solve certain issues such as competency, however there can be issues of communication breakdown and disconnection such as questions about when the assessment will occur and who is doing the assessing. The participant recommended increased collaboration and access to the psychiatrist performing the competency assessment.

#### **Geriatric Program Assessment Team (GPAT) or Geriatric Mental Health Team (GMHT)**

Social workers employed on a Geriatric Program Assessment Team (GPAT) or Geriatric Mental Health Team (GMHT) work directly with a geriatrician on all issues including mental competency. They are trained to complete cognitive assessments such as a Mini-mental status examination (MMSE) and/or Montreal cognitive assessment MoCA and provide the collateral information to the geriatrician who makes the final determination. The geriatric clinician reported a high level of job satisfaction due to high levels of autonomy and collaboration with team members and defined roles. This participant had no recommendations for change with how the competency assessment process works with the GMHT and GPAT.

I think if I worked in isolation like in child and family services I would probably be more stressed than ever, but in situations that I encounter with the type of support I get from my team and from my program and from my management, I don't really see any kind of

recommendations that I can really make at this point. We have a policy that we developed for competency assessments that we follow from, from one to ten. (Lorraine)

### **Personal care home**

Personal care home social workers initiate the assessment or reassessment process to the attending physician or GMHT geriatric psychiatrist. The social worker usually then completes the cognitive assessments and provides the collateral information to the physician or geriatrician.

The director of care talked to me about taking over [completing all cognitive assessments] so there was a little bit better consistency. We were changing OTs quite frequently...so she wanted that consistency of one person doing the testing with the residents and the timeliness of things. (Jessica)

The social worker in a personal care home often occupies the administrative role and therefore has a high level of authority and autonomy. The personal care home social workers had few recommendations for change as they saw the competency assessment process as straightforward; their main recommendation was for increased collaboration amongst team members and recognition of the power physicians have when it comes to competency assessments.

### **Well-Functioning Approaches to Competency Assessments**

Only Lorraine and Hebert shared experiences about well-functioning approaches to competency.

Lorraine has direct access to a geriatrician and a structured process:

A ten step protocol that we follow and it's clear, it's concise, it's very simple, and if ever there is a situation where we're having some issues or ethical dilemmas or even some pragmatic problems in, in how getting that assessment done, we have backups.

According to Lorraine, the community geriatric program approach works well. She did not have any recommendations for change. Hebert also spoke to the team approach as the ideal method when assessing competency, as he's experienced a more collaborative approach in out-of-province healthcare settings:

I think it's very much, it has to be a collaborative effort. It doesn't really make sense for one discipline to kind of take it on, just that we provide interdisciplinary care. We need the team to kind of inform the capacity assessment.

He also brought up the collaborative care project the WRHA (Winnipeg Regional Health Authority) is working on and he indicated he hopes it's a platform to showcase the role that everybody contributes to the assessment of patients and clients.

Parker-Oliver and Peck's (2006) study explored interdisciplinary team experiences of hospice social workers and found that the participants saw collaboration as good communication, mutual trust and respect, role appreciation, as well as administrative interest and support. Challenges to collaboration included large caseloads, focus on the medical model, limited visits and personality and team conflict (Parker-Oliver & Peck, 2006).

### **Team Dysfunction**

Participants cited serious dysfunction in assessment approaches occurring in all settings except the previously described geriatric program. From hospital settings, to personal care homes and home care, participants reported the competency assessment process as not as collaborative as it could, or should, be. Naik et al. (2013) stated that interdisciplinary dialogue and collaboration are critical to addressing issues with vulnerable adults.

The lack of collaboration was the biggest issue in the community for home care case



coordinators. Changes to the assessment process have amplified/introduced involvement of the geriatric program which has displaced the social worker from the process. As a home care case coordinator, Bonnie said, the coordinator is now far removed from the assessment and decision-making process, “Now, you get a couple of lines on a referral form and that’s your thesis.” Previously, case coordinators got one-on-one time with the team psychiatrist to assess and discuss their client’s competency. Social workers also got immediate feedback from the team’s solitary decision-maker, a person who is now largely inaccessible. Bonnie felt the change in process has been a major loss for new case coordinators and recommended a return to a more collaborative approach.

In the hospital, Gina felt the process was disorganized and leaderless, which led her to question the whole process, “Who was really the expert in competency assessment? Is it the team approach or is it a psychiatrist’s opinion?” Gina felt the assessment process should be more of a holistic team approach, not just one person coming into the situation and making the decision.

Greg has seen the competency assessment process in every healthcare setting. Overall, he felt the community geriatric program has a more effective approach than a hospital setting. In community geriatrics, there is more time spent investigating the issues and better appreciation of the consequences, “Should it be a team approach? Absolutely” (Greg). He didn’t think anyone needed to occupy a specific role, but that the issue of competency should be looked at from a multi-disciplinary perspective, an opinion shared by Hebert, “This whole idea of capacity assessment doesn’t really belong to one discipline alone. It needs to have input from everybody.”

Mary acknowledged that a collaborative approach and consensus, rather than one opinion, may be a better approach to competency assessments, “I don’t know if it is always

physicians that are the best people to assess that, maybe, maybe not. I like to see assessments be more of a team, a team consensus.” A collaborative approach is safer and more ethical for the patient/client and the professionals conducting the assessment.

Generally, if you were following a line of thought that seems to be supported by at least a few other professionals that you respect, then chances are you’re...heading in the right direction. And so, I think that that’s a huge safety check that we have to do as professionals that (is) ethical decision-making. (Bonnie)

### **Professional Role of the Social Worker**

The Canadian Social Work Code of Ethics (CASW, 2005) states that social workers are committed to upholding human rights, and supporting the needs and promotion of self-empowerment of discriminated, oppressed and vulnerable individuals and groups.

Most participants referenced the above code of ethics as guiding their practice, professional behavior and decision-making. As well, most of the social workers’ discussion was framed around their commitment to human rights, and the needs of the discriminated, oppressed and vulnerable individuals and groups.

Systems theory helps to explain the role and function of the social worker. At the micro level the social worker assesses and interacts with patients/clients and their families. Social workers provide support or referral to community resources to meet the needs of their clientele. Lastly, social workers often work on interdisciplinary teams.

At the macro level, social workers advocate for equality and fair access to services in order to meet basic needs at the community and government level. Social workers research and develop programs to satisfy the unmet needs of their communities. Social workers are involved

with developing policies to address community, national and international social problems.

### **Advocacy Roles**

At the micro and macro level, the social work profession is dedicated to the rights of the individual and the promotion of self-determination and autonomy. Self-determination is the motivation behind the choices that people make without any external influence or interference. It focuses on the degree to which an individual's behavior is self-motivated and self-determined (Deci & Ryan, 2002).

In relation to self-determination, autonomy is seen as one of three innate needs that we as humans need in order to fully function and grow (Deci & Ryan, 2002). Autonomy is seen as freedom of choice and one's sense of independent action. In this study, participants referred to their role as advocate. They presented themselves as the voice of their clients'/patients' civil rights and freedoms. Autonomy is also a western concept that does not fit with collective cultural beliefs. Individual autonomy may be subjugated to family goals and values.

Hebert's story came from a place of advocacy and his desire to question things when he didn't feel right about the situation, "Very much advocating because I had seen a lot of people just kind of, you know, pushed through the system or decisions made on their behalf." He also talked about being the unpopular voice at the table sometimes because of his role as the client advocate. Tara also spoke about advocacy as an important function of social workers, "An advocacy role in ensuring that a person's rights and freedoms are being, valued and, and not placed to the side in terms of convenience or efficiencies." Being an advocate to uphold her clients' rights and freedom is a commitment Tara says she takes very seriously. She said, she would not be bullied by other professionals to forfeit her morals and ethics in this area.

## **Protecting Clients' Rights**

Participants spoke about protecting their clients' rights and autonomy from intrusive interventions, as well as, their professional duty to shield clients from mistreatment, abuse and poor conditions. All professionals are treading a line between overly intrusive intervention, which unnecessarily removes people's rights and choices, while at the same time, not overlooking a situation that leaves the individual vulnerable to abuse or mistreatment (Perkins, 2002).

Crisis intervention is a big part of Lorraine's job, so she spoke a great deal about the need to balance protection of individual rights with the duty to intervene when necessary, "You want to maintain their self-determination...their sense of self and their safety...as social workers, we have a responsibility to our clients to protect them in that regard." Bonnie echoed Lorraine's sentiments, adding that sometimes an intrusive intervention is the only way to protect the client from harm (including from themselves). However, intervening to force someone to look after themselves should be the least used intervention. Other options need to be considered first, "Competency is needed for protection and, sometimes in the most intrusive and hopefully least used example is to you know force somebody to take better care of themselves than they have been" (Bonnie).

The danger, noted several participants, can come in the form of over-protection. Sometimes even the kindest motivation can be misguided and is a violation of a client's or patient's wishes and undermines quality of life as defined by the patient/client. Mary said some healthcare professionals act in sincerity, but fail to consider the individual's needs and desires, "It was done with all best intentions you know to protect them, to look after them, to keep them

together, and so on, but that's not what they wanted." The participants identified, as did Cummings & Cockerham (1997) that the social work role in these borderline situations of potential risk to the patient is to ensure individual values and rights are not compromised in order to protect the patient from perceived harm.

### **Informing Clients**

Part of the social work role as advocate and protector is to help inform the client/patient of their own assessment situation. All healthcare professionals should be taking the time to explain what a competency assessment is and the consequences prior to its commencement (Perkins, 2002). The patient/client should be informed as much as possible to provide them with the opportunity to decline participating until they have all the information (Perkins, 2002). Hebert referenced the common term used in healthcare assessment: 'lacks insight,' and questioned the social worker's responsibility to inform, "How much effort have we made in giving them insight? Have we actually taken the time to explain this (process) to somebody in terms that they will understand so they're actually making an informed decision?"

### **Holistic Ecological Perspective**

Social workers provide a holistic perspective of the person through biopsychosocial assessments, as well as their understanding of theories and principles that help explain human behavior (McInnis-Dittrich, 2005), including the social conditions and inequities that shape individuals and societies. This ecological perspective helps explain complex transactions between individuals, and their physical and social environments (Bronfenbrenner, 1994). Tina sees social workers as big picture thinkers 'seeing the forest for the trees' expanding further, "We don't come at things just from a...functional perspective or physio, just the mobility

perspective or nursing, just the medical perspective. We kind of take that all into account.”

Ecological knowledge informs the larger assessment and intervention (if necessary) by working toward congruency with the client/patient’s unique social situation. By understanding their unique social situations and relationships with their support systems and environment, the appropriateness of the intervention and plan is more likely to meet the clients’ needs versus the professionals’ needs.

Social workers come at their assessments from a holistic perspective and are able to take all aspects of an individual’s life and functioning into account when writing assessments and developing care plans. “And beyond the competency assessments, we also are also looking at an entirely holistic assessment of their functional and cognitive needs, as well as their emotionals” (Lorraine). She added ‘their emotionals’ to signify that you cannot just take into account the functional, cognitive and medical needs, you also need to consider emotional needs and the tremendous effect emotions can have on function and cognition. Hebert noted the different perspective social brings to the client/patient assessment, “Social work often does, coming at it from a strengths perspective to look at, you know, instead of focusing on the pathology and the diagnosis” (Hebert).

Tara says she connects a client’s biopsychosocial information with their history, in terms of how they’ve interacted with their families, and with society at large. She described herself as the one professional on the healthcare team that represents the individual fully, “We case manage, we provide the psycho-social background that might provide the groundwork or foundation for that person’s life and their existence.” Unfortunately this type of approach can be met with resistance from institutions such as hospital settings because the hospital system tends

only to consider a patient's medical issues and relies on a pre-set expected length of stay determined at the patient's emergency registration. The length of stay is based solely on the patient's medical concerns.

Because social workers take a long view regarding patient care (rather than the shortest path and least amount of work to address client/patient issues), they often run counter to institutional momentum for brisk patient flow-through. Social workers working within highly restrictive environments reported greater issues with stress and tension due to managing or balancing their role and simultaneously protecting the individual's autonomy and rights (Gray, 2010; Landau, 2000; Gregorian, 2005). All of the hospital social workers in this study concurred with these findings.

The social worker in a hospital is given limited amount of time to address complex social issues. Often the social worker has barely scratched the surface before being pressed by the healthcare team into providing a band aid solution to get the patient discharged within the expected length of stay. Any delay to the timeline and the social worker risks major backlash from administrators. "There's been times when I agree (with an assessment)... and there is absolutely been times when I don't agree...but I don't have a voice or any position to do anything about it" (Tina). The majority of participants registered frustration with the social worker's lack of authority. Landau (2000) found that ethical decision-making is an interdisciplinary process, but felt that, "social workers rarely make the final decision," (p. 81) a view supported by participants in this study.

Greg said, social workers should lead discharge planning, as they do in some settings, because of their abilities to pull all of the information together and use their knowledge of

resources and supports to develop care plans that respect the individual. All of the hospital social workers referred to the need for strong managerial support in order for frontline social workers to ever gain any authority in their workplace, “Without really, really strong social work managerial support (greater authority for social workers) won’t happen” (Tina).

Part of the difficulty may lie in the holistic nature of the social worker’s role. Because a social worker’s scope is so wide, they, and their social work administrators, can struggle with articulating what social workers can offer and how it can contribute to patient care, so the function often goes underutilized (Gregorian, 2005). Additionally, because the scope is so wide, social workers often find themselves dealing with things that are not necessarily an appropriate use of their skills, but done in an effort to maintain funding and look like team players. This can leave social workers’ time monopolized by remedial or inappropriate tasks and result in their being kept away from contributing to care planning. “They’ve (hospital social workers) allowed themselves to become busy, in doing some work that they just don’t need to do, somebody else on the team can pick it up or maybe it’s not even necessary” (Greg). Greg stressed that he was not condemning hospital social workers but felt they could contribute more meaningfully to the care plan and spend more time with families, if they spent less energy on tasks that don’t add value to the patient and their families.

Spending time on actions that don’t add value, contributes to a social worker’s overall feelings of not *feeling* valued. The lack of value and respect for the social worker’s expertise and ability to meaningfully contribute to patient care can, in turn, lead to burnout if the social worker’s only option is to go along with plans set in motion by other professionals, “Often we kind of lose the magic that social workers can provide” (Tina). While sometimes going along



with a plan is perfectly legitimate, Tina said she did not feel she had authority to influence changing the plan's outcome, "It's kind of like a speeding train on the rails, once it kind of is heading in that direction, it's almost impossible to stop." Again she brought up the need to allow for creativity and collaboration with care planning, with equal input from all team members.

### **Recommendations for Change**

One of the final questions posed to the participants was their recommendations for change in social work practice or in healthcare systems that would help social workers involved in competency assessments. All participants were able to provide recommendations for change. Three major themes emerged; further education and training, pre-planning and early intervention, and expansion of the social work role.

#### **Further Education and Training**

The focus of further education and training was broken down into three groups: social workers, healthcare professionals including physicians, and the general public.

**Further training for social workers.** Five participants indicated that there needs to be dedicated education and training on competency and capacity assessment for social workers, "I think there needs to be, very deliberate and focused training for social workers" (Hebert). Four participants felt the education and training should be offered at the BSW level. Mary felt BSW graduates only come out with skills learned in their placements, therefore their scope of practice and knowledge may be limited, and "I don't think social workers are that particularly well equipped when they graduate to work anywhere other than maybe where they had a field placement." Both Tara and Greg presented the need for education for social workers at the BSW level as they feel the concept of competency and the ability to assess someone's capabilities

should be seen as universal skills social workers should have when they complete the BSW degree.

There has to be training in...the BSW level in terms of theory and clinical experience...it should be part of ongoing training and education...working in any setting whether it's a community or a hospital setting where social work is going to be asked to participate and forming an opinion regarding somebody's abilities. (Tara)

You have to know whether you're talking to somebody who's cognitively intact or not...there's some core concepts that need to be taught...it's a core competency...because it's dangerous...to really not know whether somebody is competent or not when you are dealing with them around certain life issues...competency is a universal concept. (Greg)

Bonnie also felt social workers should receive more education and training at the BSW level and in their workplace:

This is something that all social workers should know about, right? I think that's a real, missed opportunity on the part of the faculty...not just the faculty did a little bit more in terms of competency assessment education but certainly each field employment.

Bonnie also suggested instructional videos to demonstrate competency assessments as a teaching tool.

**Further education for all healthcare professionals including physicians.** Mary felt there needs to be education for healthcare professionals to inform them that competency is not an all or nothing concept.

I would like to increase the education of people in the healthcare system...any of the disciplines but the people (patients) who are considered to be incompetent are not

necessarily globally incompetent. They may not be able to do certain things and may be not competent to manage their financial affairs but they may be competent to, you know, give direction in other areas of their life.

Jessica felt further education and training is needed to improve consistency across the province.

I think that because there isn't that formal training and that, that there's probably a great deal of inconsistency, and there needs to be more consistency in how competency is seen more formal training for people in, in doing it...general practitioners, family doctors, are not very good at this.

Tara also spoke about the need for more training for all healthcare professionals to improve consistency in approach across all healthcare settings, "I don't think there's consistency across the healthcare system in terms of the hospital setting or even in the community settings as to who actually is the best trained to do some of these cognitive competencies."

Lorraine pointed her recommendations towards physicians as she feels there needs to be more training in competency assessments:

Presently, we don't have enough of those types of physicians and doctors available to us to do those types of timely assessment...so we're bringing people in for competency assessments into emergency. That's not necessarily the best area to do that.

Lack of trained professionals to perform competency assessments or identify the need for a competency assessments, is placing a strain on other resources because competency assessments are occurring mainly when things become a crisis.

**Further education is needed for the general public.** The general public would benefit from further education about competency and capacity. Three participants brought forward

multiple reasons why educating the general public would benefit the collective.

Hebert focused on the importance of education around pre-planning, early detection and available resources in order to identify and deal with competency issues:

We're not gonna educate or empower everybody in the public to kind of look out for people's best interests 'cause that ain't gonna happen', but there's institutions, you know, like the legal system, like the banking system, like major corporations or whatever that, you know, have the potential to kind of watch out for that and to kind of safeguard that kind of stuff.

This speaks to the need for the general public including professionals and corporations such as banks, to be aware of red flags and resources to turn to when issues with competency are suspected. Lorraine pointed to the lack of knowledge about competency and available resources:

We need to put a lot of attention towards our elderly now as well, and I think we take it for granted that our elderly have, have been here for many years and they should know how to access things but they don't...they think the resources are being addressed only when the need finally comes up that, it's a crisis almost for people that are seeking that type of help.

### **Pre-Planning and Early Interventions**

Pre-planning and early interventions refers to older adults and their families taking a proactive approach to dealing with legal, financial, medical and housing needs before a crisis occurs. The benefits of pre-planning and early interventions tie into the need for further education and training. There is a need for people in the general public to think about their

futures and consider planning for the possibility that they may not be able to manage their affairs or make decisions about their care.

Two participants spoke about legal pre-planning and advanced care planning: “As early as possible in the process people are really encouraged to do that advanced care planning. You know, I think everybody should have a will, an enduring power of attorney, and a healthcare directive” (Hebert) and, “because you see lots of people come in who haven't done a power of attorney, haven't done those things, and they can no longer do it” (Jessica). Both spoke about the consequences when pre-planning is not completed as the aftermath can be negative for both the individual and their loved ones.

The other recommendation related more generally to the need for early interventions. “I think in terms of resources, education, [and] the ability to provide timely interventions” (Lorraine). Timely interventions would help reduce the stress on limited resources and address issues as they arise, not waiting for a crisis to occur.

### **Expansion of the Social Work Role with Competency Assessments**

The third major subtheme within recommendations is something that half of the participants addressed: expanding the hospital social worker's role to include taking the lead with families, discharge planning and a greater role in competency assessments. “I think we should definitely be more involved in competency assessments” (Gina). The holistic perspective of social workers should place them as lead discharge and care planners.

I think we should be kind of drivers of care plans and not just facilitators of care plans that other people have come up with...we don't come at things just from a, you know, functional perspective or physio, just the mobility perspective or nursing, just the medical

perspective. We kind of take that all into account so I kind of think we should be the lead when it comes to some of the care planning. (Tina)

Tina felt that social workers should be given more recognition for their contributions to patient care planning. Greg brought forward what he saw as the missing link in the social work role in hospitals, being an advocate and educator for families and their inter-professional team.

I think that social work could expand their role...work on the advocacy role...on the educational role...I think their focus really ought to be more on the team and the family...because I don't know who else can do that function on the unit, so I think that would be helpful around the competency issues.

Greg felt that during the initial assessment process the social work focus can be on the family, not the patient because the rest of the team is primarily concerned with assessing the patient. A large part of the social work perspective involves the family.

Tara felt that social workers already assume the role with organizing and pulling together assessments for discharge planning:

Providing the evidence to why you're saying that someone is incompetent, but those individuals (referring to physicians and allied health in hospital) really need to draw on the assessment from other team members in terms of formulating and making their decision...social work does and should assume a key role in, having a little bit more authority or training in terms of being able to...have a strong role in those assessments.

She is saying that social workers just need to be given the authority and further training to assume a role they already occupy in hospitals.

Hebert felt that other professionals do not see that it is within social work's scope of practice to assess competency of their patients/clients.

You know, that's not seen as the social worker's role (assessing competency). That's the nurse's role, so kind of, you know, adding a bit of credence to social work's role to actually be able to if not take the lead at least participate in the process, so kind of having that recognition that we do have that expertise... (as) social workers, we're constantly assessing. (Hebert)

However he argues that it is within social work's purview because we are already educated, trained and involved in assessing the capacity and capabilities of our clients. He further argues that social work should be given the recognition and permission to be involved in the competency assessment process.

### **Summary of Results**

This study has revealed several key concerns. First, participants expressed unanimous concern about various aspects of the competency assessment process in healthcare settings in Winnipeg. While social workers have had many positive experiences in different settings, they all variously questioned the motivation behind what triggers an assessment, the means and methods used to determine competency, inequitable treatment of the patient throughout the assessment depending on their cultural or socioeconomic background and the under-valued role a social worker often plays on the assessment team.

Second, participants revealed how, with greater reliance on the social worker's holistic perspective, creative problem-solving abilities and capabilities, client centered planning could occur and competency assessments could be avoided. Part of the discussion about centered-care

planning in relation to assessing capacity or competency was the call for decision-specific capacity assessments, determining capacity in specific areas of decision-making.

Lastly, the participants supported collaborative team approaches to assessing competency. The current legislation places all authority on physicians to determine competency. The participants referred to this current practice as a huge missed opportunity to involve multi-disciplinary teams which could be available to inform the evaluation and assessment rather than placing the responsibility and outcome on one professional. Additionally, involving multiple professionals allows for identifying and providing interventions that may avoid the need for the formal competency assessment.



## Chapter Seven: Conclusions

The goal of this analysis was to answer the original research question: what are social workers' experiences with competency assessments with older adults in a healthcare setting. This chapter provides the conclusions and implications of this study.

This study shared the professional stories of nine social workers. Their stories add to the research known about social workers in health, those working with older adults and their experiences with competency assessments. Although the findings from this study are very tentative and must be verified through further research, they do raise interesting questions and imply that there are still many areas of research unexplored on this topic. This research has great implications for social work practice. The findings from this study present many areas of strength and weakness in our current practices and approaches to competency assessment in a variety of healthcare settings in Winnipeg.

I chose this topic because I feel passionate about working with older adults and my experiences in various healthcare settings have raised a lot of questions. I was curious to hear from other social workers about their experiences in healthcare settings to see whether my concerns were unique to the institutions I've worked at or if the issues were wide spread and well known. I also wanted to provide a platform for the social work voice to be heard as it is often silent. This may be because social work positions are not often held in high regard and the social worker is often more concerned about advocating for their clients than for their own needs. Nine participants graciously donated their time to discuss this topic and shared interesting, critical perspectives of their roles, their profession, how the healthcare system works and how it's

deficient in many ways. Further studies would also offer the opportunity to explore other dimensions of this topic not captured within this study.

### **Original Research Question and Objectives**

The purpose of this research was to better understand the lived experiences of social workers in Winnipeg who have worked in a healthcare setting and who have been involved in competency assessments with older adults. My original research question was: What are social workers' experiences with competency assessments with older adults in healthcare settings? I chose a narrative analysis because it allowed for rich descriptions of their experiences in their own words. Narrative allows for the unique story of the individual to be told as well as allowing for connections to be made about the collective stories of all participants. The participant accounts provided a rich in-depth description of their experiences and the narrative approach to interviewing and data analysis was an appropriate method as it allowed the participants to share their accounts in the way in which they felt most comfortable. They retold their stories through recounting their professional experiences and/or case examples, in order to share and describe their involvement and process with competency assessments. It also allowed for the participants to share their reflections of the impact that the cases have had on their perspectives and interactions with patients, families and other healthcare professionals.

Objectives of the study were the following:

- 1) to obtain a better understanding of social work practice in healthcare with older adults;
- 2) to learn about what it is like to be involved in assessing the mental competency of older adults;
- 3) to learn about changes recommended by social workers practicing in this area.

I also wanted to find out;

- a) what issues social workers are facing in the field;
- b) how social workers feel about their role in healthcare settings;
- c) what training/preparation may be necessary to prepare social workers to deal with competency assessments with older adults;
- d) what (if any) processes are followed in assessing competency;
- e) what (if any) are the differences in how competency assessments are handled;
- f) how prevalent is the issue of assessing competency across different healthcare settings.

I believe that these objectives were met as described in the previous chapters.

### **Limitations of this Study**

Even though recruitment was not an issue there are limitations that must be discussed about the recruitment process. The initial recruitment plan was to approach only hospitals but due to multiple obstacles recruiting participants from healthcare institutions, the thesis committee recommended approaching social workers through the Manitoba Institute of Registered Social Workers (MIRSW) and the University Of Manitoba Faculty Of Social Work Alumni. This recruitment strategy was successful, however, this approach may have excluded a portion of social workers who are not registered with MIRSW, as registration has only become mandatory for newly hired social workers in the past 10 years. It also excluded social workers who did not attend the University of Manitoba for their BSW or MSW education and those who did complete their studies at the University of Manitoba, but have not updated their information with alumni services and therefore may not have received the email.

The strength of recruiting participants from a range of settings provided a rich mix of experience from multiple healthcare settings. Recruiting through MIRS, rather than through their place of employment, provided an easier method for the researcher to ensure confidentiality to those who decided to participate. Initially, I thought having a very experienced participant pool was only a strength for the resulting data set. However that excluded the voices of the less experienced and younger generation of social workers. The majority of the participants were very experienced; four were at mid-career with more than a decade of experience (13 to 25 years of experience), four with over 30 years and one participant did represent the younger generation with 6 years' of experience, including only one year in a hospital setting. The interest from the more experienced social workers in healthcare suggests possibly more practice examples or confidence to speak about this complicated area of practice, as a majority of the other 55 individuals who expressed interest were also very experienced with over ten years of experience in healthcare. Future studies could benefit from including a more generous mix of inexperienced and experienced voices of social workers in healthcare in order to compare and evaluate if there was a difference in perspective or approach to this topic.

Another limitation is that this is a retrospective study, participants were asked to recall events and experiences from the past; memories can be influenced by a multitude of factors. Also, since the researcher asked five specific questions and probed at times, this may have influenced the way the participants presented and told their stories.

### **Recommendations and Implications**

Section seven encapsulates my recommendations and discusses the implications and opportunities based on the study findings.

## **Recommendations for the Competency Assessment Process**

**1) Greater consideration given to alternatives to formal assessment.** Many examples were provided by the participants in this study about ways they have solved problems to avoid formal competency assessments. There needs to be greater recognition of alternatives to competency assessments and more consideration of harm reduction principles as part of the problem-solving process. The intervention chosen by the professional should be the least restrictive option in relation to the individual's autonomy (Kane, 1998).

**2) Be more creative and solutions-oriented when assessing capabilities of person.** Even within our current laws and legislation, there are opportunities for creative, solution-oriented care planning. But in order to involve the entire team in the decision-making process, legislative and clinical changes need to occur. This would mean giving allied health professionals more authority to assess and make recommendations for care planning. As presented in the literature review and findings, other provinces (such as Alberta) have included all allied health professionals in legislation giving them the authority and training to assess capacity. This recognizes that many professionals, not only physicians, are educated and capable of assessing individuals' capabilities and capacities.

**3) Patient-centered discharge planning needed.** In the WRHA mission, vision, values and strategic directions for 2011-2016, the first strategic direction is 'Enhance Patient Experience' (Winnipeg Regional Health Authority, 2011). The WRHA defines this directive as follows: "Enhance patient experience and outcomes by listening more carefully to patients and considering their needs when designing and delivering services" (Winnipeg Regional Health Authority, 2011).

The identification of patient-centered care speaks to the understanding that patients want guidance and unbiased information about the available options in order to make informed decisions about their care. The earlier patients/families are included in their care planning, the earlier appropriate resources can be identified and the greater the cost savings for the healthcare system.

**4) More collaborative process – ultimate decision-maker needs to be accessible.**

Legislation should be revised to include a more collaborative approach to competency assessments, giving the decision to more than one profession. The weakness of the current process in Manitoba, as pointed out by all participants, is that the final decision always rests with the physician. The physician sometimes has spent the least amount of time with the client/patient to get to know them and may or may not take into consideration the assessments completed by other professionals.

Often times, especially in a hospital setting, social work may not even be part of the assessment process. Psychiatry is often the only team member guaranteed involvement in the assessment process. This appears to be a missed opportunity, especially when there is a multi-disciplinary team available who could help inform the larger assessment. Rather than relying on one individual to make the final decision, a collaborative approach would provide greater assurance that the assessment results are as objective as possible. As stated by Lichtenberg (2010), a coordinated, collaborative team approach leads to better outcomes and should be the standard approach to geriatric assessments and care.

Since we are operating under current legislation and practice policies, there should be consideration given to standard practice including each team member having direct

communication with the ultimate decision-maker (physician). The WRHA is working on a collaborative care project which may be an avenue to explore how competency assessments can be a more collaborative effort than the current more insular approach (Winnipeg Regional Health Authority, 2011).

**5) Assessment should be the last resort.** A competency assessment should be the last resort and only pursued if there is some benefit to the individual. Of course, sometimes it is necessary, such as when there is risk of imminent harm to the individual or others around them, and when they are no longer able to speak for themselves or recognize the danger they are in. “It’s a mechanism that’s essential but it should always be last resort and it should be used with an abundance of caution” (Tina).

There are multiple assessments and interventions that should be explored prior to deeming someone mentally incompetent and removing their rights. There are instances where deeming someone incompetent puts them at greater risk of being taken advantage of because they no longer have legal authority over their own affairs.

If a competency assessment is warranted, there should be a reassessment process in place to revisit and review a patient’s competency to ensure the initial assessment remains true to their evolving capacity. Sometimes an individual’s impairment eases after having time to convalesce and may regain global competency or partial capacity to make some decisions about their lives.

**6) What is a *valid trigger*?** The identification and lack of consensus regarding what constitutes a valid trigger appears to need more discussion and education in Manitoba. A dialogue around what constitutes a valid trigger and what prompts a healthcare provider to consider initiating a formal competency assessment, appears to be a good starting point for

physicians and team members as an opportunity to openly discuss the specific issue and discuss possible alternatives to a competency assessment.

### **Implications for the Role of Social Workers**

**1) Greater reliance on social work as an under-utilized resource.** Greater reliance and use of social work resources would reduce the need for more costly assessments and resources. Social workers have expertise that could help inform the larger competency assessment, “If we’re used to our capacity for creative thinking and creative care planning...there wouldn’t need to be competency assessments” (Tina). Social workers are creative thinkers and should be recognized for the unique skills and perspectives they bring to patient/client care in all healthcare settings. Some settings in healthcare have given social workers more authority as team leaders for care and discharge planning.

**2) Social worker should be stronger advocates for people and their families.** Social workers are, and need to be, active, essential participants in the ever changing field of healthcare, “I do think that there’s a role for social work to act more as a strong...stronger advocate for clients” (Tina). Social workers practice creatively and independently across a continuum of services in an effort to enhance the health and well-being of older adults and their families (Berkman, 2006). Social work executes an important role in developing and delivering healthcare services by means of case management helping clients and caregivers access appropriate, tailored services for their situation. Social work plays an essential role in advocating for the equitable distribution of resources and addresses issues of gender, race, ethnicity and class.

Half of the participants referred to the advocacy role leaving them feeling like *the fly in*



*the ointment* sometimes; however all felt social workers should embrace this role because it means they are not afraid to speak up and question things when necessary. Their advocacy skills are necessary in an atmosphere that often deemphasizes the personal/social side of patients and families' lives by focusing on the etiology and disease.

**3) Support from social work administrators buffers resistance from team members and improves social work's status.** Important discussion needs to occur at the administrative level. In order for higher level changes to occur, frontline social workers need support from their administrators. Social work administrators may need or benefit from further training and education to contend with the challenges of working in this area in healthcare.

**4) Continuing education for healthcare team members.** As reported by participants, general practitioners are not always the best equipped or most comfortable with dealing with competency issues and questions. Further education and training is necessary since they are the legally-designated decision-maker who determines the mental competency of their patient. Further education regarding available supports and resources would also help to address lack of attention to these issues due to lack of knowledge and experience.

**5) Social workers need access to education and training.** Social workers in all settings can benefit from knowing more about the needs of older adults. All levels of social work (educators, practitioners, researchers, policy makers) must fully embrace gerontological practice by developing, implementing and evaluating approaches to meeting the needs of this population. This starts at the institutional level of professional education and field placement opportunities, so that they can enter the field and not perpetuate negative stereotypes or be unprepared to work with clients and families that are aging or facing age-related issues. The shortage of trained

clinical social workers needs to be addressed at both the BSW and MSW levels, by addressing negative attitudes and myths about working with older adults. In order to increase awareness about the needs of working with older adults, social workers need to have the opportunity during their education and career to learn about the core competencies required to practice effectively and competently.

Social workers also need to generate meaningful evidence-based and theoretically based research, as well as have the expertise to develop and evaluate effective interventions to address age related psycho-social concerns. This will facilitate social workers competing with the medical based institutions and professionals with whom they work. Contributing to new approaches and interventions with this population would serve the profession of social work in a positive manner by increasing credibility within the medical community, at the policy level and with the general public.

### **Implications for Methods and Tests**

**1) Decision-specific capacity assessment tools need to be developed.** Other provinces have been successful in the development and implementation of decision-specific capacity assessment tools (Alberta, Ontario, Newfoundland). Manitoba should consider adopting a different approach to capacity assessments as well as tools that are adaptable to each patient's specific situation. This would deal with a multitude of issues brought forward by the participants of this study including issues related to culture, language, and education by tailoring the assessment to the unique situation of the client. It would also aid in addressing issues related to the confusion about what capacity the individual still retains as it would specify in what areas they lacked capacity and those areas that remained intact.

This would mitigate over-reliance on MMSE and other cognitive assessment testing by giving greater weight to biopsychosocial assessments and the MoCA, among others.

Assessments should give greater consideration to cultural context and language barriers experienced by the older person.

**2) Risk analysis and older adults.** The findings from this study highlight that the definition and threshold of risk is not universal and is highly influenced by the subjectivity of the assessor as well as the influence of the healthcare professionals' impressions of acceptable risk. These findings present both a sound appreciation of risks present with any level of cognitive impairment but also a call for greater tolerance for risk taking. The issue of paternalistic behavior by other healthcare professionals presents both moral and ethical conflicts as well as questions about how to go forward on this topic. The overall consensus of the research subjects presented harm reduction and case management strategies as alternatives to overly intrusive interventions in an attempt to eliminate risk.

### **Implications for Education and Early Detection**

**1) Educate the public regarding future planning such as power of attorney, and providing early detection in the community.** The general public must receive education about the importance of future legal planning. When a person delays appointing power of attorney the individual risks losing the option of naming his or her substitute decision-maker and may have one appointed by the province instead. As Hebert stated it, "Not making a decision is making a decision."

The initial cost to appoint a power of attorney is a lot less expensive and time consuming than having to make legal arrangements for private committee ship after an assessment of

incompetence has been reached. Additionally, a power of attorney can live out of province while a private committee must live in the province. This exposes the individual to the additional risk of having the Public Guardian and Trustee of Manitoba appointed as a committee when her or his loved ones live outside of Manitoba.

### **Opportunities for Legislative Change**

#### **1) Registered social workers need equal authority with other professional team**

**members, depending on the healthcare setting.** Consideration needs to be made to include social workers in the assessment process and their recommendations should be given as much weight as other professionals.

#### **2) Manitoba could look at adopting a model of more collaborative decision-making**

**teams like in Ontario and Alberta.** Participants highlight a need to examine the current legislation around collaborative decision-making teams including the education and training available in other provinces such as Ontario and Alberta. Further research and study is required in this area.

**3) The Competency Continuum.** Language around competency needs to change, specifically, the view that competency is an all or nothing issue (Kane, 1998). “A diagnosis of dementia...doesn’t have to mean that they can’t make some decisions in their life, so what kind of decisions can they make?” (Hebert) The inability of a competency assessment to recognize an individual’s capacities relative to a continuum was cited as a systemic weakness in the assessment process. The downfall of Manitoba’s current legislation is that when someone is deemed incompetent and placed under an order of supervision, they are deemed globally incompetent and the Public Guardian and Trustee has full authority over both personal and

property affairs. This fails to recognize that the individual still may retain legal capacity to make decisions about their lives. A frequent reason for an order of committeehip is to establish an entity that will authorize personal care home placement and guarantee payment to the personal care home. In these cases, the individual may not be able to manage their finances but may remain competent enough to make other decisions. Regardless of the individual's overall capacity, the physician is forced to deem them globally incompetent rendering the individual without legal authority to make any decisions about their lives and care. This appears to be a major weakness in our current system and a civil and human rights injustice in Manitoba.

**4) Competency versus capacity --- a person can be incompetent but still retain certain capacities.** Current legislation needs a change in spirit and language to include capacity, for example, recognizing that an individual may lack capacity to manage their bank account but still decide where they want to live. As one of the participants mentioned, there was a committee looking at 'partial committees' to take this possibility into consideration, but it never got off the ground. This issue could be re-examined. Additionally, the all or nothing order of committeehip to the Public Guardian and Trustee should also be reviewed. The legislation already exists under the Vulnerable Persons Living with a Disability Act (Vulnerable adults are people who have a mental disability that has affected them before they were 18 years old) that the Public Guardian and Trustee can be appointed for property only, personal care only, or both property and personal care. This could be considered for adults who do not fall under this legislation but under the Mental Health Act.

### **Opportunities and Areas of Further Study**

**1) Analyze effectiveness of other competency assessment models.** A national study

aimed at examining and analyzing the effectiveness of other competency assessment models across Canada would be interesting. This information could help to inform what type of competency assessment model would work best in Manitoba. There are research and discussion papers available on the various types of team structures and legislative frameworks (Pachet, Newberry & Erskine, 2007; Ontario Ministry of the Attorney General, 2011; Nova Scotia Department of Health, 2002).

**2) How do social workers' experiences in competency assessment in Manitoba compare to the frontline experiences in healthcare settings in Alberta, Ontario, British Columbia, Quebec and Atlantic Canada?** Considering competency assessments are performed differently in other provinces in Canada, research in this area of social work practice could be explored, especially in provinces where social workers are legally allowed to perform capacity assessments. It would be fascinating to hear if their experiences are similar or dissimilar to the reports of these nine participants.

**3) Explore this topic on a larger scale in Manitoba.** This is an interesting and important issue that needs further research and attention. This study presented the stories of nine social workers practicing in different healthcare settings. Their stories provide us with a voice that is not often heard or listened to. Their stories emphasized the role that they play within a larger system, acknowledging the hierarchy of power in the healthcare system, while always remaining true to their professional code of ethics. Such practice advocates for the right to fair and equitable treatment for all, but with a particular interest in protecting the rights of the vulnerable, discriminated, and oppressed

**4) Research from the perspective of other people in the system (i.e. families and**

**other healthcare professionals**). It would be interesting to explore this topic from the perspective of others such as the individual, the family and other healthcare professionals.

**5) Research that explores experiences in just one of the organizational settings (i.e. home care, hospital).** By exploring each organizational setting individually this would allow the researcher to draw more conclusions about the effects of the setting on the perspective of the social worker.

### **Concluding Statements**

#### **On a Personal Note**

Engaging in this research has been a dream come true for me. Being able to start out with a question about practice issues I saw in my workplace and then talking with others about it has been amazing. I absolutely loved every minute of sitting with the participants and hearing their stories. The work that is being done by social workers across healthcare is humbling. This study provides a small window into the everyday lives of social workers in the field. Even though all of the participants acknowledged the great challenges of their positions, they all appeared steadfast in their desire to continue a challenging, but rewarding, career as a social worker.

## References

- Banks, S. (2008). Critical commentary: Social work ethics. *British Journal of Social Work*, 38(6), 1238 -1249. doi:10.1093/bjsw/bcn099
- Berkman, B.J. & Harootyan, L. (2006). *Social Work and healthcare in an aging society*. Springer Publishing Company: New York, NY, USA.
- Berkman, B.J., Maramaldi, P., Breon, E.A., & Howe, J.L. (2003). Social Work Gerontological Assessment Revisited. *Journal of Gerontological Social Work*, 40(1-2), 1-14.
- Berwick, D.M. (2009). What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs*, 28(4), w555-w565.
- Boland, K. (2006). Ethical decision-making among hospital social workers. *Journal of Social Work Values and Ethics*, 3(1), 1-29.
- Brofenbrenner, U. (1994). Ecological models of human development. In *International Encyclopedia of Education*, Vol. 3, 2<sup>nd</sup>. Ed. Oxford: Elsevier.
- Byrne, B. (2003). Reciting the Self: Representations of the Self in Qualitative Interviews. *Feminist Theory* 4(9)
- Castillo, J. (2009). Population Sampling Techniques. Retrieved November 7, 2013 from: <http://www.experiment-resources.com/population-sampling.html>
- CASW. (2005). Code of ethics and guidelines.
- Canadian Institute for Health Information, *Healthcare in Canada, 2011: A Focus on Seniors and Aging* (Ottawa, Ont.: CIHI, 2011)
- Canadian Mental Health Association, Winnipeg Region (n.d.). The Mental Health Act [Brochure]. Retrieved May 12, 2013 from



<http://www.cmhawpg.mb.ca/docents/MBMentalHealthActinfo.pdf>

- Cattarinich, X., Gibson, N., & Cave, A. J. (2001). Assessing mental capacity in Canadian Aboriginal seniors. *Social Science & Medicine*, 53(11), 1469-1479. doi:10.1016/S0277-9536(00)00434-2
- Chalmers, S. & Rosso-Buckton, A. (2008). Are you talking to me? Negotiating the challenge of cultural diversity in children's healthcare. Centre for cultural research: University of West Sydney.
- Cohen, D. (2006). Qualitative Research Guidelines Project. Semi-structured interviews. New Jersey: Robert Wood Johnson Foundation. Retrieved May 13, 2013 from <http://www.qualres.org/HomeSemi-3629.html>
- Cole, P.L. (2012). You want me to do what? Ethical practice within interdisciplinary collaborations. *Journal of Social Work Values and Ethics*, 9(1)
- Creswell, John W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Cross, T., Bazron, B., Dennis, K., & Issacs, M. (1989). Towards a culturally competent system of care, vole 1. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Crouch, M. & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social science information*, 45(4), 483-499.
- Cummings, S.M. & Cockerham, C. (1997). Ethical dilemmas in discharge planning for patients with Alzheimer's disease. *Health & Social Work* 22(2), 101-108.
- Deci, E., & Ryan, R. (Eds.), (2002). *Handbook of self-determination research*. Rochester, NY:

- University of Rochester Press.
- Denzin, N.K. & Lincoln, Y. S. (2000). *The handbook of qualitative research* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications Inc.
- Doyle, O., Miller, S. & Mirza, F. (2009). Ethical decision-making in social work: Exploring personal and professional values. *Journal of Social Work Values and Ethics*, 6(1), 1-36.
- Duffy, F., & Healy, J.P. (2011). Social Work with older people in a hospital setting. *Social Work in Healthcare*, 50(2), 109-123.
- Elliot, J. (2005). Using narrative in social research. London, England: SAGE publications Ltd.
- Fish, A. & Siberfield, M. (1994). When the mind fails: A guide to dealing with incompetency. University of Toronto Press: Scholarly Publishing Division.
- Fraser, H. (2004). Doing narrative research: Analyzing personal stories line by line *Qualitative Social Work*, 3(2), 179–201.
- Friedman, B. & Neuman-Allen, K. (2011). Systems Theory. In Brandell, J. R. (2011). *Theory & Practice in clinical Social Work* (2<sup>nd</sup> ed.)(pp. 3-20). Wayne State University: Sage Publications, Inc.
- Gray, M. (2010). Moral sources and emergent ethical theories in social work. *British Journal of Social Work*, 40(6), 1794.
- Gray, S., & Zide, M. R. (2008). *Psychopathology: A competency based assessment model for Social Workers*. Belmont, CA, US: Thomson/Brooks Cole.
- Gregorian, C. (2005). A career in hospital social work: Do you have what it takes? *Social Work in healthcare*, 40(3), 1-14. doi:10.1300/J010v40n03\_01
- Guzman-Clark, J. R.S., Reinhardt, AK, Wilkins Schantz, S. & Castle, S. (2012). Decision-

- making capacity and conservatorship in older adults. *Annals of long term care: Clinical and Aging*, 20(9), 36-39.
- Hancock, B. (1998). *Trent Focus for Research and Development in Primary Healthcare: An Introduction to Qualitative Research*. Trent Focus, 1998.
- Healy, T. C. (2003). Ethical decision making: Pressure and uncertainty as complicating factors. *Health & Social Work*, 28(4), 293.
- Hepworth, D, Rooney, R., Dewberry-Rooney, G., Strom-Gottfried, K., & Larsen, J. (2009). *Direct social work practice: Theory and skills* (8<sup>th</sup> ed.). Belmont, CA, USA: Brooks/Cole, Cengage Learning.
- Horning, S.M., Wilkins, S.S., Dhanani, S. & Henriques, D. (2013). A case of elder abuse and undue influence: Assessment and treatment from a geriatric interdisciplinary team. *Clinical Case Studies*, 12(5), 373-387.
- Issacs, M. & Benjamin, M. (1991). *Towards a culturally competent system of care*, vole 2. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
- Jones, K. (2003). The turn to a narrative knowing of persons: one method explored. *Nursing Times Research*, 8(1), 60-71.
- Judd, R. G., & Sheffield, S. (2010). Hospital Social Work: Contemporary roles and professional activities. *Social Work in Healthcare*, 49(9), 856-871.
- Kane, M. N. (1998). Consent and competency in elders with Alzheimer's disease. *American Journal of Alzheimer's Disease and Other Dementias*, 13(4), 179 -188.
- doi:10.1177/153331759801300404

- Kirst-Ashman, K. & Hull, G.H. (2006). *Understanding Generalist Practice*. Belmont, CA, USA: Thomson Brooks/Cole.
- Kropf, N.P., & Cummings, S.M. (2008). Chapter 14: Evidence-Based Interventions with Older Adults: Concluding Thoughts. *Journal of Gerontological Social Work*, 50(S1), 345-355.
- Laforest, J. (2009). *Guide to Organising Semi-Structured Interviews With Key Informant*. Charting a course to save living. Quebec: Government Quebec. Retrieved May 13, 2013 from: [http://www.inspq.qc.ca/pdf/publications/guide\\_entretien\\_vol11\\_eng.pdf](http://www.inspq.qc.ca/pdf/publications/guide_entretien_vol11_eng.pdf)
- Landau, R. (2000). Ethical dilemmas in general hospitals: Differential perceptions of direct practitioners and directors of social services. *Social Work in Healthcare*, 30(4), 25-45.
- Larsson, S. & Sjoblom, Y. (2010). Perspectives on narrative methods in social work research. *International Journal of Social Welfare*, 19, 272-280.  
doi 10.1111/j.1468-2397.2009.00672.x
- Lichtenberg, Peter A. (2010). *Handbook of assessment in clinical gerontology*. USA: John Wiley & Sons, Inc.
- Lloyd, L. (2006). A caring profession? The ethics of care and social work with older people. *British Journal of Social Work*, 36(7), 1171 -1185. doi:10.1093/bjsw/bch400
- Mack, N., Woodsong, C., MacQueen, K.M., Guest, G. & Namey, E. (2005). Qualitative Research Methods Overview. In *Qualitative Research Methods: A Data Collector's Field Guide*. (pp.1-12). Research Triangle Park, North Carolina: Family Health International.
- Manitoba Law Reform Commission (1999). *Informal assessment of competence*. Report # 102. Canadian cataloguing in publication data.
- Manitoba's Mental Health Act (n.d.). Retrieved January 5, 2011 from

<http://www.gov.mb.ca/health/act.html>

- Marson, D (2008). Competency assessment and research in an aging society. *Mental health and mental illness in later life*, 26(1), 99-103.
- Mattison, M. (2000). Ethical decision making: The person in the process. *Social Work*, 45(3), 201.
- Mayo, A.M. & Wallhagen, M.I. (2009). Considerations of informed consent and decision-making competence in older adults with cognitive impairment. *Research in Gerontological Nursing*, 2(2), 103-111.
- McGibbon, E., Etowa, J., & McPherson, C. (2008). Health-care access as a social determinant of health. *The Canadian Nurse*, 104(7), 23-27.
- McInnis-Dittrich, K. (2005). *Social Work with Elders: A Biopsychosocial approach to assessment and intervention* (2<sup>nd</sup> ed.). Boston, MA, US: Pearson Education, Inc.
- Mensinga, J. (2009). Storying career choice employing Narrative approaches to better understand students' experience of choosing Social Work as a preferred career. *Qualitative Social Work* 8(2) 193-209. doi: 10.1177/1473325009103375
- Merrill, B. & West, L. (2009). *Using Biographical Methods in Social Research*. London: Sage
- Mikkonen, J. & Raphael, D. (2010). Social determinants of health: The Canadian facts. Toronto: York University School of Health Policy and Management.
- Mitchell, M & Egudo, M. (2003). A review of narrative methodology. Edinburgh South Australia: Australia. Retrieved April 21, 2012 from <http://www.dsto.defence.gov.au/corpaorate/reports/DSTO-GD-0385.pdf>
- Moberg, P. J., & Rick, J. H. (2008). Decision-making capacity and competency in the elderly: A

- clinical and neuropsychological perspective. *NeuroRehabilitation*, 23(5), 403-413.
- Moye, J., & Marson, D.C. (2007). Assessment of decision-making capacity in older adults: An emerging area of practice and research. *Journal of Gerontology: Psychological Sciences*, 62B(1), 3-11.
- Naik et al. (2010). Assessing safe and independent living in vulnerable older adults: Perspectives of professionals who conduct home assessments. *JABFM*, 23(5), 614-621.
- Nasreddine et al. (2005). The Montreal Cognitive Assessment (MoCA): A Brief Screening Tool for Mild Cognitive Impairment. *Journal of the American Geriatrics Society*, 53, 695-699.
- Newberry, A. M., & Pachet, A. K. (2008). An innovative framework for psychosocial assessment in complex mental capacity evaluations. *Psychology, Health & Medicine*, 13(4), 438-449. doi:10.1080/13548500701694219
- Novak, M., & Campbell, L. (Eds.). (2006). *Aging and society: A Canadian perspective* (5th ed.). Toronto: Nelson Thompson Ltd.
- Nova Scotia Department of Health (2002). A cultural competency guide for primary healthcare professionals in Nova Scotia. Retrieved: May 2, 2014 from:  
[http://www.healthteamnovascotia.ca/cultural\\_competence/cultural\\_competence\\_guide\\_for\\_health\\_care\\_professionals.pdf](http://www.healthteamnovascotia.ca/cultural_competence/cultural_competence_guide_for_health_care_professionals.pdf)
- Ontario Ministry of the Attorney General. (2011). *Capacity Assessments*. Retrieved October 20, 2011 from <http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.asp>
- Pachet, A., Astner, K., & Brown, L. (2010). Clinical utility of the Mini-Mental Status Examination when assessing decision-making capacity. *Journal of Geriatric Psychiatry and Neurology*, 23(1), 3-8. doi:10.1177/0891988709342727

- Pachet, A., Newberry, A., & Erskine, L. (2007). Assessing capacity in the complex patient: RCAT's unique evaluation and consultation model. *Canadian Psychology*, 48(3), 174-186. doi:10.1037/cp2007016
- Parker-Oliver, D. & Peck, M. (2006). Inside the interdisciplinary team: Experiences of hospice social workers. *Journal of Social Work in End-of-Life and Palliative Care*, 2(3), 7-21.
- Pashby, P., Hann, J., Elinor, M., & Sunico, S. (2009). Dementia care planning: Shared experience and collaboration. *Journal of Gerontological Social Work*, 52(8), 837-848.
- Perkins, C. (2002). Assessing capacity. *Journal of New Zealand Family Physician*, 29(1), 41-43.
- Pockett, R. (2002). Staying in hospital Social Work. *Social Work in Healthcare*, 36(3), 1-24.
- Polkinghorne, D.E. (2007). Validity issues in narrative research. *Qualitative Inquiry*, 13(4), 471-486.
- Québec charte des droits et Libertés de la Personne. (1975, C.6). Retrieved January 5, 2011 from [http://www2.publicationsduquebec.goChartuv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C\\_12/C12\\_A.html](http://www2.publicationsduquebec.goChartuv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_12/C12_A.html)
- Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health*, 21(2), 221-236. doi:10.1080/09581596.2010.485606
- Raphael, D. (2004). *Social determinants of health: Canadian Perspectives* (2<sup>nd</sup> ed.). Toronto, Ontario: Canadian Scholars' Press Inc.
- Riessman, C. K. (2004). 'Narrative Analysis', in M. S. Lewis-Beck, A. Bryman and T. Futing Liao (eds) *Encyclopedia of Social Science Research Methods*, pp. 705–9. Newbury Park, CA: Sage.
- Reissman C. & Quinney, L. (2005). Narrative in social work: A critical review. *Qualitative*

*Social Work*, 4(4), 391-412. doi 10. 1177/1473325005058643

- Roscoe, K.D., Carson, A. & Madoc-Jones, L. (2011). Narrative social work practice: Conversations between theory and practice. *Journal of social work practice*, 25(1), 47-61.
- Saha, S., Beach, M.C., & Cooper, L.A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of National Medical Association*, 100(11), 1275-1285.
- St. Amant, O., Ward-Griffin, C., De Forge, R.T., Oudshoorn, A., McWilliam, C., Forbes, D., Kloseck, M., & Hall, J. (2012). Making care decisions in home-based dementia care: Why context matters. *Canadian Journal on Aging*, 31(4):423-34.
- Srivastava, R.H. (2008). The ABC (and DE) of cultural competence in clinical care. *Ethnicity and inequalities in health and social work*, 1(1), 27-33.
- Statistics Canada. (2011). *Estimates of population, by age group and sex for July 1, Canada, provinces and territories, annual* (CANSIM Table 051-0001); and Statistics Canada. *Projected population, by projection scenario, sex and age group as of July 1, Canada, provinces and territories, annual* (CANSIM table 052-0005). Ottawa: Statistics Canada, 2011. Retrieved March 1, 2013 from <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@eng.jsp?iid=33>
- Strang, D. G., Molloy, D. W., & Harrison, C. (1998). Capacity to choose place of residence: Autonomy vs. beneficence? *Journal of Palliative Care*, 14(1), 25-29.
- The Mental Health Act, continuing consolidation of statuses of Manitoba. (2005, c. M110) Retrieved May 12, 2013 from <http://web2.gov.mb.ca/laws/statutes/ccsm/m110e.php>
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence based nursing* 3(3), 68-70.



Trigger (n.d.). In dictionary.com online. Retrieved July 1, 2014 from

<http://dictionary.reference.com/browse/trigger?s=t>

Tuokko, H. (2001). Competency and dementia in later life. *Aging, Neuropsychology, and Cognition*, 8(3), 161. doi:10.1076/anec.8.3.161.828

Widera, E, Steenpass, V., Marson, D, & Sudore, R. (2011). Finances in the older patient with cognitive impairment: “He didn’t want me to take over”. *Care of the Aging Patient JAMA*, 305(7), 698-706.

Wilkinson, R. & Marmot, M. (2003). *Social determinants of health: The solid facts* (2<sup>nd</sup> ed.)

Winnipeg Regional Health Authority Board of Directors. (2011). *Mission, Vision and Values: Strategic Directions*. Retrieved July 14, 2014 from: <http://wrha.mb.ca/about/mission.php>

## Appendices

Appendix A: Email Script Introduction - (Sent to MIRSW and the Social Work Alumni)

Hello,

My name is a Krystal Kaposi. I am a MIRSW member and graduate student at the University of Manitoba in the Faculty of Social Work. I am working on my Master's degree and, for my thesis project; I plan to interview social workers with current or past hospital experience who are willing to discuss their involvement in competency assessments with older adults. If I provide you with a brief write-up of my thesis project and a project poster would you consider sharing this information with your members? Ideally, it would be appreciated if this information could be shared with your members via email circulation as well as an advertisement spot in your newsletter; however, please let me know if you have a particular preference to either option. As I would like to send this information to you as promptly as possible, please let me know if there is a submission deadline. I am open to answering any questions that you may have in regards to this request.

Thank you for your time and attention to my inquiry. I look forward to hearing from you soon.

Regards,

Krystal Kaposi, BA, BSW, RSW  
MSW Graduate Student  
Email: [XXX@cc.umanitoba.ca](mailto:XXX@cc.umanitoba.ca)  
Telephone: XXX-XXX-XXXX

\*(Once I received a YES response, I will send Appendix B and G by email and I will ask that both documents are shared via email to their members. I will also send Appendix H for the organization to use to advertise in their newsletter and to display in their or to display at their establishment for further exposure.)

Appendix B: Email Recruitment Script - (Sent to MIRSW and the Social Work Alumni)

Hello,

Please find attached a letter of invitation to participate in a Master of Social Work thesis project about social workers' experience with competency assessments with older adults. Please feel free to share this information widely to your contacts or to anyone you feel may be interested in participating in this project.

Please respond to me by email or by telephone (contact information located below) by January 31, 2014. Thank you for taking the time to read this. I look forward to meeting with you!

Regards,

Krystal Kaposi, BA, BSW, RSW  
MSW Graduate Student  
Email: [XXX@cc.umanitoba.ca](mailto:XXX@cc.umanitoba.ca)  
Telephone: XXX-XXX-XXXX

### Appendix C: Telephone Script with Potential Participants

Hello,

My name is Krystal Kaposi and I am a graduate student at the University of Manitoba in the Faculty of Social Work. Did you receive my letter of invitation to participate in my research project (Appendix G)? Are you interested in hearing more about the project?

I want to make it clear that you are not under any obligation to participate in this research project and I will not tell anyone about who has agreed to participate or not. (Organization's name) is only helping me by passing out recruitment letters and providing me with names of social workers I can contact.

**THIS SCRIPT CAN BE USED BOTH OVER THE PHONE OR IN-PERSON**

As the letter says this research project is part of my thesis for a Masters of Social Work degree (MSW). I am a student and not affiliated in any way with your organization.

It is my understanding that you meet the following criteria to participate: (1) you have worked in a healthcare setting that provides services to older adults that for at least one year; (2) you have worked with at least one client during your career that has had their mental competency evaluated; (3) you are fluent in English and agree to have the interview tape-recorded and transcribed for analysis; and (4) you have at least a Bachelor degree in Social Work from an accredited university. I would like to explore with you, your work related experiences as a social worker with this client group, and get a detailed description of that experience as it was for you.

In the interview I will ask you to reflect on what is or was like to be a social worker in a healthcare setting and your experiences with competency assessments with older adults.

Please understand that you are free to not answer any question with which you are uncomfortable

answering or to stop the interview at any time and/or drop out of the study at any time.

As mentioned in the recruitment letter, the interview will be audio taped. After the interview I will be listening to the tapes and hiring a person to transcribe all of the interviews. After interviewing five to seven social workers, I will analyze the transcripts exploring common themes and differences. From this information I will write a final report.

All of the things you say during the interview will be kept confidential. I will not use any real names, only pseudonyms will be used in the final report and I will not identify the names of the participants in the final report and will not tell anyone the names of the participants in the study. I will not show anyone the tapes or transcriptions after they are recorded except for my thesis advisor if I have any questions about the research process. I will not reveal any names of the participants and I will make sure you cannot be identified. I will keep all the tapes and transcriptions in a locked filing cabinet in my home and I will destroy all of the material, except the final report, no later than December 31, 2015, one year after the completion of my study.

The information gathered will help me with writing my thesis to graduate with my MSW degree. The information gathered from the study will also help other social workers in healthcare to get a better understanding of what it is like to be involved in competency assessments with older adults in a healthcare setting.

There will be no form of payment given to the participants of this study. I will give everyone a thank you card.

I will be happy to send you a copy of the final report when it is finished. Also, if you would like, we can meet in-person to discuss the final results of the report. So I've covered a lot, do you have any questions at this time about anything I've said?

Would you be interested in participating in this study?

IF NO- Thank you very much for your time and speaking with me today. Please feel free to call me at XXX-XXX-XXXX if you have any more questions or have second thoughts about participating. Take care. Bye.

IF YES- Thank you very much. What time/place works best for you to meet to conduct the interview? Thank you again, I look forward to meeting you and hearing about your experiences. Please feel free to call me at XXX-XXX-XXXX if you have any more questions or have second thoughts about participating. Take care. Bye.

## Appendix D: Interview Guide

Before beginning the interview, the consent form will be reviewed and the participants will be informed that their participation is completely voluntary. I will emphasize that they can choose to not answer any of the questions or end the interview at any time and they do not need to provide an explanation and no negative repercussions will occur if they chose to drop out of the study.

1. Please tell me your story about your experiences with competency assessments with older adults in a healthcare setting.
2. Please tell me about your experiences as a social worker working with other professionals doing competency assessments in a healthcare setting.
3. Please tell me about your experiences of competency assessments with older adults of different backgrounds.
4. Please tell me about your emotional experience of participating in competency assessments with older adults.
5. Please describe any recommendations for change in social work practice or in healthcare systems that you feel would be helpful for social workers involved in competency assessments.
6. Is there anything you wish to add or feel that you haven't had the chance to say?





UNIVERSITY  
OF MANITOBA

## Faculty of Social Work

### Appendix E: Informed consent for participation

521 Tier Building  
Winnipeg, Manitoba  
Canada R3T 2N2  
Telephone (204) 474-7050  
Fax (204) 474-7594  
Social\_Work@umanitoba.ca

**Research Project Title:** Social Work Practice: A Look at Competency Assessments  
with Older Adults

**Researcher:** Krystal Kaposi, Graduate student, Faculty of Social Work, University  
of Manitoba

E-mail: [XXX@cc.umanitoba.ca](mailto:XXX@cc.umanitoba.ca)

Phone number: XXX-XXX-XXXX

**Research Supervisor:** Lyn Ferguson, Associate Professor, Associate Dean, Graduate  
Programs and Research Faculty of Social Work

E-mail: [XXX@ad.umanitoba.ca](mailto:XXX@ad.umanitoba.ca)

Phone number: XXX-XXX-XXXX

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The purpose of this research is to understand social workers' experiences of competency assessments with older adults in a healthcare setting.

I have received an explanation about the nature of the study and its purpose. I understand the following:

1. My participation is voluntary and I can decline to participate, or withdraw my participation at any time, without any negative consequences.
2. That I will be interviewed regarding my experiences of working with older adults whose mental competency was assessed. I will be asked to provide my own personal narrative of these lived work experiences, and to share and reflect on my thoughts and reactions to these experiences as a social worker. The interview will be conducted in person and will normally take approximately 60-90 minutes to complete.
3. It is anticipated that participation in this research involves minimal risk. However since I will be asked to reflect and recall past experiences and situations of working with older adults, there is some potential risk to re-experience any negative emotions and feelings associated with these past experiences. I will be provided with listing of counseling resources who I can contact after the interview (such as Klinik or Aurora Family Therapy Centre).
4. If you decide to participate in an interview and you disclose that someone is being abused the principal researcher will not be able to keep that information confidential. The principal researcher would report the incident to the Vulnerable Persons Unit with the Winnipeg Police and to the Persons for Protection in care and they will decide whether the matter warrants an investigation.
5. All interviews will be recorded on a digital audio recorder and transcribed into written format. Upon the recorded data being transcribed the digital file will be destroyed.
6. Any transcribed information will remain confidential and held in storage in a locked cabinet at the researchers' place of residence. All participants will be given code names to protect their identities. Upon completion of the study all transcribed data will be shredded and destroyed. Any identifying information will be stored separate from transcribed data and only be accessible to the researcher. Any identifying characteristics may be changed to disguise participants from being identified, and no individual or agency will be identified in any report of the results or papers published. All other data will be stored as mentioned and will be accessible only to the researcher and the faculty advisor. This information will also be shredded and destroyed upon completion of the researcher project, by December 31, 2015.
7. That all measures will be undertaken to ensure that your identity, the agency you work at, or any identifying client information will not be revealed in any publications or report.

Your responses and any materials you provide will be kept confidential and anonymous. These consent forms with your name and signature will be stored at the researcher's home. The

interview recording and transcripts will be stored on the researcher's computer in a password-protected file. All materials will be accessed only by the researcher and the research supervisor, and will be destroyed no later than December 31, 2015. All identifying information will be deleted or substituted when results are presented.

The results of this study will be a part of the researcher's thesis, completed in partial fulfillment of requirements of the Master of Social Work degree. In addition, these results may be used in conference presentations and/or journal articles.

The interviews will be held in Winnipeg, Manitoba from January to March 2014.

Please provide your contact e-mail below if you would like to receive information on research results. The results will be disseminated to participants in August 2014, and will also be presented at the Faculty of Social Work at the University of Manitoba.

---

*Contact e-mail or postal address*

You may refuse to answer any questions if you do not feel comfortable doing so. You may withdraw from participation in this study at any point, and ask for all data you have provided to be removed. No negative consequences are intended to follow this action.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved

institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Han Ethics Coordinator (HEC) at (204) 474-7122 or [margaret.bowman@umanitoba.ca](mailto:margaret.bowman@umanitoba.ca). A copy of this consent form has been given to you to keep for your records and reference.

If you agree to each of the following, please place a check mark in the yes box. If you do not agree, please place a check mark in the no box:

YES      NO

I have read or had read to me the details of this consent form.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

My questions have been addressed.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

I, \_\_\_\_\_ (print name), agree to participate in this study.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

I agree to have the interview audio-recorded.

 

I agree to be contacted by phone or e-mail if further information is required after the interview

 

I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity.

 

---

*Your name (please print)*

---

*Your signature*

---

*Researcher's name*

---

*Researcher's signature*



UNIVERSITY  
OF MANITOBA

Faculty of Social Work

521 Tier Building  
Winnipeg, Manitoba  
Canada R3T 2N2  
Telephone (204) 474-7050  
Fax (204) 474-7594  
Social\_Work@umanitoba.ca

### Appendix F: Counseling Resources

#### **Klinic Community Health Centre**

870 Portage Avenue

24 hour crisis line: 204-786-8686 / Toll free 1-888-322-3019

General number: 204-784-4090

#### **Aurora Family Centre**

515 Portage Avenue (University of Winnipeg)

Intake line: 204-786-9251



UNIVERSITY  
OF MANITOBA

Faculty of Social Work

521 Tier Building  
Winnipeg, Manitoba  
Canada R3T 2N2  
Telephone (204) 474-7050  
Fax (204) 474-7594  
Social\_Work@umanitoba.ca

### Appendix G: Letter of Invitation to Participant

Date: January 2014

Dear Colleague:

My name is Krystal Kaposi and I am a graduate student at the University of Manitoba. Please consider participation in my research study as it explores the experiences of social workers in healthcare settings and their involvement in competency assessments with older adults. The aim of the study is to explore, from a narrative perspective, social workers' experiences of assessing competency of an older adult in a healthcare setting. This study is part of an effort to better understand this area of social work practice and help bring the everyday lived experiences of social workers, like you to a larger audience.

In order to participate in this study you must meet the following criteria: (1) you have worked in a healthcare setting that provides services to older adults for at least one year; (2) you have worked with at least one client during your career that has had their mental competency evaluated; (3) you are fluent in English and agree to have the interview tape-recorded and transcribed for analysis; and (4) you have at least a Bachelor degree in Social Work from an accredited university. I would like to explore with you, your work related experiences as a social worker with this client group and, get a detailed description of that experience.

Should you agree to take part in this research, you will be asked to participate in an in-person interview, which will take about an hour to an hour and a half of your time. In the interview I will ask you to reflect on what is or was like to be a social worker in a healthcare setting and your experiences with competency assessments with older adults. Your participation

will be confidential. Even though the interviews will be audiotaped, at no time will your identity be included in any reports or discussions about the outcome of the study. You may withdraw at any time during the interview if you feel uncomfortable.

The knowledge gained from your participation in this research will be a stepping-stone to bridging the existing gap in the research literature about this significant aspect of social work practice. Hopefully it will also facilitate better understanding about what improvements need to be made. All participants will be asked to leave their address or email on the consent form if they wish to receive a summary of the findings of the final report, which should be available by August 2014.

Should you have any questions about this project and what is expected of you please feel free to call me or my Faculty Advisor, Dr. Lyn Ferguson. I am hoping to start my interviews by January 30, 2014.

Sincerely,

Krystal Kaposi, BA, BSW, RSW  
MSW Graduate Student  
Ph: XXX-XXX-XXXX  
E-mail: [XXX@cc.umanitoba.ca](mailto:XXX@cc.umanitoba.ca)

Dr. Lyn Ferguson, Ph.D., Associate Professor  
Associate Dean, Graduate Programs and Research  
Ph: XXX-XXX-XXXX  
Email: [XXX@umanitoba.ca](mailto:XXX@umanitoba.ca)



### Appendix H: Advertisement Poster

Advertisement poster that is going to be disseminated to research participants and used for participant recruitment is presented on the next page.

# YOU ARE INVITED

To participate in a MSW project about Social Workers' experiences with competency assessments with older adults

## CRITERIA:

- You have worked in a healthcare setting that provides services to older adults for at least one year
- You have worked with at least one client during your career that has had his or her mental competency evaluated
- You are fluent in English and agree to have the interview tape-recorded and transcribed for analysis
- You have at least a Bachelor degree in Social Work from an accredited university

- All participation is voluntary and confidential.
- If you agree to participate, you will be asked to take part in an in-person interview, which will take 60-90 minutes. I will ask you to reflect on what is like or was like to participate in competency assessments with older adults.

I would like to begin interviews by January 30, 2014.

**To participate or for more information please contact Krystal Kaposi, Master of Social Work student, University of Manitoba at: [XXX@cc.umanitoba.ca](mailto:XXX@cc.umanitoba.ca)**



Appendix I: Human Research Ethics Board Approval  
(Presented on the next page)



UNIVERSITY  
OF MANITOBA

**Research Ethics and Compliance**  
Office of the Vice-President (Research and International)

Human Ethics  
206-194 Dutoit Road  
Winnipeg, MB  
Canada, R2T 2N2  
Phone: 204-474-7122  
Fax: 204-269-9177

**APPROVAL CERTIFICATE**

January 22, 2014

**TO:** Krystai Kapasi (Advisor L. Ferguson)  
Principal Investigator

**FROM:** Jacquie Vorauer, Chair  
Psychology/Sociology Research Ethics Board (PSHEB)

**Re:** Protocol #P2014:001  
"Social Work Practice: A look at Competency Assessments with older adults"

Please be advised that your above-referenced protocol has received human ethics approval by the Psychology/Sociology Research Ethics Board, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

**Please note:**

- If you have funds pending human ethics approval, please mail/e-mail/fax (204-261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in CRS in order to initiate fund setup. (How to find your UM Project Number: <http://umanitoba.ca/research/crs/mrfaq.html#crd>)
- If you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at [http://umanitoba.ca/research/ce/ethics/human\\_ethics\\_REB\\_forms\\_guidelines.html](http://umanitoba.ca/research/ce/ethics/human_ethics_REB_forms_guidelines.html)) in order to be in compliance with Tri-Council Guidelines.