ADDRESSING ISSUES OF COMPETENCY IN OLDER ADULTS WHEN DISCHARGE PLANNING: A SOCIAL WORK PERSPECTIVE

By Sarah Ann Torontali

B.Sc., The University of Toronto, 1990
BSW, Ryerson Polytechnic University, 1998

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Department of _Social Work & Family Studies_

The University of British Columbia
Vancouver, Canada

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ABSTRACT

Addressing Issues of Competency in Older Adults
When Discharge Planning: A Social Work Perspective

An aging Canadian population suggests that social workers in hospital settings will increasingly encounter older adults whose capacity to make decisions regarding place of residence may be impaired. There is a lack of discussion in the social work literature around the issue of competency to make this decision, specifically, how competency is determined, and how the assessment process unfolds. Qualitative research was conducted in order to explore the process of discharge planning with elderly, hospitalized patients, when there are concerns about their competency to make decisions regarding place of residence. The results of this research highlight the key role social workers play in both informal and formal assessments of competency in elderly patients. The findings suggest that competency to decide place of residence was based on the patient's mental capacity, as well as his/her ability to function in the chosen environment. As a result, an assessment of risk was integral to the assessment of competency and discharge planning. The assessment of risk, and thus the assessment of competency, are highly subjective processes, influenced by the values of the assessor, the organizational context, and the societal and legislative context. The research also emphasized that formal competency assessments were used as a last resort, due in part to the gaps in the current legislative context. This research provides an emerging social work perspective which was previously untold, and establishes a basis from which to further develop knowledge in this intriguing and important area for social work practice.

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CHAPTER I

INTRODUCTION

It was through a Bachelor of Social Work student placement at an acute care hospital in Toronto, Ontario, that I began to develop an interest in the topic of competency to make decisions regarding place of residence. One of the main roles of social work at this hospital was discharge planning, and referrals for social work usually arose when there was an elderly patient whom the attending physician believed required placement in a long-term care facility. In Ontario, social workers who were members of the Ontario College of Certified Social Workers were eligible to evaluate capacity for admission to a long-term care facility. Although guidelines and a questionnaire were provided to assist the social workers in their evaluation, discussion with the social workers at this hospital revealed a number of challenges which appeared both ethical and practical in nature.

I began to explore the literature to find answers to this intriguing and complex issue, and found there was a lack of information around assessing competency to choose place of residence, especially in the social work literature. I was fascinated by the inherent ethical dilemma in being a social worker, trained to enhance the self-determination of the client/patient, while at the same time, having a responsibility to act in his/her best interest and protect him/her from harm. I was also interested in how social workers dealt with having the responsibility and authority to remove the patient's decision-making ability in an area as fundamental to their sense of self as choosing where one lives.

A move to British Columbia and an Masters of Social Work practicum in a geriatric hospital renewed my interest in the topic of competency. I found that in British Columbia, the

relevant legislation had yet to be proclaimed, and social workers and other professionals were operating under what appeared to be inadequate legislation. The absence of clear roles and guidelines for assessments was even more evident.

My interest in this topic continued in my full-time position as a case manager at the Office of the Public Guardian and Trustee for British Columbia. Working with vulnerable adults, as well as working in the organization which has helped to spearhead the implementation of the new adult guardianship legislation, has provided me access to excellent resources on this topic. As a case manager, discussions with other colleagues in communities around British Columbia confirmed that competency to choose place of residence was a current issue and topic of interest to social workers, as well as other professionals. As a result, I decided to explore this topic through research for my MSW thesis, and the results of my research are presented in this paper.

In Chapter Two I begin by reviewing the current literature on competency to choose place of residence and competency assessments. Traditionally, competency has been considered the domain of the medical and legal professions, and as a result, the majority of the literature comes from these perspectives. The concept of competency is discussed, followed by ethical and legal dimensions of competency, as well as practical considerations in the assessment of competency. Recent developments in the area of assessment guidelines are presented. The need for a social work perspective pertaining to the assessment of competency specific to choosing place of residence is highlighted by this literature review, leading to one of the goals of this research. This research also attempts to develop an understanding of how social workers discharge plan with elderly, hospitalized patients, whose competency to make decisions regarding place of residence is questionable. The literature review suggests that

qualitative research into the area of competency assessments is needed to better understand the process to then develop guidelines for assessments.

Chapter Three outlines the methodology used in this research. The rationale for choosing a qualitative research method is presented. The methods of individual interviews and a focus group, which were used in this project, are discussed, as well as the advantages of this multi-method approach. The data collection and data analysis methods are presented and the potential challenges to this qualitative research project are discussed.

Chapter Four presents the findings of this research project. A description of the process of discharge planning with questionably capable elderly patients is presented using the data from the participants. The conditions under which competency becomes a concern are made explicit, as well as the role of social work in the informal and formal assessment process. A number of challenges faced by social workers when discharge planning with questionably competent older adults are identified.

Chapter Five will situate the findings within the current literature and discuss the implications of the findings to social work practice, from the level of individual practice to social policy issues. Limitations of the research and areas for future research are identified.

Chapter Six summarizes this research and provides a conclusion to this paper.

CHAPTER TWO

LITERATURE REVIEW

Canada's population, like that of most Western industrialized nations, is rapidly aging (Gordon & Verdun-Jones, 1992; Hamilton & Trépanier, 1994). It is estimated that by the year 2031, 21% of the population will be 65 years and older, which at that time will be equivalent to six million people (Gordon & Verdun-Jones, 1992). The fastest growing cohort are those 80 years and older, whose numbers are quickly increasing due to improvements in health care and social conditions. The resultant increase in longevity does not preclude the decline of mental and physical abilities in old age, although it is inaccurate to assume that old age equals dependency, as the majority of the elderly are still capable of functioning independently (Tarman, 1994).

However, some older adults experience a significant decline in their mental capacity. Of the population 65 years and older, approximately ten percent have dementia: this number increases to about 20-40 percent in those 80 years plus (Clarfield, 1989; Tarman, 1994). Other conditions such as chronic mental illnesses, cerebral vascular accidents (stroke), mood disorders, brain injury, or developmental delays may also affect an older adult's mental capacity. The impaired mental capacity of these older adults may then affect their ability to make decisions regarding their health care, finances, and other personal matters (Naglie et al., 1995). As a result, protection may need to be provided for vulnerable persons in these areas to guard against abuse, neglect, and the infliction of harm against self or others (Verma & Silberfeld, 1997).

Adults 80 years and older are also most likely to utilize health care services and need hospitalization (Hamilton & Trépanier, 1994). Health care professionals, including social workers in hospital settings, will increasingly need to address issues of patient competency to consent to interventions and determine life choices. An impaired mental capacity will have a significant impact on the ability of the patient to participate in decision-making regarding discharge plans (Abramson, 1988). According to Silberfeld and Fish (1994), "the issue of capacity to choose one's residence is often raised when a person is in hospital for the treatment of an illness and will soon be ready to be discharged" (p. 11). As a primary role of social work in hospitals is discharge planning (Holosko & Taylor, 1994), this suggests that issues of competency will be increasingly relevant to social work practice in hospital settings.

Assessing an individual's competency, and finding him/her incapable of making decisions about his/her place of residence, can have a number of potential consequences for the well being of the elderly patient. A number of studies have suggested that loss of personal control over "the social and physical environment is associated with impaired physical and mental health, decreased personal and social well-being, and increased mortality rates, especially for elderly people forced to relocate" (Abramson, 1988, p. 443). Autonomous decisions are also related to the ability of the individual to self-actualize: limiting self-determination may influence the individual's level of well-being and health status (Hertz, 1996).

Admission to a nursing home challenges the older person's struggle for independence and autonomy and may result in a number of physiological and psychosocial disturbances, such as anxiety, increased confusion, depression, sleep disturbances, changes in eating habits, and withdrawal (Manion & Rantz, 1995). These effects may be exacerbated by patients who are

deemed incapable of providing consent to the admission decision: perceived control over the relocation decision may reduce stress levels and facilitate adjustment (Davidson & O'Connor, 1990). On the other hand, incorrectly assessing a patient to be capable may result in the patient returning to live at risk in the community, experience multiple hospital readmissions, or even mortality (Schogt & Sadavoy, 1987). It is interesting to note that there is little discussion of the consequences of assuming an older adult capable to make the decision to move to a long-term care facility, when in reality they may be incapable.

Despite this apparent significance of the assessment of competency to the life of the older adult and to discharge planning, there is little discussion of this aspect of social work practice in the literature. The literature reviewed was predominantly medical-legal, and focused on issues of competency to make health care decisions, competency to manage financial/legal affairs, and competency to stand trial. There was little explicit discussion around competency to make the decision regarding place of residence and how the assessment process unfolds. A review of the medical-legal literature, however, identified key ideas relevant to the concept of competency, and to the assessment process, which were used as a starting point for this research project.

The Concept of Competency

It is important to explore the concept of competency upon which the assessment is based, as there are different conceptualizations with corresponding implications for the assessment process and outcome. These differing conceptualizations reflect the notion that competency is a social construct (Carney, 1997; Glass, 1997; Verma & Silberfeld, 1997). The defining and assessing of competency will therefore reflect a particular social and historical

context, such as the legislation in force at that point in time, the values of society, and the assessment tools available.

Traditionally, the defining and assessing of competency has been dominated by the legal and medical professions. The concept of competency is often viewed as a legal construct, arising from a number of legislative developments: the need to assess an accused's mental competency to stand trial; the increased recognition of the patient/client's right to informed consent or the right to refuse treatment; and the need to protect the vulnerable members of society from abuse and neglect (Bloom & Bay, 1996; Fulbrook, 1994; Gordon & Verdun-Jones, 1992).

A review of predominantly medical and legal literature suggests that a uniform, universal definition is lacking, although a number of key themes arise. Simply put, "the notion of competence functions to distinguish persons who are able to make their own choices from those who are not" (Glass, 1997, p. 5). The term *competency* is often used interchangeably in the literature with the terms *capability*, as used in legislation in British Columbia, or *capacity*, as found in Ontario legislation. The terms capability or capacity have been recently adopted in order to focus the definition on the individual's abilities in the context of specific decision, rather than focusing on competency as a global phenomenon (Ho, 1995). However, this paper will reflect the usage of all three terms.

In addition to differences in terminology, there are different definitions of competency in the literature, and in different pieces of legislation. These different definitions have an impact on how competency is assessed. One definition of competency to make decisions, as found in the literature, requires that a person is able to comprehend his/her particular situation, relate information received to his/her current situation, weigh the risks and benefits of all

options against a set of personal values, and make a choice and communicate both the choice

and reasons for it to others (Pruchno, Smyer, Rose, Hartman-Stein, & Henderson-Laribee,

1995).

In the new adult guardianship legislation in British Columbia, portions which came

into force on February 28, 2000, the determination of incapability is based on the adult

demonstrating an understanding of the information provided and that the information applies to

themselves (*Health Care (Consent) and Care Facility (Admission) Act, s. 7*). This can be

compared to the definition of capacity found in Ontario's legislation (the *Substitute Decisions*

Act, 1992, and the *Health Care Consent Act, 1996*) where capacity is defined as "the ability to

understand information relevant to making a decision and the ability to appreciate the

reasonably foreseeable consequences of a decision or lack of decision" (Bloom & Bay, 1996, p.

12).

The terms *understand* and *appreciate* are critical to these definitions of competency.

Understanding implies a full awareness and clear perception of the meaning of a situation

(Glass, 1997). *Appreciating* implies a critical judgement of the information being understood

and involves an emotional as well as cognitive component. To appreciate the consequences of a

decision, individuals must not only be able to apply the information to their own particular

situation, but apply a judgement about this information. According to Glass (1997), the

"difference in meaning between mere understanding and appreciation can have an enormous

impact upon the assessment of a patient's competence" (p. 13).

There has also been a growing recognition of the effect that emotions have on a

person's ability to understand and appreciate a decision, and that decision-making can be

impaired due to extreme emotional distress, or psychiatric disturbances such as depression.

White (1994) identifies the importance of including cognitive and affective components to any definition of competence, as emotions and cognitive status play an influential role in decision-making. For example, an individual may have the cognitive abilities to understand the implications of a particular decision, but an affective disorder may impair his/her ability to appreciate the consequences.

In addition to being able to understand and appreciate the consequences of a decision, some definitions of competency set a higher standard, in which the individual assessed must also be able to implement a decision. As a result, competency may refer both to decision-making abilities, and the ability to perform specific functional tasks, such as activities of daily living. Task-oriented definitions of competency focus on the individual's ability to adequately perform specific tasks, such as the activities involved in independent living (White, 1994). In discharge planning, when assessing the competency of patients to choose their place of residence, it is necessary to consider both their ability to choose where they will live, as well as their ability to function or thrive in the chosen place of residence (Silberfeld & Fish, 1994).

This can be contrasted to the concept of competency to make decisions regarding a proposed health care treatment, which does not usually include a functional component to the decision. The individual being assessed for his/her ability to provide consent for medical treatment must only be able to demonstrate an understanding, or an understanding and appreciation of the consequences of his/her decision. As Dubler (1988) highlights, discharge planning requires not only the cognitive ability and judgement required in making treatment decisions, but also "present functioning [and] continuing ability to address the challenges of independent living" (p. 78). A growing recognition of the unique processes of decision-making

for each particular type of decision, has led to a corresponding shift in the to view competency as being task or decision specific.

In addition to now viewing competency as decision specific rather than being all-encompassing, the literature, policy, and legislation surrounding competency and competency assessments have gone through other significant changes in recent years. Historically, competency was viewed an "all-or-nothing" phenomenon, that is to say, a person was either competent, or incompetent. Competency is now understood to exist along a continuum, and is present in a matter of degrees. Another important shift has occurred in making explicit the need to assume an individual as capable unless he or she is determined to be incapable: thus it is incapability that needs to be proven, not capability, as has been the historic practice (Etchells, Sharpe, Elliott & Singer, 1996; Ho, 1995; Scott & Lynch, 1994; Silberfeld & Fish, 1994; White, 1994).

Ethical Considerations

Further review of the literature highlighted that the definition of competency, as well as the assessment process, had a large ethical component which impacts the process by which social workers discharge plan with elderly patients. As a social construct, the concept of competency is itself value-laden, shaped by societal and individual values, and is subject to interpretation in assessment (Fulbrook, 1994). As well, the professional and personal values of the assessor will have a significant impact on the assessment process and outcome (Glass, 1997).

Social work practitioners are "nurtured in the tradition of client empowerment and self-determination" (Murdach, 1996, p. 26). The profession of social work has long embraced the principle of client self-determination, which asserts that the client has a right, as well as a need,

to be free to make his/her own life choices (Reamer, 1995). The Canadian Association of

Social Work (CASW) Code of Ethics (1994) outlines the philosophy of social work to be one

of commitment to the value of self-determination, and the National Association of Social Work

(NASW) Code of Ethics (1994) declares that social workers have an obligation to maximize

the self-determination of the client (CASW, 1994; NASW as cited in Reamer, 1995).

Social workers also have a primary duty to act in the client's best interest, which

according to the CASW Code of Ethics (1994), is defined to be:

> that the wishes, desires, motivations, and plans of the client are taken by the social
>
> worker as the primary consideration in any intervention plan developed by the social
>
> worker subject to change only when the client's plans are documented to be unrealistic,
>
> unreasonable or potentially harmful to self or others …[and]…that all actions and
>
> interventions of the social worker are taken subject to the reasonable belief that the
>
> client will benefit from the action (p. 4).

However, in social work practice, the goals of client self-determination and client best interest

may not always coincide. In fact, research by Proctor, Morrow-Howell, and Lott (1993) found

that the most common ethical dilemma in hospital social work involved conflicts between the

principles of client self-determination and client best interest, especially when the patient's

mental status was impaired.

The struggle between the principles of self-determination and acting in the client's best

interest, or beneficence, has been well documented in medical and social work literature

(Abramson, 1989; Burstein, 1988; Clemens, Wetle, Feltes, Crabtree, & Dubitzky, 1994; Hertz,

1996; Rabins & Mace, 1986; Rathbone-McCuan, 1996). The majority of this literature is

descriptive rather than research based, although several articles use case studies to elucidate the

key issues. Self-determination, or autonomy, requires that an individual possess the three

conditions of voluntariness, competence, and knowledge (Beauchamp & Childress, 1983;

Stebnicki, 1994). In a competent individual, his/her autonomous decisions must be respected,

unless there are compelling reasons to do otherwise, such as the potential to inflict harm to the

self or others (Mappes & Zembaty, 1986).

In the client whose competency is compromised, there is a reduced ability to make

autonomous life choices. For cognitively impaired older adults, there is the assumption that this

may lead to an increased risk for harm, abuse, or neglect, which then justifies protective

intervention. Abramson (1989) describes paternalistic beneficence as protective interventions,

sometimes made without the client's consent, which are intended to enhance the client's

quality of life. This paternalism, or encroachment upon the client's right to self-determination,

is justified according to Abramson, when an individual is mentally incompetent, and unable to

comprehend the potential consequences of his/her actions.

Murdach (1996) builds on Abramson's concept of paternalistic beneficence, and

outlines a model of protective intervention based on the degree of decision-making impairment,

and the degree of risk to the client if he/she is free to determine his/her own choices. The result

is paternalistic intervention in degrees: limited, selective, and extensive. Murdach defines

limited beneficence as interventions that protect the client from harm, but do not significantly

interfere with his/her autonomy. Selective beneficence are those interventions which aim to

protect specific areas of a client's interests. When interventions act to protect all aspects of the

client's life, Murdach defines this as extensive beneficence.

While this model provides a conceptual framework for ethical dilemmas involving

self-determination and beneficence, it also contains some ambiguities and assumptions which

may be challenging in practice. The model assumes that adequate assessment tools exist to identify incapability, and that the process and the tools used are themselves value-neutral. In fact, the rigour of the tests for competency depends on the values, such as the degree of paternalism, held by the assessor (Mappes & Zembaty, 1986). The initial questioning of an individual's competence itself reflects professional and personal values: those individuals who refuse treatments and are deemed "noncompliant" or "difficult patients" are more likely to have their competency challenged (Fulbrook, 1994).

Thus an individual's competence is related to societal norms, and power relations in society, as those who hold more power, the "professionals" or "experts", are in a position to question another individual's right to self-determination (Fulbrook, 1994). Assessments of competency also reflect different societal, cultural and historical values. Over time, Western societies have increasingly embraced the value of self-determination, which may reflect an individualistic ideology not present in other cultures (Reamer, 1995). Different cultures and socio-economic statuses may also create in the individual different notions of acceptable risk and quality of life standards, which may not be held by the dominant culture and health care professionals (Rathbone-McCuan, 1996).

These ethical dimensions to the concept and assessment of competency must be considered by all social workers who intervene in the lives of cognitively impaired older adults. Societal, professional, and personal values interplay to affect the choices that individual social workers make when working with the elderly in health care settings.

<u>Legal Considerations</u>

  Social workers are not only confronted with these ethical aspects of discharge planning with patients with questionable competency to make decisions regarding place of residence, but they must also be aware of the relevant legislation. The concept of competency, as well as the corresponding assessment process, arises from a particular legislative context. Historically, mental health, capacity, and consent law has evolved over time, reflecting changing societal values and norms. The origins of current legislation respecting incapacity or incompetency can be traced to 19th century English lunacy law (Gordon & Verdun-Jones, 1992). During this time, the legal doctrine of *parens patriae* became accepted, in which the Crown became responsible for the care and custody of the property and persons of those who were unable to take care of themselves due to incompetency. The historical emphasis has been on caring for the estate of those incapable to do so themselves, and thus the laws developed reflect this emphasis and lack provisions to deal with issues of incapability in areas pertaining to the person. These early laws were also paternalistic in the emphasis on protection from harm, and lacked recognition of the rights of individuals to make their own choices, even if they placed the individual at risk.

  Since this time, however, advances in health care, changing demographics, and increased awareness of the rights of individuals, have created the impetus to change mental health and capacity legislation. These legislative reforms have been guided by the following principles:

  (1) Adults have a right to autonomy and self-determination.

  (2) Adults are entitled to the most effective but least restrictive, intrusive, stigmatizing, and depowering form of assistance, support, or protection if their decision-making ability is impaired and they are unable either independently or interdependently to

provide for and protect themselves or their property from harm. (Gordon & Verdun-Jones, 1992, p. 6-39).

While guardianship legislation reforms have occurred across Canada, there remains subtle yet significant variability in the interpretation of critical terms in relevant legislation which makes it difficult to provide universal and consistent services across the country (Verma & Silberfeld, 1997). Competency assessment tools that have been developed in one province may not be applicable to an assessment in other province due to differences in definitions of competency. For example, the defining of competency to make decisions regarding admission to a care facility, and the corresponding process in Ontario is specific to that legislation, and cannot be simply transferred to the British Columbia context. In Ontario, the assessment does not begin with an assumption of capability, and thus it is capability that is being determined, rather than incapability, as in the British Columbia context.

In addition to provincial and territorial statutes which govern the determination of incapacity and the appointment of guardians, there are other relevant statutes including: mental health laws and regulations; laws governing the public trustee, pensions and benefits; consent to treatment in health care; and substitute decision-making legislation. This legislation exists at the provincial level, and thus Canadian law lacks consistency in this area across the provinces and territories. Social workers must be familiar with the particular legislation existing in their jurisdiction and how it affects their practice. In British Columbia, the relevant legislation includes the *Patient's Property Act*, the *Mental Health Act*, the *Adult Guardianship Act, Part 3*, and the *Health Care (Consent) and Care Facility (Admission) Act*. Tables 1 and 2 summarize the key aspects of these pieces of legislation, and they will be discussed in greater detail below.

The Patient's Property Act

Under the *Patient's Property Act,* competency is divided into two categories, person and estate, although these terms are not specifically defined in the legislation. Competency with respect to the person pertains to the ability to provide consent for health care, personal care, admission to a long-term care facilities or the ability to care for oneself. Capability of estate refers to the ability of the individual to manage his/her financial and legal affairs. Although the *Patient's Property Act* pertains to both issues of the person and estate, only the aspects relevant to incapability of the person will be presented here, as these are the aspects that are relevant to placement issues.

The *Patient's Property Act*, sets out the judicial hearing procedure through which a Committee of Person may be appointed. Statutory definitions of competency or capacity are important as they specify the initial criteria which must exist before intervention can be considered. This can be done by either defining terms such as "incompetent person" or "mentally disabled person", or by specifying the conditions which must exist before a person can be treated as incompetent (Gordon, Verdun-Jones, & MacDougall, 1986). The *Patient's Property Act* does not define either the term competency, or the criteria necessary for an assessment (Donnelly, 1996), which suggests this is a matter left to the determination of the assessor and the courts. Instead, the legislation identifies those who are eligible for guardianship by specifying factors that must be established to the satisfaction of a court. In British Columbia, the court must be satisfied that a person is incapable of managing his/her affairs and/or him/herself, because of either "(a) mental infirmity arising from disease, age or otherwise, or (b) disorder or disability of mind arising from the use of drugs" (*Patient's*

Property Act, s. 2(1)). If these conditions are met, the individual is considered a "patient" under the Act.

The *Patient's Property Act* sets out the steps which must be followed when it is believed that a person is incompetent or incapacitated, and in need of protection. The Public Guardian and Trustee, a near relative or any other person may apply to the Supreme Court of British Columbia for an order declaring that a person is incapable of managing him/herself, or his/her finances, or both, due to mental infirmity or disorder, or disability of the mind. The application must be supported by the affidavits of two medical practitioners and information on the next of kin, assets, income, expenses and liabilities of the individual (Mclellan, 1999). Notice of the application is usually served on the proposed "patient" and the Public Guardian and Trustee of British Columbia, as well as the next of kin. Once the application is heard, the court has the option of either appointing a Committee (Guardian) of Person, Estate, or both, or referring the case to trial for determination.

Pursuing Committee of Person under the *Patient's Property Act* is seen as appropriate only when there are a number of issues to be dealt with, such as consent to health care treatment, in addition to placement issues. Committee of Person is not recommended solely for placement decisions, as it is very intrusive and strips the individual of his/her decision making authority in a wide range of areas. Committee of Person is also a long-term solution to issues of incapability, as the authority continues as long as the person lives, until the appointment is rescinded and/or the individual is deemed to be capable. The process is also costly and time consuming, which may be a hindrance when discharge planning in an acute care hospital, and when decisions regarding placement need to be made in the short term.

<u>The Mental Health Act</u>

Although the *Mental Health Act* does not provide mechanisms through which people can be declared incapable to manage themselves or their finances, it does describe the law of civil commitment of mentally disordered persons, as well as who has the authority to consent to treatment provided. It is a piece of legislation which allows an individual to be admitted, against his/her will, to a provincial mental health facility or psychiatric unit if the individual is mentally disordered, and requires medical treatment and care, supervision and control for his/her own protection or for the protection of others (*Mental Health Act*, s. 22(2)(c)). When an elderly person has a mental disorder as defined by the American Psychiatric Association's Diagnostic and Statistical Manual, and is requiring medical treatment and supervision for his/her own protection, he/she may be admitted involuntarily to a hospital psychiatric unit under this provision.

An involuntary admission requires two medical certificates to be completed after the individual has been examined, no more than 14 days before admission (Clements, 1991). Both certificates should be signed before the patient is detained and treated, although provisions exist for emergency involuntary admission on the basis of one medical certificate, with the second to be completed within 48 hours. Involuntarily admitted patients may be detained for up to one month, and if they are perceived to need further hospitalization, the initial detention may be renewed for another 30 days, then three months, and then six months at a time. The following criteria must be met in order for a physician to complete the certificate. The patient must:

be suffering from a mental disorder that seriously impairs the person's ability to react

appropriately to his or her environment, or to associate with others; requires psychiatric

treatment in or through a designated facility; requires care, supervision, and control in

or through a designated facility to prevent the person's substantial mental or physical

deterioration or for the person's own protection or the protection of others; and, is not

suitable as a voluntary patient (British Columbia Ministry of Health and Ministry

Responsible for Seniors, 1999)

A controversial provision of the *Mental Health Act* is the extended leave section, which

allows involuntary patients to be released to the care of others for a specified period of time.

This may include conditions that an individual must meet to prevent being recalled to the

psychiatric facility, conditions such as following specific living arrangements, or continuing to

take prescribed medications. This provision has also been used to certify involuntary patients

into long-term care facilities, when older adults with dementia or other mental disorders may

be refusing placement but are requiring the care and supervision provided in a facility. The

extended leave provision has been considered questionable, since "it is difficult to reconcile

how a patient's condition could satisfy the committal criteria but still permit residence in the

community [since] if patients need protection or society needs protection from them, patients

should remain within the facility" (Clements, 1991, p. 163). The committal procedure can be

extremely stressful and stigmatizing for patients and families, especially for older adults with

cognitive impairments.

As presented above, the *Patient's Property Act* and the *Mental Health Act* have

significant limitations in their ability to appropriately and effectively address the issue of

elderly persons who may be questionably capable of choosing their place of residence. These

Table 1: Highlights of the Patient's Property Act and the Mental Health Act
Relevant to Placement Decisions and Incapability

	Patient's Property Act	Mental Health Act
Definitions	Does not define capability or incompetency or outline how incapability is to be determined; uses the term incapable rather than incompetency;	Does not define capability or incompetency; term capability or incompetency not used
	A patient under the Act is a "person who is because of mental infirmity arising from disease, age or otherwise, is incapable of managing his or her affairs" (s. 1)	person with a mental disorder means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability to (a) react appropriately to the person's environment, or (b) to associate with others (s. 1)
		criteria for involuntary admission is that the person (i) requires treatment in or through a designated facility, (ii) requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or
		physical deterioration or for the protection of the person or patient or the protection of others (s. 22(3)(c))
Criteria for Assessment	Requires the presence of mental infirmity arising from disease, aging or otherwise, the disorder or disability of the mind can be the result of the use of drugs (stated explicitly in the Act)	Requires the presence of a mental disorder
	The determination of incapability does not make explicit reference to issues of risk or protection from harm	The person must also require protection from harm, either to themselves or for the protection of others. Implicit is the notion of risk.
Process	A court application, based on the medical opinion of two medical practitioners that the subject of the application is incapable of managing himself or herself and/or his/her affairs	Based on the assessment and certificates of two medical practitioners
	Results in the appointment of a Committee of Person; authority in place until person dies, or an order is made declaring them capable of person or appointing another individual as Committee	Person under certificate (I.e. involuntary admission) must initially be admitted to a provincial mental health facility or a psychiatric unit of a hospital, and then the extended leave provision can be used for placement in a long-term care facility
	The Committee of Person has the "custody of the person of the patient" (s. 15(1)(b)(ii))	The Certificate (for involuntary admission) can be renewed while the person is in the community or facility, or can be allowed to lapse

Table 1: Highlights of the Patient's Property Act and the Mental Health Act
Relevant to Placement Decisions and Incapability

Implications	The process of appointing a Committee of Person may not be appropriate for placement decisions due to the cost ($1500 $3000) and timeliness (2-3 months)	This process is quicker and cheaper, but requires the person to have a mental disorder
	Appointing a Committee of Person is seen as very intrusive as it grants the Committee "custody" of the person, I.e. the authority to make a wide range of decisions on behalf of the patient thus is not recommended for placement only	The adult must be admitted to hospital first before they can be placed in a long-term care facility under extended leave
	The Act emphasizes the management of the estate of the incapable person, rather than the role of the Committee of Person	Some facilities feel Certification under this Act gives enforceability to the placement decision if resident tries to leave

deficiencies have been part of the impetus for legislative reform, as well as the ageing

population and the growth of fields such as gerontology, which have increased attention to

issues such as law and ageing. A growing awareness of abuse and neglect of the elderly in both

community and institutional settings has led to an examination of the use of guardianship

legislation as a protective mechanism.

Adult Guardianship Legislation

In July of 1993, the British Columbia legislature passed four Acts that significantly

reformed adult guardianship and will influence social work practice. The guiding principles for

the development of this legislation include: a confirmation of the rights of adults to self-

determination, including the right to refuse health care, as long as they are capable and do not

cause harm to others; the principle that adults should receive the most effective, but the least

restrictive and intrusive, form of support or protection when they are unable to care for

themselves or their assets; the role of family and friends in providing adults with support and

assistance and substitute decision-making should be reinforced; the new legislation should

address the issues of abuse, neglect, and self-neglect of adults who are vulnerable; and that a

range of options for substitute or assisted decision-making should be provided (Office of the

Public Trustee, 1999).

Briefly, the four Acts are: *The Representation Agreeement Act*, which provides a legal

mechanism for capable adults to choose a representative to make decisions on their behalf if

they become incapable to do so; *The Health Care (Consent) and Care Facility (Admission)*

Act, which outlines the process for health care practitioners when working with adults who may

be incapable of providing consent for health care treatment and admission to a care facility;

The Adult Guardianship Act, which outlines processes for identifying adults suffering from

abuse, neglect, or self-neglect, for reviewing an adult's need for support and assistance, assessing their ability to refuse these supports, and outlines processes to provide services to adults when they are assessed as incapable of refusing support; and the *Public Guardian and Trustee Act*, which expands and clarifies the role of the Office of the Public Trustee as well as changes the official name.

The parts of these four acts that pertain to representation agreements, support and assistance for abused and neglected adults (the *Adult Guardianship Act, Pt. 3*), the *Public Guardian and Trustee Act*, and the *Health Care (Consent) and Care Facility (Admission) Act* (except Pt. 3), were proclaimed in force February 28, 2000. The balance of the legislation, which includes the court ordered decision-making, care facility admission and use of restraints legislation, will be reviewed and possibly proclaimed in force at a later date.

The adult guardianship legislation most relevant to assessing capability to make decisions regarding place of residence can be found in the *Adult Guardianship Act, Pt. 3* (which is in force), and *Health Care (Consent) and Care Facility (Admission) Act, Pt. 3* (which is not yet in force). See Table 2 for highlights of these two acts. In both of these acts, the presumption of capability is specified in section three. Regulations have been approved which include practice guidelines for assessing incapability to reject a support and assistance plan under Part 3 of the *Adult Guardianship Act*. These guidelines will be reviewed in greater detail in the following section. An interesting shift in this legislation is from referring to assessments of *capability*, as now being assessments of *incapability*, emphasizing that all adults are presumed to be capable, and therefore only incapability needs to be determined (Gordon, July 14, 1999). The legislation also sets out the duty to communicate in a manner appropriate to the adult's skills and abilities when conducting an assessment of incapability.

Under the *Adult Guardianship Act, Part 3*, a support and assistance plan can be developed which includes facility placement. If the adult rejects the plan, and is assessed as incapable, a support and assistance court order can be pursued to implement the provisions within the plan, including long-term care placement. The adult is assessed by a team of assessors who are authorized by the Public Guardian and Trustee's Office. The legislation has shifted from a medically dominated assessment process, as assessors do not have to be physicians, and in fact, other professionals, such as social workers, are encouraged to become assessors. The *Adult Guardianship Act, Part 3*, may provide a process which can be utilized by social workers discharge planning in hospitals, particularly while the relevant provisions of *the Health Care (Consent) and Care Facility (Admission) Act* are not yet in force. The timeliness of the process of assessment and obtaining a court order, as well as the cost, may be a hindrance of the applicability of *the Adult Guardianship Act* in this regard.

<u>The Health Care (Consent) and Care Facility Admission Act (Pt. 3)</u>

Although the portion of the *Health Care (Consent) and Care Facility (Admission) Act* which pertains to admission to a care facility is not yet in force, it will be presented here for discussion purposes, as this part of the Act is directly relevant to discharge planning in a hospital setting. The Act outlines the procedures which should be followed when admitting an adult to a care facility and contains provisions for obtaining a substitute decision maker for an individual who is incapable of making this decision (Gordon, 2000). Part 3 of the Act also includes provisions about the use of restraints in facility, but this section of the Act will not be discussed here. Part 3 of the Act is not yet in force, will be reviewed within the next two years, and will likely be proclaimed in force following any necessary amendments (Gordon, 1999).

The Act has yet to define a care facility, but it will likely include a wide range of facilities such as group homes for mentally challenged persons and others to be listed in a regulation (Gordon, 2000). If a proposal for facility care is rejected by an adult, section 21 of the Act states that an assessment by a designated agency may be arranged to determine if the adult is incapable of making that decision, if there is reason to believe that "(a) the adult needs and would benefit from admission to the care facility mentioned in the facility care proposal, and (b) the adult is incapable of deciding to reject the proposal" (s. 21(1)(a), (b)). When assessing if the adult is incapable of rejecting the facility care proposal, the assessor must "consider whether the adult demonstrates that he or she understands the facility care proposal, and the reason for admission to the care facility" (s. 21(3)(b)) and comply with the regulations governing these assessments, which are still to be drafted.

If the adult is assessed as incapable, the legislation outlines who can accept the proposal on the adult's behalf (s. 22). A person who will act on the adult's behalf must be 19 years of age, have had contact with the adult during the previous 12 month period, have no dispute with the adult, and themselves be capable of accepting or rejecting the proposal (s. 22(3)). The legislation explicitly states that the adult's current wishes, values and beliefs must be considered (s. 22(5)), and that admission should be considered only if the adult would benefit from such a plan. If family is unavailable to act as a substitute decision maker, then the Public Guardian and Trustee could act in this role.

The Act states that the referral for an assessment should be made to the designated agency, but this is yet to be defined. If the individual is in a hospital, ideally the hospital should be named as a designated agency, as the expertise for performing the assessment of incapability already exists in the hospital. A designated agency external to the hospital could

raise issues of timeliness of discharge if there is a waiting period to have the assessment performed. However, assessors of incapability from within the hospital may be subject to organizational pressures to reduce hospital lengths of stays, which may then impact upon the assessment process and outcome. The Act also does not specify whether the assessor will be a medical practitioner, or whether other professionals will be included as formal assessors. The Community Coalition for Implementation of Adult Guardianship Legislation (1995) also points out that the Act does not require the assessor to inform the individual about a finding of incapability, the right to a review, or whom they have chosen to make the decision for the incapable person. These suggestions may be incorporated in the eventual regulations.

The Act lists those people who can arrange for an assessment of incapability: a substitute decision maker, the individual's spouse, children, parent, brother or sister, or anyone related by birth, the medical practitioner, or the Public Guardian and Trustee, if no one else is available. The list should include a social worker, particularly in a hospital setting, as it is the social worker who is involved in the placement process and would be aware, through his/her informal assessment, of the need for a formal assessment. In the community, the long-term care case manager may be the most aware of the individual's need for an assessment of incapability to make the placement decision.

Gordon (2000) explains that the Act "does not apply if a proposal is explained to an adult and the person co-operates while being moved to the facility. The co-operation may be interpreted as an acceptance of a proposal" (p. 141). An assessment of incapability is only conducted if the patient rejects the care facility proposal. This approach is consistent with the spirit of the new legislation, which assumes the individual to be capable of making the decision and attempts to remove decision making ability only as a last resort. However, it may

conflict with the principle of informed consent, which makes capability a requirement for consent to be valid.

The assessment of incapability is decision-specific: for example, the individual assessed as incapable under Part 3 of the Act, is not assumed to be incapable of providing consent for health care. The Act also sets out, in Part 4, the process for a review and appeal of a finding of incapability and for a review of the decision a substitute decision maker. The individual who has been assessed as incapable cannot ask for a review of the person who may be appointed to be the substitute decision maker (Community Coalition, 1995). There is a time limit of 72 hours from when the decision was made to request a review. However, this may not address situations where an individual is not told right away about the assessment of his/her incapability, or if a slightly confused patient is occupied with adjusting to his/her move to a facility.

The Act does not specify how the adult finds out about his/her right to a review. It also does not address how to deal with an individual who wants to move out of a facility. It is not clear if the person assessed as incapable to make the admission decision is also assumed to be incapable to make the decision to leave the facility (Community Coalition, 1995). Although the *Health Care (Consent) and Care Facility (Admission) Act* provides a shift in viewing the patient as capable unless assessed otherwise, and makes explicit the rationale of assessing incapability only as a last resort, it is clear that there are still unanswered questions and room for improvement. As the legislation is not yet in force, these changes can be made to the Act itself, or to the forthcoming regulations. The care facility admission portion of the *Health Care (Consent) and Care Facility (Admission) Act* will be reviewed prior to being proclaimed in force.

Table 2: Highlights of the Adult Guardianship Legislation Relevant to
Placement Decisions and Assessing Incapability

	Adult Guardianship Act, Pt. 3	Health Care (Consent) and Care Facility (Admission) Act, Pt. 3 (not yet in force)
Definitions	Incapability is not explicitly defined in the Act although the presumption of capability, rather than incapability, is stated in s. 3	Incapability is not explicitly defined in the Act, although the presumption of capability is stated in s. 3
	Self neglect means "any failure of an adult to take care of him/herself that causes or is reasonably likely to cause...serious physical or mental harm or substantial damage to or loss of assets..." (s. 1)	When assessing incapability, the assessor must "consider whether the adult demonstrates that he or she understands the facility care proposal, and the reason for admission to the care facility" (s. 21(3)(b))
Criteria for Assessment	Is not based on the person having a specific illness or disorder, but is based on the notion of risk and harm	Is not based on the adult having a mental disorder, but on the adult rejecting a care facility proposal
	Guidelines for assessing incapability under this Act are set out in the regulation	The care facility proposal must benefit the adult. It is unclear if this means protection from harm and the notion of risk
	The assessment of incapability determines whether the adult understands a) the services described in the support and assistance plan; and b) why the services are being offered to the adult; and c) the consequences of not accepting the services	s. 21(3)(a) states that the assessor must comply with the regulations governing assessments. These guidelines have yet to be developed.
Process	Adult is identified who is experiencing abuse, neglect or self-neglect; a support and assistance plan is offered; if rejected and the adult appears incapable, a request for a formal assessment of incapability is made to the Public Guardian and Trustee	If the adult would benefit from admission to a care facility, rejects a care facility proposal, and appears to be incapable, an assessment of incapability can be requested by family or the medical practitioner, to a designated agency
	If the adult is assessed as incapable, an application can be made to Provincial (Family) Court for a Support and Assistance Order	
	Placement in a long term care facility can be a part of the support and assistance plan and possible court order	

Table 2: Highlights of the Adult Guardianship Legislation Relevant to
Placement Decisions and Assessing Incapability

Implications	Invoives court proceedings for placement, which is not consistent with the care facility admission portion of the Health Care (Consent) and Care Facility (Admission) Act	Designated agencies who will perform the assessment have not yet been specific (will they be different than those designated under Pt. 3 of the Adult Guardianship Act? - could be confusing)
	However, this does incorporate due process as the adult has an opportunity to be involved/oppose the court hearing and the decision can be appealed to the Supreme Court	The adult can request a review of the decision of the person who makes the decision on his/her behalf, if they have been assessed as incapable
	Support and assistance orders, including admission to a care facility, are valid for a specified period of up to 6 months, with one renewal for an additional 6 months	It is unclear if a person is considered incapable of making the admission decision, if they are then considered, incapable of deciding to leave the facility, or if the decision of the substitute is final
	However, there is a cost and there may be an issue of timeliness with this process - may be an issue if the adult is an in-patient in hospital	This process is based on what may already be happening in current practice

Practical Considerations when Assessing Competency in Older Adults

Although it is now recognized that competency exists in a matter of degrees, rather than being all or nothing, the law continues to require a threshold which divides those who are competent from those who are not. This creates challenges in making this determination, as in reality, this distinction is arbitrary and difficult to identify. In fact, difficulties in assessing capacity arise when an individual lies in the middle of the continuum, which Ho (1995) refers to as the "grey zone [of] 'marginal' capacity" (p. 260).

The law assumes that capacity or competency may be accurately identified by health care practitioners, but the legislation does not require a particular assessment technique be used (Gordon & Verdun-Jones, 1992). In practice, there is no standardized way to conduct capacity assessments, although a review of the literature identifies elements that may be common to most assessments. Naglie et al. (1995) identify a number of key issues that may be addressed in a competency assessment: the ability to express oneself; memory impairments; attention; orientation; reception of information; learning and retention of information; reasoning; judgement; ability to implement a decision; responsiveness to the social environment; the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs); and the distortion of reality, congruence of beliefs, feelings and actions.

Silberfeld and Fish (1994) distinguish between informal and formal assessments of competency. Informal competency assessments may be performed by professionals or the concerned lay-person, and involve screening the individual to determine whether a formal assessment of competency may be necessary. Informal assessments require the identification of: the area of concern or the problem that makes an assessment necessary; whether or not a

formal assessment will resolve this problem or if a voluntary solution is possible; the legal

mechanisms available for substitute decision making and the laws relevant to incompetency in

that particular jurisdiction; whose interests would be served by further assessment; and the

risks involved in the current situation (Silberfeld & Fish, 1994).

Silberfeld and Fish expand on the notion of assessing risk during an informal

assessment of competency, and suggest that the following questions should be asked:

1. Is the risk new or old?

2. Are there concrete instances of failure?

3. How grave is the risk?

4. Is the risk imminent or remote?

5. What is the risk of harm to others?

6. How objective is the assessment? (or the assessor)

7. Is a risk chosen or accidental? (pp. 61-65)

A risk assessment attempts to address these question based on objective evidence, although

Silberfeld and Fish do not describe who provides the evidence, and how it is provided. It is

interesting to note that their conception of an informal assessment does not include the actual

assessment of the person's decision making ability, as this is done only in the formal

assessment.

Formal assessments of capacity usually involve three different measures: "1) cognitive

function testing, 2) general impressions of capacity, and 3) specific capacity assessments"

(Etchells et al., 1996, p. 659). Cognitive function tests are easy to administer and are generally

reliable, but they have important limitations. Cognitive status is only one component which

underlies competency, and thus must be used in conjunction with other types of evaluations

(Stebnicki, 1994). The Mini-Mental State Examination (MMSE) (Folstein, Folstein, &

McHugh, 1975 as cited in Foreman, 1987) has been found to be a reliable and valid measure of

cognitive status of elderly hospitalized patients, and is used extensively in most hospital

settings. Criticisms of the MMSE include that it has a lack of cultural specificity, which is not

addressed by merely translating the test; that poor education is a predictor of poor performance

on the test; and the test is highly dependent on the absence of visual and hearing impairment

(Clarfield, 1989; Pruchno et al., 1995). There may also be a tendency in practice to equate poor

scores on the MMSE with incompetency.

General impressions of capacity are the conclusions that are drawn without a thorough

assessment, usually based on observation or even simply the presence of a diagnosis of a

mental disorder. Forming an impression of a patient's capability is often simple and quick, but

the determination is usually unreliable, inaccurate, and easily biased (Etchells et al., 1996).

There is a tendency, however, for health care practitioners, including social workers, to form an

initial impression regarding an elderly person's competency, which may be difficult to

disregard when further assessing, in spite of the requirement of the presumption of competence

(Scott & Lynch, 1994). It is also critical to remember that the presence of a psychiatric,

neurological, or mental disability alone is not sufficient evidence to conclude an individual is

incompetent (Stebnicki, 1994).

A number of factors present in hospitalized older persons may influence the assessment

of capacity. Competency may fluctuate from day to day, even hour to hour, with changes in a

patient's underlying medical, physical, and psychological conditions (Ho, 1995; Scott &

Lynch, 1994; Stebnicki, 1994). Language barriers and speech disturbances such as aphasia

raise important communication challenges (Etchells et al., 1996). Intense pain and various

medications may also influence an elderly patient's mental functioning, and thus the assessment of capacity (Ho, 1995). An important challenge exists when assessing patients who are in a state of denial regarding their prognosis, as accurate evaluations of their understanding of risks associated with particular decisions may be obscured (Ho, 1995; Scott & Lynch, 1994).

These limitations of capacity assessments make accurate and reliable determination of competency in older persons challenging indeed. Social workers must be aware of the limitations of their assessments, and be adaptable to new, tested methods as these arise, if they improve the reliability and consistency of competency determinations. Ideally, the finding of incompetency should not depend on who is doing the assessment, but rather the characteristics of the individual being assessed. The goal of standardization of capacity assessments attempts to eliminate the variability of determinations between and within health care professions (Scott & Lynch, 1994).

Specific capacity assessments have a number of strengths and weaknesses. Strengths of specific capacity assessments are that they are clinically feasible to execute, and can adapt to assess a number of different areas of competency. However, the assessment is highly dependent upon the extent of the disclosure of the individual being assessed. To improve the efficacy and accuracy of specific capacity assessments, the assessor can follow a number of recommendations: the individual being assessed should be as comfortable as possible; there should be no language barriers or limitations; the evaluation should be communicated at a level appropriate to the client; the evaluator should be aware of his/her own attitudes and biases prior to testing, as well as the cultural, social, and personal values of the client; information about the client's history should be gathered, if necessary from family and friends; medical records should be reviewed; mental-status and physical examinations should be completed; and the

assessment should be performed in stages, rather than in one visit (Bay, Fram, Silberfeld, Shushelski, & Bloom, 1996; Silberfeld & Fish, 1994; Wahl, LeClair, & Himel, 1996).

In recent years, a number of legislation specific competency assessment methods have been developed in order to standardize the assessment process within a particular jurisdiction. The majority of these specific capacity assessments focus on competency to consent to medical treatment, rather than personal care decisions or choosing place of residence. However, two methods will be highlighted due to their close connection to the issue of assessing competency to make decisions regarding place of residence.

The first method is that found in Ontario under the *Health Care Consent Act, 1996*. Under this Act, social workers who are members of the Ontario College of Certified Social Workers can act as evaluators of capacity for admission to a long-term care facility. Other professionals who are considered to be qualified evaluators include audiologist and speech-language pathologists, nurses, occupational therapists, physicians and surgeons, physiotherapists and psychologists. It is interesting to note evaluators do not require specific training, simply membership in their professional college.

Under this legislation, capacity is defined as the ability to understand information relevant to a decision, and the ability to appreciate the reasonably foreseeable consequences of a decision, or the lack of a decision (*Health Care Consent Act, 1996*). Evaluators of capacity for admission to a long-term care facility are provided a standardized questionnaire to assist them in making this determination. The questionnaire highlights the importance of identifying and addressing any barriers to communication (e.g. hearing impairments) as well as the need to communicate at a level compatible with that individual. This questionnaire is a required component of the long-term care application process, meaning that all individuals who are to

be placed in, or wait-listed for, a long-term care facility must have their capacity evaluated. Evaluators are also reminded that they are specifically assessing capacity to make the admission decision, and that it is not a global determination of mental capacity.

The questionnaire for the determination of capability contains five questions:

1. What problems are you having right now? (Does the person understand her/his condition or problem?)

2. How do you think admission to a nursing home or home for the aged could help you with your condition/problem? (Does the person appreciate the foreseeable consequences or admission or not?)

3. Can you think of any other ways of looking after your condition/problem? (Does the person understand the condition/problem?)

4. What could happen to you if you choose not to live in a nursing home or home for the aged? (Does the person appreciate the foreseeable consequences of admission or not?)

5. What could happen to you if you choose to live in a nursing home or home for the aged? (Does the person appreciate the foreseeable consequences of admission or not?) (*Health Care Consent Act, 1996*)

There are several limitations in the transferability of this questionnaire to the British Columbia context. Central is the definition of capacity: in Ontario, the assessment focuses on the individual's ability to understand *and* appreciate the consequences of a decision. In British Columbia, capacity is defined as having an understanding of the consequences, a lower level of capacity. Another key difference is that the evaluation does not begin with the presumption of capability, and thus it is an assessment of capacity, rather than incapacity, to make the facility

admission decision. In British Columbia, the emphasis is placed on assessing incapability, rather than capability. This subtle difference has significant implications for the entire assessment, as it is incapability, rather than capability, which must be proven.

The second approach which is relevant to assessing capacity to make long-term care admission decisions can be found in the practice guidelines for assessing incapability under Part 3 of the British Columbia *Adult Guardianship Act*. These practice guidelines were developed by the Incapability Assessment Steering Committee, in collaboration with the Public Guardian and Trustee of B.C., and the Ministry of Health. Individuals and organizations also participated in the development of the guidelines through consultation forums and written feedback. Assessors under Part 3 of the Act are required to conduct assessment of incapability in accordance with these guidelines (Public Guardian and Trustee of British Columbia, March 17, 2000)

Some of the key components of these guidelines will be reviewed here, to highlight those aspects that may be especially relevant to assessing capability to make decisions regarding place of residence. A number of principles are identified to guide the process of incapability assessments under the *Adult Guardianship Act*, Part 3. Some of these principles include conducting assessments only as a last resort and only if there are no other ways of meeting the adult's needs; ensuring the assessment is serving the interests of the adult; and beginning with the assumption of capability. The assessment of incapability is specific to the decision of the adult to accept or not accept the services offered in a support and assistance plan. A finding of incapability is relevant only to this specific decision, and it is not a permanent finding.

There is a shift from a medically based assessment of incapability, as other professionals with appropriate expertise and who meet specific criteria, can act as assessors under this Act. The assessment specifically determines if the adult understands the services described in the support and assistance plan; the reasons the services are being offered; and the consequences to the adult if the services are not accepted. It is mandatory under these guidelines to gather collateral information from those actively involved with the adult's life: a spouse, available relatives or friends; and those who have provided social or health care services to the adult within the last six months.

The guidelines present a framework for determining understanding, and envision the assessment as a dialogue with the adult. An adult is said to demonstrate "understanding" when he/she can express, in his/her own way, the information he/she has been given, and can indicate that this applies to him/herself. The guidelines remind the assessor that the presence of a diagnosis of some kind, or a cognitive impairment, should not lead the assessor to conclude the adult is incapable of making this decision. The guidelines also emphasize that:

> the presence of abuse, neglect or self-neglect does not mean an adult is incapable of decision-making;
>
> the adult may voluntarily incur risk if he [sic] understands the consequences of making that choice (Public Guardian and Trustee, 2000, p. 20).

These guidelines are specific to the *Adult Guardianship Act, Part 3*, but may be a useful starting point for the development of practice guidelines for assessing capability to make facility admission decisions. However, as capability is decision specific, the practice guidelines must reflect the unique nature of the placement decision process.

The Rationale for this Research Project

This review of the literature demonstrates that the concept of competency is multi-dimensional, containing ethical and legal dimensions, and practical challenges when trying to assess capability. The literature is lacking in research-based knowledge, as the majority of the articles are commentaries or discussion pieces, and a few use case studies to illustrate points of discussion. The few research-based articles are from a medical perspective, and focus on quantitative measures of competency to make decisions regarding health care.

Scott and Lynch (1994) conducted a one-day snap-shot survey of health care professionals working in a palliative care unit, to explore how they made judgements regarding the competency of patients to make decisions about their care. They found that professionals often made quick judgements about a patient's competency, without a formal assessment, and without being aware of having done so. Scott and Lynch also found that determinations of capability varied widely between and within disciplines on the team, but the sample was too small to see if there were any patterns. The results of this study were also specific to the palliative care population, and the researchers cautioned applying the results to other populations due a unique set of clinical issues that arise in palliative care: frequently fluctuating levels of competency, strong medications that are used for pain control which can impair decision-making ability, and issues of denial about prognosis. Scott and Lynch suggest that qualitative research is needed to explore the process of clinical assessment of competency, as understanding the process would help in the development of assessment guidelines.

The Competency Clinic at the Baycrest Centre for Geriatric Care has been a leader in research in the area of competency and competency assessments. One study which attempted to identify key components of a competency assessment was that by Naglie et al. (1995) at the

Competency Clinic at the Baycrest Centre. Naglie convened three separate panels of multidisciplinary experts to define items relevant to most, if not all, assessments of competency. The panels were also asked to assign weights for the corresponding importance of these items. Each of the three panels reached a consensus on the list of assessment items which they believed were important to assessments of competency. However, the panels were unable to assign relative weights to the items, explaining that the weights would differ with the specifics of each case being assessed and that the weights would therefore not be generalizable. This emphasizes the specificity of competency assessments to a particular context. The participants were apprehensive about the potential misuse of a quantitative index through the identification of a threshold "score", which would then be used to separate those who were incapable from those who were capable. The participants felt that competency is so context specific that that it would be difficult for a quantitative index to capture the nuances of each individual case. All three panels agreed with the notion of decision-specific competency determinations and as a result, this study failed to develop an index of assessment items relevant to any or all competency assessments. Naglie et al. identified directions for future research, such as developing guidelines for specific types of competency assessments. In particular, Naglie et al. suggest that qualitative rather than quantitative decisional aids may be more likely to be accepted in practice as qualitative aids can better capture the complexities of each individual case.

The benefits of establishing specific competency assessment guidelines, such as for the decision regarding discharge destination include:

(i) establishing practice guidelines which could help to ensure that important

aspects of capacity assessments are not overlooked and that all those being assessed

receive equitable treatment; (ii) minimizing the risk that judgements

of incapacity may reflect individual biases of the assessors; and (iii) providing

a framework which reflects how experts arrive at mental capacity decisions,

thus serving as an important teaching model for those training in how to

carry out capacity assessments (Naglie et al., 1995, pp. 698-699).

As previously discussed, incapability assessment practice guidelines have been drafted for the

Adult Guardianship Act abuse and neglect provisions, as well as for health care consent, but

none have been drafted for the decision of admission to a care facility.

This review of the literature highlights the lack of research specific to the process of

assessing of competency to make decisions regarding place of residence, and how this is

relevant to social work practice. Although the literature clearly suggests that societal,

professional and personal values affect the discharge planning and competency assessment

process, there is a lack of discussion in the literature of how this unfolds in social work

practice.

As a result, I felt it was important to consult with those who are often faced with the

issue of working with individuals whose competency to make decisions regarding place of

residence is questionable. Social workers in hospital settings who discharge plan with elderly

patients, often appeared, from my experience, to be involved in situations where competency to

make discharge plans was a concern. I felt that the expertise of these social workers in this area

could help make explicit the way competency to make decisions regarding place of residence

was perceived, and how the questioning of competency usually unfolded. The experiences of

social workers could also highlight the issues or unique challenges that arise in the assessing of

capability to determine place of residence. Thus this research project explored how social workers discharge planned with elderly hospitalized patients, when there were concerns about the patient's competency to make decisions regarding place of residence. The goal of this research was to generate a rich description of this process and to identify implications for social work practice and areas for further research. This knowledge base could then serve as the starting point for developing guidelines for assessing incapability to make decisions regarding place of residence, and to identify ways to improve the process to ensure it enhances the self-determination and well-being of the older adult.

CHAPTER THREE

METHODOLOGY

<u>Method</u>

The goal of this research was to generate a rich description of the process of discharge planning by social workers with elderly patients whose competency to make the decision regarding place of residence was questionable. Qualitative research methods were chosen for this study as a qualitative approach was consistent with this purpose. Qualitative research is especially suited to research with goals of generating an understanding of the experiences of participants, an understanding of the context within which the participants act, identifying unanticipated phenomenon and generating new theories, understanding the process by which events take place, rather than simply outcomes, and exploring relationships between phenomenon (Maxwell, 1996).

Qualitative research methods were also appropriate for this study as the project was exploratory in nature, attempting to explore, from a social work perspective, the process of discharge planning when there are issues of competency. As presented in the literature review, there is a lack of research based understanding of this process, and a need for qualitative research was specifically identified (Naglie et al., 1995; Scott & Lynch, 1994). Qualitative research is also an iterative, continuous, and flexible process, which fit the emerging nature of this research project. This study was conducted in two phases: the first phase, individual interviews, were used to provide direction for the second phase, a focus group. Individual interviews and focus groups are methods commonly used in qualitative studies (Creswell, 1998).

The method and design of this study received the approval of the Behavioural Research Ethics Board at the University of British Columbia on May 4, 1999 as well as the approval of the St. Paul's Hospital Ethics Committee for Human Experimentation, on April 6, 1999. The Certificates of Approval can be found in Appendices A and B.

Sampling

In this study, social workers were recruited who were currently working in a hospital in the Vancouver area. Individual social workers were recruited on the basis of their ability to provide information-rich cases for in-depth study, and their ability to share their experiences discharge planning with elderly patients whose competency to make decision regarding place of residence was questionable. This was consistent with a purposeful and homogenous sampling strategy (Patton, 1990). This sample provided a degree of homogeneity, as all the participants worked in a hospital environment and I assumed this would mean they would have similar experiences in discharge planning (e.g. similar organizational structure, similar hospital policies and culture). The criteria for participation included self-identification as a social worker. I did not request a particular social work designation, such as an MSW or RSW, as I did not want to exclude anyone who had valuable work experience to share in this research project, based on educational status.

The individual interview participants were recruited from a geriatric hospital in Vancouver, British Columbia. This site was chosen as it was my MSW field placement and a rapport had been developed with the social workers and potential participants. This site met the sampling strategy by providing participants who worked with older adults, experienced issues with competency when discharge planning, and provided a fairly homogenous sample as all the

social workers worked within the same organization. The rationale for restricting research to this one site was to obtain a homogenous sample which could be analyzed in greater depth to identify key themes and categories. The drawback of restricting research to one site was that results may not be generalizable to social work practice at other settings. The second phase of this research project, the focus group, drew from other hospital settings and broadened the sample base, thus strengthening this research.

The recruitment for the individual interviews drew from a pool of six full-time and two part-time social workers at this hospital, including my field instructor. My field instructor was excluded at the time of recruitment as she was responsible for evaluating my field placement performance, and I did not want her to feel there was any conflict of interest. However, my field instructor acted as a resource person and assisted me in gaining access to research participants, a process recommended by Creswell (1998). The head of the social work department was approached to elicit her support for the research project, which she enthusiastically endorsed.

In order to address ethical concerns of voluntary participation, a letter was sent to all seven social workers (eight less my field instructor) outlining the research project, their right to withdraw from the study at any time, the procedures to be used in collecting data, the issue of confidentiality of participants, and any risks or benefits to participating in the research. This method of recruiting participants was used to enhance the voluntariness of participation. A copy of this letter is provided in Appendix C. Four social workers responded by telephone and agreed to be interviewed. No one contacted me to decline participation. I proceeded with the sample of four participants to obtain in-depth descriptions from these information-rich sources, which would then provide me with preliminary findings to further explore in the focus group.

These four participants were all female, had an MSW, and at least two years social work experience in hospital settings.

The focus group also followed a purposeful sampling strategy. Focus groups tend to be characterized by homogeneity, but should have some differences to allow for variation in opinions (Krueger, 1994). Participants may be more likely to share their experiences with people they perceive as similar (Carey, 1994).The literature suggests that the sample be homogenous in terms of occupation, education level, age and gender (Carey, 1994; Krueger, 1994). The focus sample was similar with respect to occupation, as all participants were social workers in hospital settings. All participants had a university education with a degree in social work.

Social workers with discharge planning experience where competency arose as an issue were recruited as focus group participants. The recruitment criteria was the same as in the individual interviews to enhance the comparability of the experiences of all participants. I decided to restrict the sample to social workers in a hospital setting, rather than open it to social workers in the community or other institutions. This was based on the assumption, derived from the individual interviews, that the organizational context may have an impact on the assessment process and outcome.

Focus group participants were recruited through departments of social work at hospitals in the city of Vancouver. An initial letter of contact was delivered to the department head of five local hospitals. A recruitment notice was forwarded to each social work department, with copies to be distributed to each social worker in their mail box. A copy of this recruitment notice can be found in Appendix D. Approximately 60 recruitment notices were distributed in total.

The literature suggests recruiting at least one to two participants beyond the number desired for the focus group (Morgan, 1997). I was hoping to have six to eight people express interest, in order to compensate for possible attrition and have a focus group of five to six people. However, only five individuals responded to the recruitment notice. Unfortunately, prior to the actual meeting, two participants had to withdraw, leaving three participants.

According to the literature, a focus group should ideally contain six to nine participants (Krueger, 1994). Although the focus group held was smaller than that recommended in the literature, a mini-focus group can also be effective because a smaller group can help to establish group cohesion (Carey, 1994; Krueger, 1994). The smaller group size also provides participants with greater opportunities to share their experiences and perspectives (Carey, 1994). Small focus groups can be used when participants have a high level of involvement with the research topic, when the topic is complex, or when recruitment factors limit other options (Morgan, 1998). The small number of participants does limit the range of experiences raised in the focus group, but can provide depth and richness of data (Krueger, 1994). As Morgan (1997) states: " I have conducted groups of three highly involved participants that would have been unmanageable at size six...ultimately, both the purpose of the research and the constraints of the field situation must be taken into account" (p. 43). This small focus group provided the participants with ample opportunity to share their experiences and provide detailed information.

The recommended number of focus groups that should be held is three: however, fewer groups may be required to achieve theoretical saturation, particularly with a homogenous sample (Glaser & Straus, 1967 as cited in Krueger, 1994) or when combined with alternative

methods for collecting data as in this study. The end result was data generated by a total of seven participants.

<u>Data Collection</u>

As previously noted, data was collected through two methods: individual interviews, and a focus group. The first stage of individual interviews allowed the testing of the interview focus, and the development of concepts and themes which were further explored in the focus group (Rubin & Rubin, 1995). Conducting a focus group after the individual interviews allowed the exploration of issues that emerge during analysis of interview data. Individual interviews are often used in conjunction with focus groups and combining these two methods enhances and strengthens the overall research (Morgan, 1997).

Individual interviews were used in order to provide in-depth and extensive data, and to allow participants the opportunity to discuss their experiences and thoughts freely. Strengths of an interview format suggest that large amounts of contextual data can be obtained and there are opportunities for follow-up and clarification of information (Morse & Field, 1995). Reported weaknesses of an individual interview format include observer effects and reactivity in which the researcher influences the individuals being studied (Maxwell, 1996). In order to minimize this effect, leading questions were avoided in the interview.

A semi-structured interview format was used, and an interview guide was loosely followed in order to build reliable and comparable qualitative data, to make efficient use of participants' time, and to provide both structure and flexibility (Bernard, 1994). A semi-structured interview is also helpful for a categorizing data analysis (Creswell, 1998). Open ended questions were used to give participants the opportunity to reveal their perspective. The participants were not given a copy of the interview guide ahead of time, but they were asked to

think of a case in their experience where competency arose as an issue when discharge planning with older adults. This provided the participants with time to review old notes and select an appropriate case. The reasoning behind utilizing a case presentation was that through discussion of a real life example, the participants would be able to describe their practice in great detail and present real life challenges they faced. The interview guide can be found in Appendix E. The interview guide was pre-tested with my practicum supervisor, who did not participate in this research project, and suggestions for revisions were incorporated in order to make the questions more easily understood (Krueger, 1994).

The four individual interviews were held in the offices of the social workers, at the hospital, and during work hours. This location was selected to facilitate accessibility and maximize convenience for the participants, and because it was the location of choice for the participants. The interviews lasted between one to one and a half hours, and were held in the spring of 1999. Interviews were audio-taped, and notes were taken of observations and key points.

At the beginning of the interview, written consent was obtained from the interviewees to participate in the study and be audio-taped. A copy of this consent letter can be found in Appendix F. The interview guide was loosely followed, however participants usually had no difficulty carrying the discussion. Most participants began discussing a case with little to no prompting, as they had been asked to come prepared with a case to discuss.

My role as interviewer was to facilitate the dialogue, and occasionally ask for clarification or expansion of an idea. In order to ensure prolonged engagement and completeness of data, the participants were encouraged to talk until they felt the interview was complete. The participants appeared to have no difficulty carrying the discussion for the hour

to an hour and a half, and in fact, several participants stated they could have continued discussing this issue if it were not for time constraints. Participants were thanked for their contributions, and were advised of the next steps of the research project, which included providing them with a copy of their transcript as well as preliminary findings. Most participants stated they were more interested in viewing the final product of my research. However, participants were sent a copy of their transcript, preliminary findings, and a thank-you note thanking them for their participation.

The second phase of this research project utilized a focus group as a data collection method. Krueger (1994) identifies six key characteristics of a focus group: "(1) people, (2) assembled in a series of groups, (3) possessing certain characteristics, and (4) who provide data (5) of a qualitative nature (6) in a focused discussion" (p. 16). Carey (1994) conceptualizes the focus group as a semi-structured group setting, moderated by a leader in an informal setting, with the purpose of collecting information about a specific topic. Utilizing a focus group as a data collection method may be "especially well suited for problems in health research where complex clinical issues are often best explored through a qualitative approach" (Carey, 1994, p. 227).

A focus group was selected as the second method of data collection as it was appropriate to the research question, and it would allow for triangulation, or the collection of data by two different methods to provide corroborating evidence (Creswell, 1998). The strengths of a focus group data collection method include a unique opportunity to gather rich descriptions of participant's experiences by using group interactions (Carey, 1994; Morgan, 1997). Another strength is the ability to gather large amounts of data relatively more efficiently than through conducting individual interviews (Krueger, 1994; Morgan, 1997).

Weaknesses of a focus group include the potential impact of censoring or conforming, where a participant adjusts his/her behaviour or contributions in response to other members of the group (Carey, 1994). If a member of the group has not yet formed his or her own opinion on the subject, he/she may tend towards consensus, or "bandwagon" in order to fit with the group (Carey, 1994). Other limitations of a focus group include that the researcher has less control over the interview process, groups can vary considerably, can be difficult to assemble, and the data can be more difficult to transcribe and analyze.

According to Morgan (1997) the "simplest test of whether focus groups are appropriate for a research project is to ask how actively and easily the participants would discuss the topic of interest" (p. 17). Based on my observations of the ease with which the individual interview participants discussed competency and discharge planning, as well as their eagerness to share their experiences, I felt it likely that the participants of a focus group would experience few difficulties discussing the topic in a group setting. The nature of the research topic was also thought to be conducive to a focus group, as it focused on professional rather than personal experiences.

The focus group followed a semi-structured format and utilized open-ended questions in order to stimulate open discussion (Krueger, 1994). The semi-structured format provided the group with the opportunity to lead and direct the discussion to areas they felt were relevant to understanding the research topic, while also providing me with questions to stimulate discussion in the event group discussion was lagging. The questions were developed after a preliminary analysis of the individual interview data and areas for further exploration and development were identified. The focus group guide was reviewed by my thesis advisor. A copy of the focus group guide can be found in Appendix G.

Krueger (1994) suggests a sequence of focus group questions, designed to produce the most effective results. The opening question is a question that all participants answer, and is used to identify characteristics that participants have in common and to encourage all to participate. The opening question of this focus group asked participants to identify themselves, their recent work experience, and why they agreed to participate in this focus group. The next question, the introductory question, is used to introduce the topic of discussion and allow "participants an opportunity to reflect on past experiences and their connection with the overall topic" (Krueger, 1994, p. 54). In my focus group, the introductory question asked the participants how competency assessments were relevant to discharge planning and social work practice in a hospital setting. The ending questions are designed to bring closure to the focus group discussion, and provide an opportunity for the participants to comment on any issues they felt were missed in the discussion, but were important to mention.

Selection of a moderator has also been identified as an important component of an effective focus group (Krueger, 1994; Morgan, 1997). The moderator should possess an understanding of group processes, be comfortable working in groups, have some familiarity with the topic of discussion, must be able to communicate clearly, and ideally be friendly and have a sense of humour (Krueger, 1994). I felt I would be able to conduct an effective focus group as I had previous experience working with groups and had prepared by reading the relevant literature.

The focus group was scheduled for a week night, at the request of the participants, and was held on December 7, 1999. Since the participants would be coming directly from work, dinner was provided. The provision of refreshments can provide an incentive to participants and offers the opportunity to engage in informal conversation before officially beginning the

focus group; this approach is recommended in the literature (Carey, 1994; Krueger, 1994; Morgan, 1998).

The focus group was held at my home. This site was selected as it was away from the physical setting associated with the research topic (i.e. the hospital) to provide a psychological break and encourage participation (Carey, 1994). I felt that providing food in a comfortable, informal atmosphere would encourage the open discussion and contributions of participants, a view which is supported by the literature (Carey, 1994; Krueger, 1994). The location was also: central to the social workers who were coming from work at the various hospitals; accessible to transit and had available parking; and it could be set up to avoid interruptions and to ensure privacy (Carey, 1994).

Following dinner, the focus group outline and research purpose were explained to the participants. Participants were reminded that participation was voluntary, they were free to leave at any time, and there was an expectation of confidentiality and anonymity among group members. The participants were given letters of consent to participate in the research project to sign. A copy of this letter can be seen in Appendix H. Although the participants had been sent a copy of the interview guide, they were given another copy to have for their reference during the discussion.

The focus group was audio-taped in order to ensure the completeness and accuracy of the data. Video-taping has been recommended in some literature to help with identifying speakers within the group during data analysis, and to identify inconsistencies between verbal and non-verbal communication. Video-taping was not used for this focus group, as the number of participants was small and identifying the speaker on audio-tape would not be as much of an issue as in a larger group. It was also felt that it would influence the participants' spontaneity,

as well as mine, and I would have required an assistant to operate the camera. Krueger (1994) and Morgan (1998) identified several reasons to avoid videotaping of focus groups, mainly due to the intrusiveness of the method, and the practical considerations involved in setting up and operating camera equipment. According to Morgan (1998), videotaping is rare when a focus group is held in a home environment.

The focus group discussion guide was used to ensure key issues were covered in the discussion. However, after asking the initial question, the participants carried the group discussion with great ease, until one participant noticed that the time was approaching 8:30 p.m. My role was to facilitate the discussion, and infrequently I asked for clarification or elaboration of a point raised in the discussion. Each participant was actively involved in the discussion. One participant then took the initiative to review the interview guide to ensure all topics listed had been discussed. My ending question attempted to summarize the key points raised in the focus group, and to ask participants if there was anything further they wished to add, or if there was anything they wished to discuss which I had not included on my focus group guide.

At the end of the session, participants were asked how the focus group experience had been for them. All indicated it had been a positive experience, educational, informative, and a welcome opportunity to network with colleagues outside the hospital setting. While this was not an intended purpose of the focus group, it is a common phenomenon to provide group members with information and social support (Carey, 1994). This process also provided an opportunity for participants to achieve a sense of closure to the focus group. The next steps of the research process were described, and participants were advised that they would receive a copy of the transcript for them to review early in the year 2000. The focus group participants

also indicated they would be most interested in reading a final version of the research paper.

However, the focus group transcript was sent to participants in February 2000. Initials were

used to identify the participants, rather than full names, in order to preserve confidentiality. A

thank-you and a gift certificate for a movie theatre was also sent to participants as recognition

for their time and contributions.

Data Management

Audio-tapes for the individual interviews were transcribed by myself, entered into

Microsoft Word, and stored on my home computer. To restrict access, a password was required

for entry to my computer. In order to preserve participant anonymity, names and identifying

features were changed in the transcribed computer files. Transcripts were assigned a

pseudonym, and the pseudonym and the corresponding participant's name and identifying

features were stored in a separate file. Back-up copies of the data were made to diskette: these

were stored in a locked filing cabinet

I also transcribed the focus group audio-tape to produce a verbatim transcript. The text

was stored in Microsoft Word on my home computer, and the same procedures were followed

as in the individual interviews to preserve participant anonymity and to manage the data in a

secure manner. After the focus group was completed, I drew a diagram of the seating

arrangement of the focus group, as well as made notes of key points in the discussion,

important observations such as the group mood or contradictory statements, which could later

be used to generate valuable insights into the discussion which may not be captured on an

audio-tape. The diagram can be a useful reference to jog the memory later regarding the

context of the discussion, or which speaker provided a certain comment (Krueger, 1998).

Data Analysis

While there may be many ways to analyze qualitative data, central to all approaches is a "concern with transforming and interpreting qualitative data - in a rigorous and scholarly way - in order to capture the complexities of the social world we seek to understand" (Coffey & Atkinson, 1996, p. 3). Data analysis often involves examining and categorizing data in order to address the research question (Krueger, 1994). In qualitative research, analysis is a reflexive activity that is incorporated into the entire research process, from research design and throughout data collection (Coffey & Atkinson, 1996). For example, in this study, a preliminary analysis of the data led to the development of the focus group interview guide.

Analysis of the individual interviews began during the interview itself, as notes were jotted down during and after the interview of key concepts that seemed to be emerging. The first interview tape was transcribed prior to the second interview: the remaining three interviews were transcribed after all the interviews had been conducted. As I transcribed the audio-tapes, I had the opportunity to listen to the interviews, and write memos or notes on what was heard in the data while transcribing. The transcripts were reviewed and compared with the audio-tape for accuracy in transcriptions. Rough observation notes from the interview were input into a Microsoft Word file and organized. Next, the interview transcripts were read and notes made on any tentative conclusions or initial categories, and to obtain an overall sense of the data.

An initial coding was performed on all four transcripts by reading the text line by line and identifying segments relevant to the research question. Codes or labels were assigned to these chunks of text using words or phrases provided by the participants themselves to stay close to the data (Coffey & Atkinson, 1996). For example, if participants discussed concerns

they had about a patient's safety in the home, this might be labelled "risk". If another portion of

the transcript was felt to be consistent in meaning with a previous portion, the text was

assigned the same code.

Further analysis was conducted by cutting and pasting sections of coded transcripts

using Microsoft Word to group them together to create categories. Categories were developed

keeping the research focus in mind. Attention was paid to text or issues that seemed not to fit

initial categories in order to challenge the developing themes. Themes were developed by

writing a description of each category, and then by exploring the relationship between

categories. This process is often referred to as data reduction, as coding is used to break up the

data into simpler, general categories, and to reduce it to a manageable size (Coffey & Atkinson,

1996).

The themes developed at this stage of the research were sent to the individual interview

participants, along with their transcripts, to allow them an opportunity to edit transcripts,

clarify points, or address omissions. Participants made minor changes to the transcripts to

protect the identity of the cases they presented for discussion, and verified the emerging themes

presented. Emerging themes were presented to colleagues through discussion and a poster

presentation for peer review. Findings were also presented to my thesis advisor for comments

and feedback.

The themes generated by the individual interviews, as well as questions that had

emerged, were used to create the focus group discussion guide. The process for analysis of

focus group data is similar to the methods used for the individual interviews, with the added

dimension of integrating the group context (Carey, 1994). Although the data from the

individual interviews and the emerging themes coloured my analysis, I attempted to initially

analyze the focus group data on its own, without reference to the individual interviews. The focus group transcript was reviewed and compared to the audio-tape to ensure it was accurately transcribed. The transcript was reviewed, line by line, and phrases or words which seemed significant to the research question were highlighted. These key phrases or words were reviewed in an attempt to assign a label or code to capture the meaning of the participants. I attempted to generate labels using the participants words, when possible. The chunks of text that were associated with a particular label were cut and pasted into another document using Microsoft Word.

As suggested by Krueger (1998), "perhaps the most useful strategy in qualitative analysis is finding patterns, making comparisons, and contrasting one set of data with another" (p. 17). After developing codes for the entire focus group transcript, I returned to the individual interview transcripts to look for similarities and differences in the codes developed. The codes for both the individual interviews and the focus group were then grouped together in order to develop the categories that appeared to emerge from the codes. Some of these categories were similar to those that arose in the data from the individual interviews, others were new as a result of the added focus group data. These categories were re-examined in order to identify major themes which captured both the codes and the categories. Four main themes emerged.

Further analysis attempted to explore the relationship between these themes. Be re-organizing the themes into a diagram, it appeared that the themes were actually stages in a process. A modified version of this diagram appears in the findings chapter. Huberman and Miles (1994, as cited in Coffey & Atkinson, 1996) refer to this as "data display", the second sub-process of data analysis (after data reduction), were data "is displayed in diagrammatic,

pictorial, or visual forms in order to show what those data imply" (Coffey & Atkinson, 1996, p. 7)

When developing codes and themes from the transcript, it is possible to lose the context within which the data arose (Krueger, 1994). As a result of this decontextualization, it is important to examine the data within the context of the overall group discussion (Krueger, 1998). First, the themes/stages were examined in relation to the individual interviews as a whole, looking for similarities, contradictions, and the overall flow and context of the interview. Then, the focus group transcript was reviewed to see if there was a flow to the discussion, and if the themes arose in a particular way.

As a part of the group level analysis, the internal consistency of the focus group was also explored to see if participants changed their opinions during the discussion (Krueger, 1998). Participants may experience censorship or conformity as a result of listening to others in the group (Carey, 1994; Krueger, 1998). There appeared to be some conformity, as participants' comments usually agreed with those of the person preceding them, and occasionally, key phrases iterated by one participant would later be incorporated into the contribution of another participant. This could be interpreted as the conformity created by the group process, or it could be a reflection of the similarity of perspectives and experiences of the participants, especially as the research criteria dictated such similarities. However, participants did express differences in perspectives which usually arose out of their different practice contexts, such as a surgical ward versus a discharge planning unit.

I did not expect a large degree of censorship, or the withholding of contributions, within this focus group. Participants were asked to share their professional experiences, rather than details of their personal life. While there is some element of risk inherent in sharing any

information in a group setting, the participants did not seem inhibited. In fact, the group seemed very relaxed, as demonstrated by a relaxed body posture, and the laughter and use of humour during the focus group.

The focus group context was also compared to that of the individual interviews, to see if there were similarities or differences in the way themes emerged. As the individual interviews utilized a case study as a tool for discussion, the format was slightly different and did not allow for direct comparison as would be possible if the same format had been used. However, some interesting patterns did emerge, which are presented in the findings.

Addressing Issues of Validity

Maxwell (1996) defines validity as the "credibility of a description, or explanation, or interpretation" (p. 87). Validity must be assessed within the context of the purposes of the research. One threat to a valid description is data that is incomplete or inaccurate (Maxwell, 1996). This was addressed by audio-recording the individual interviews and the focus group, reviewing the transcripts while listening to the audio-tape, and by providing transcripts to all participants to review and correct any errors in the transcription. As I did all the transcribing of the audio-tapes, this increased the descriptive validity, as all the transcriptions were made by the same person (Maxwell, 1996).

Interpretive validity is the extent to which the interpretation of the data reflects the meaning or understanding of the participants, rather than simply that of the researcher (Maxwell, 1996). While qualitative research does not raise the expectation of researcher neutrality, it is important for the researcher to make his or her values and research expectations explicit and explain possible biases. One of the best ways to address interpretive validity is through member checks, also known as participant verification. Participant verification

encourages researchers to ensure their analysis is consistent with the meaning intended by participants (Krueger, 1994). There are several ways this can occur, "such as including an opportunity for an individual summary statement or critical questions, or a chance to respond to the moderator's summary of key points while still in the focus group, or a post-focus group verification of the written report (Krueger, 1994, p. 128).

For the individual interviews, participants were provided a copy of the initial findings that emerged from the data analysis, were asked for comment and feedback, and to review tentative conclusions to improve the validity of the research (Creswell, 1998). One participant responded, in large part, to discuss concerns about confidentiality of the case she presented, but also provided positive comments on the themes developed. For the focus group, a summary of the key points of the group discussion was presented at the end of the group, for comments and feedback. The focus group members indicated that they were not interested in receiving preliminary findings, but only the final research paper. A copy of the preliminary focus group findings were not sent for this reason, as well as due to the time that had elapsed from the date of the focus group to when the preliminary findings were available (approximately one year). Feedback from others is also a way to address threats to interpretive validity (Krueger, 1998). The findings of the individual interviews were presented both in a poster presentation to fellow MSW students at the University of British Columbia, and in a written report to my thesis advisor. Comments and feedback were incorporated into the focus group analysis.

Theoretical validity of qualitative research is threatened when attention is not paid to negative cases or discrepancies in the data (Maxwell, 1996). Both the individual interviews and the focus group transcripts were reviewed, searching for alternate explanations of the findings, as well as cases or descriptions that did not seem to fit with the themes being developed. These

were then used to stimulate further analysis and to revise the findings. Triangulation, or the use

of two different data collection methods, also reduces the risk of systematic biases or

limitations of a specific method (Maxwell, 1996). Individual interviews and a focus group are

both based on self-reporting of participants, but the additional group interaction provided a

more complete and accurate account than either method on its own.

Another challenge directed at qualitative research is the generalizability of the results,

or the extent to which the findings can be extended to other populations (Maxwell, 1996).

Qualitative researchers usually study a small number of individuals from a specific setting

using purposive rather than random sampling, which limits the extent to which findings can be

generalized. The purpose of this study was not to generalize, but to generate an in-depth

description of the process of discharge planning with questionably competency elderly patients

in hospital settings. Ideally, this description of the process could be used as a basis for further

research, such as the development of incapability assessment practice guidelines. Although the

results may not be generalizable outside urban hospital settings, the findings may be

transferable to other settings (Krueger, 1998). The researcher does not make conclusions about

the applicability of the research to other settings: the decision is made by the recipient whether

or not the findings may have some applicability to his/her own setting. This means that the

reader of this research makes his/her own decision as to whether or not the findings may be

relevant to his/her own practice setting.

CHAPTER FOUR

FINDINGS

The goal of this research was to develop an understanding of how social workers discharge plan with elderly hospitalized patients when there are concerns regarding the patient's competency to make decisions regarding place of residence. From the analysis of the data, stages in this process appeared to emerge, beginning with conditions which initially raised competency as a concern for social workers interviewed. If competency is raised as a concern, this can lead to an informal assessment, in an attempt to determine if a formal assessment of competency is required. The informal assessment may identify a need for a formal assessment, or it may conclude that a formal assessment is not appropriate, and other options could then used to facilitate discharge planning. These stages are outlined in Figure 1.

I noted that five out of the total seven participants used the term "competency" in discussion, which was the term used in recruitment notices, introductory and consent letters, and questions posed in the interviews and focus group. The use of the term "competency" by most of the participants reflects the terminology used in the medical and legal literature. Two participants specifically used the term "capability" rather than "competency" to reflect the terminology found in the new guardianship legislation. These two participants were also actively involved in groups which helped to develop and critique the new guardianship legislation, and thus they were familiar with the new terminology.

FIGURE 1: The Process of Discharge Planning with Elderly Patients Who are Questionably Capable to Make Decisions Regarding Their Place of Residence

When Competency Becomes an Issue in Discharge Planning
•frequency
•conditions that cause concern
•refusing placement
•an issue raised by social workers

The Informal Assessment - Building A Case
•determining the need for a formal assessment
•the role of social work
•understanding and appreciating risk
•assessing risk and functioning
•negotiating different perceptions of risk

Formal Assessment not Conducted
•acquiescence
•strategies of persuasion
•balancing risk versus protection

Formal Assessment Conducted
•when is a formal assessment requested?
•Three legislative options
•the current and future role of social work

Patient Makes Own Decision

Health Care Team/Family makes decision for client - capability not formally determined

Patient assessed as capable and makes own decision.

Patient assessed as incapable of making placement decision. Health care team, family makes decision on patient's behalf as per applicable legislation

When Competency Becomes an Issue in Discharge Planning

Frequency of Competency Arising as an Issue

The participants confirmed that competency does arise as an issue on a regular basis, when discharge planning with older adults. In the four individual interviews, participants were requested to identify one challenging case in which competency had been an issue: not only did participants identify one case with great ease, all participants raised a second case for discussion during the interview, and indicated that there were many more possibilities that could have been discussed. According to one participant:

> *"there's been a number of cases along the way, but he's the one that, you know, stands*
>
> *out for me"*

Competency was an issue that arose in discharge planning, *"more than occasionally, but its not routine"*. As one participant stated:

> *"this sort of stuff comes up all the time, its sort of the bread and butter - there are*
>
> *always cases that I'm working actively with where this is the issue"*

A second participant echoed this thought and said *"this, as you say, is bread and butter - [competency] is what comes up daily for these patients...what part, what role do they play in the decision making of going into care, or going home"*.

Conditions Which Trigger a Questioning of Competency

Issues of competency were linked by most participants to the age of the patient: *"competency does come up quite often because we have so many older people "*. Cognitive impairment was also a factor in the questioning of competency: *"we have an increasing number of dementia patients"*. In one social worker's words:

"in my 18 bed unit, 16 people are at any given time waiting to go into facility care -

most of them are demented to some degree, most of them have some form of cognitive

impairment".

One participant did point out that *"people can be incompetent because of things other than*

dementia" but added that a common perception among many of the health care professionals

she worked with was that a diagnosis of dementia was most closely linked with issues of

incompetency.

When asked why competency assessments are *"bread and butter"* to social work

practice, one participant elaborated:

"we're dealing with the elderly, I think all of us [in the focus group] are, and most of

them have a cognitive impairment, or if they don't, they lack insight into their

situation".

In addition to the age and cognitive status of the patient, living alone and self-neglect

seemed to trigger competency as an issue. One participant described the situation of an elderly

person who lived alone at home:

"she had quite a few cats, and the cats were not going outside to toilet...and she was

just throwing the remains of her food on the floor...and then she became unable to

attend to her ADLs [activities of daily living]...and she became fecally incontinent".

One social worker summarized when competency is likely to be questioned:

"if they're living alone, and they show signs of confusion or disorientation, or you know

physically they can't manage, and they're insisting they're going home, and there's

nobody there to look after them. Or else people who may be responsible for somebody

else, who you know either physically or mentally can't do it".

Refusing Placement/Disagreeing with Discharge Plans

When there is disagreement about final destination between either the formal and informal caregivers, and/or members of the health care team, and if the patient insists on returning home and the health care team feels this would be unsafe, competency is raised as a concern:

"when a person either has no family, and/or the patient or the family is at odds with the professional caregivers - that's when we run into troubles with competency. Or when the professional caregivers and the family have big disagreements about what's best".

One participant explained how *"we've tried to go with a discharge plan that seemed to everybody reasonable, except usually the patient. And they're absolutely refusing to go along with it. So that's when you bring it up"*

Another participant from a family practice unit concurred: *"if you work with the family, they've chosen a facility, and that person is digging in their heels and saying no, and that's when we ...get the competency done".*

Who Raises Competency as an Issue?

Competency to decide place of residence was usually questioned by the social worker involved and occasionally by family members or the health care team:

"they're not always, we feel, or family feels, capable of making that decision...someone is always willing to question their competency - could be a family member"

Another participant had similar experiences: *"families raise it as an issue...oh they couldn't go back [home] because they're not competent, they're not making the decisions"*

For one social worker, who worked on a surgical unit, the health care team often raised competency as an issue with the view to expedite the discharge planning process by finding the person incapable and having someone else make the placement decision for them:

"I find that many times its a question that's raised by the team, especially on my

surgical ward, they're wanting that to go very quickly...they see that as a means to an

end. If they get it done quickly, then that means that we can make some quick decisions

and we're going to make some quick moves"

The participant who worked at a family practice unit stated concerns about competency *"usually come from me"*. Another social worker concurred, that *"usually it is myself or the other social worker on the unit"* who raised competency as an issue. It appears that social workers are the ones most likely to identify issues of competency as they are the ones planning for discharge, collecting collateral information about the patient, and, as the next section will discuss, are actively involved in informal assessments of competency.

The Informal Assessment - Building a Case

Determining the Need for a Formal Assessment of Competency

If competency was raised as an issue during discharge planning, the social workers interviewed informally assessed the patient to determine if a formal assessment was needed. One participant called it an *"informal screening"*, and another confirmed that *"we're usually the ones that identify that the patient needs to be assessed"*.

The terms informal and formal assessment were not defined or referred to specifically in the interview or focus group questions. The participants did not distinguish between these two processes at first, and only labelled them as such when I specifically prompted them for

clarification, perhaps reflecting the lack of formal recognition of this process and social work's role in it. For example, when I asked the focus group participants to elaborate on the frequency with which competency arose as an issue, they explained:

> "*we talk about competency in general terms. Talking about competency is different than actually having that signed piece of paper...I think its more sort of informally we talk about their competency*"

Another focus group participant stated: "*we're involved in informally assessing [competency] on an ongoing basis*", while another participant concurred: "*constantly, constantly*".

The Role of Social Work in the Informal Assessment

The key role of social work, as described by all the participants, was to gather collateral information and to use this information to make a determination about the need for a formal assessment. Many of the participants, in both the individual interviews and the focus group, described this process using terms which suggest a comparison of their role with that of a detective:

> "*gather information to **support your position** if you're trying to **make a case for** something, one way or another*" [emphasis added]

> "*social work is...**doing detective work**"*

> "*that **collateral evidence** is incredibly important for me to gather, and I gather it from as many sources as I can*"

*"we've got her on a self-medication program here **to give more evidence**, for lack of a*

better word, that she's not able to do this"

If the participants gathered enough "evidence" which suggested to them the patient may be

incapable of making the placement decision, this was used to support their request for a formal

assessment.

In addition to gathering evidence, several participants highlighted the role of social

work in the informal assessment as trying *"to find the flavour of the person, then*

communicating that to the team". One participant explained that *"social workers need to*

determine what each patient's social construct is". Once the social worker has a sense of the

person, they look at his/her history for any sudden or significant changes in behaviour:

"you use the patient's past behaviour as a guide...if this person used to be absolutely

immaculate or absolutely terrified of going out at night, and suddenly is out wandering,

and this is such a change, and they can't describe it or explain it...then that's saying

something".

This information could then be used in the informal assessment, or communicated to the formal

assessor.

<u>Understanding and Appreciating Risk</u>

In addition to gathering information about the patient and his/her context, the social

workers interviewed were involved in a key component of the informal assessment: the

determination of the patient's understanding and in some cases, appreciation of the risks

involved in his/her decision. One focus group participant describes the key questions in an

informal assessment:

"its just a really good look at their understanding of their life and how they can relate that to you...does it make sense in the context of their environment?. Do they have a sense of what was happening at home? Do they have a sense of the dangers involved in that? Can they make a plan? Can they tell you [about] relationships with other family members and how those work? Its just a really good look at their understanding of their life and how they can relate that to you"

The term "understand" was used by all participants, but some also added that they explored the patient's ability to "understand and appreciate" the risks. All participants made reference to risk as a component of the informal assessment:

*"do they really **understand** all the ramifications of what they're saying that they want to do, and do they really **understand** that they're going to be at risk?"* [emphasis added]

*"its a lot easier if the person actually cannot tell you the consequences, if they say, this will not happen to me...you kind of know that they've lost it. At that point they aren't capable of **understanding** the nature and consequences of their decision"*

*"try to get a sense of what they **understand** and the consequences"*

*"She does not **understand** the risk"*

*"whether they **appreciate** the need for their care and protection is a whole other question"*

*"[they must be] capable of **understanding** the nature of and consequences of their decision. And that's the definition of capacity ...now that's the highest level of the definition of capacity "*

*"**understanding** of risk and their ability to take on risk. Knowing that they're taking it on, but are they also causing risk to others that might be in their environment".*

Another participant elaborated on the understanding of risk and its relationship to assessing competency:

*"its risk we're speaking of, and that's really the same question that would be involved in a formal assessment of competency. Does the person **understand** the risk they wish to assume? But when you're doing it informally, I think we then factor in, well, maybe they don't **appreciate** the risk, so then the question is, can their needs be met out there?"*

The terms "insight" and "judgement" were used by several participants, to reflect the patient's ability to appreciate the potential risk, in addition to demonstrating an understanding:

*"she has no **insight** into her inability to function"*

*"she has no **insight**. Absolutely none. And no **judgement**. Because if she did, she would look after herself better when she's at home"*

In the last quote, it appears that the social worker made inferences about the patient's capability based mainly on the presence of self-neglect.

On the other hand, one participant stated that part of the social work role in the informal

assessment is: *"to convince the nursing staff and families and everyone else that lack of **insight***

does not equal incompetency". In this situation, the social worker saw her role as one of

challenging the common assumptions that appear to exist regarding competency.

Assessing Risk and Functioning

In order to assess the patient's understanding (and appreciation) of the risks, the

participants indicated the need to have an assessment of the risks associated with a given

decision. This was done based on the collateral information gathered by the social worker, and

the input of the health care team. Several participants mentioned specifically the importance of

the occupational therapist's assessment:

> *"what we're doing is a risk assessment. The team works very carefully around that. The*
>
> *occupational therapist writes up a very careful assessment...and I get all sorts of*
>
> *information from the homemaking agencies and the people at the daycares and*
>
> *families...and I use a checklist about what kinds of behaviours are dangerous"*

> *"And we've got the OT [occupational therapist's] assessment of functionality, and the*
>
> *doctor's trying to get the medical situation under control, and then together we are*
>
> *coming to the conclusion that she cannot manage independently"*

The goal of the risk assessment is to *"figure out whether the risk is greater than the risk to the*

client and to the population at large, is greater than the benefit...I mean, if the risk is

untenable". Only one participant explicitly discussed the notion of doing a risk assessment,

although all participants discussed the importance of having information about a person's ability to function safely at home.

The risk associated with a discharge plan was linked to the patient's level of functioning. One theme that arose throughout both the individual interviews and the focus group was that assessing competency to choose place of residence was based on both the mental capacity to make this decision (i.e. an understanding of the risks involved), as well as the ability to safely function in the chosen setting. As one participant stated: "*looking at competency is, at least for myself, is to say, okay, how do they see their world and how do they function within it?*". In one case described by a participant, a patient who had a chronic alcohol problem was repeatedly admitted to hospital, and after withdrawing from the alcohol, would always be assessed as competent. The social worker questioned this patient's competency to make decisions regarding a place of residence:

> "*you may say when you talk to him that he's competent, but in fact, he's really not. I mean, he can't look after himself...he goes home, drinks himself into oblivion and then calls, himself calls 911 to get brought into the hospital...so here's a real dilemma...here's a guy who clearly isn't functioning in a competent way, but when he's sober, which is almost never, he talks a good line. But he's almost never sober except when he comes into the hospital*"

Another participant discussed a particularly challenging case of a woman in her early 60's who had suffered a brain injury as the result of a stroke. This woman had lost the ability to execute plans, and as a result "*she had lost 11 kilos...she was just sitting in her apartment*". This case pointed out the short-coming of relying solely on mental status tests, such as the mini-mental status exam, to determine an individual's capability to make the decision

regarding place of residence: *"this lady scored 29 out of 30 on the mini-mental [MMSE]...but*

she fails miserably on every executive function test. So the interventions you put in won't work

because she can't follow them through". In this situation, the risk was high due to the woman's

inability to follow through on plans made. This participant identified *"two real risks. One is the*

risk of starvation, and the second is the real risk is that she isn't spending her own money on

her benefit...those are the two big risks that I think are hers, and I think the consequences of

our not intervening in this case would be her death".

Another social worker described those cases in which incapacity is most easily

determined as those when a patient has advanced dementia so that *"not only is their memory so*

bad, but that their function is really thrown. And those cases are really easy". This is why,

especially for individuals with dementia, assessments of capability are based *"more on function*

than you do on [neuro-psych] findings, because the dementias...often people function much

better in their own community, with their own things". Another participant explained that when

an individual clearly cannot function at home safely, yet is stating they wish to return home,

this is seen as an indicator of his/her lack of understanding of the risks and thus, a sign of their

incapability: *"you find it easier with people who are at the extended care level. That's so*

straightforward because physically we know they can't return home, so even if they're saying

they don't want to go into care, its much easier".

The same participant stated that assessments are easier when the patient is exhibiting

behaviour that is dramatically different than long-term behaviour patterns, such as an

individual who was previously known to be very clean and meticulous who suddenly appears

to be uncaring about cleanliness and personal hygiene: *"or, if this person used to be absolutely*

terrified of going out at night and suddenly is out wandering [at night] and they can't describe

it or explain it...if the behaviour is really different, and its dangerous, then I'm far more likely

to say, my [risk] tolerance is much lower".

Negotiating Different Perceptions of Risk

The participants identified one of the challenges of assessing risk as negotiating the

different perspectives of risk held by the patient, family, other social workers, and other health

care professionals. This highlights the subjective nature of assessing risk. One participant

suggested that *"more-medically focused team members will say, no, they can't go home, this*

person has to go into placement" because the risk is too great for them to live at home. Another

participant described how an occupational therapist's assessment that the risk was too great for

the patient to return home, influenced the discharge planning process:

> *"the OT assessment...felt he wasn't safe to return home...whereas I would have looked*
>
> *at it somewhat differently and really really pushed for his being able to go home and*
>
> *not just basing it on what the OT's assessment is for purposes of our planning for*
>
> *discharge. We need her input, but its not her say as to whether or not this person can or*
>
> *cannot go home. Its a team decision and the input from the OT is very important"*

Another participant related how a nurse advised her *"we want you to find some place for her*

now...its interesting, because everybody has a different risk acceptance/tolerance level". This

same participant felt that the different perceptions of risk occurred at an individual rather than a

group level:

> *"I found it very interesting because at one time we tended to think it was, that it was*
>
> *discipline specific or you know group specific or something. But I found in all of these*
>
> *years I was working there are those of us that are at the risk avoidance end, like me,*

and there are the risk takers…and then there are people in the middle. And you have to

at least recognise that part of where you are on that continuum, and be really up front

with it with people and say, you know, I'm really risk averse".

The individual interview participants explicitly stated their personal values with respect to risk. As the participant above stated: *"I'm the rescuer, everybody knows this".* Another participant described herself as: *"I'm sort of very strong on people having their rights to live the way they want, as long as they're not going to harm themselves or somebody else".*

One participant shared a case in which a social worker in the community challenged her discharge plan of placement due to different perspectives of risk:

"She [the community case manager] put up such a fight - she phoned the doctor and he

just said 'whoa'…so he said fine, then we'll discharge her [the patient] back to the

community and she can assume responsibility for her…I told the case manager in the

community that I don't support this, that the lady seems to have crossed over the line of

being safe. And anyways, so off she went. We put in all kinds of home supports for her,

increased her number of hours…and within 72 hours the case manger in the community

had made an application for emergency placement for her. So in that case, it was

colleague to colleague butting heads".

In this situation, it was two individuals within the same profession, but in different work contexts, having different perceptions of acceptable risk. The participant described her feelings of frustration and concern with this case, but at the same time said *"you have to pick your battles".* In this case, she chose to express her dissent with the plan, and the responsibility became that of the social worker in the community. These findings highlight that the risk

tolerance level of the professionals involved will have a significant impact on the discharge planning process.

Alternatives to the Formal Assessment

Acquiescence

Competency is not likely to be formally assessed, if the patient is, as one participant termed it, *"acquiescing"* with the placement decision. In these situations, as one participant describes below, the patient is usually very confused and demented, but is not asserting a choice or adamantly refusing placement. Then, the discharge plan is implemented, and the decision regarding discharge destination is made by the social worker and/or family:

> *"because the person is so confused and demented that its called acquiescence. Acquiescence means that the person doesn't verbally or physically say no...and this is what people do in practice if you really stop and think about it"*.

The same participant described how with some people who may still be in the community:

> *"actually with some people we just pick them up and say, you tell them they're going into hospital for a couple of weeks...until they get stronger. And tell the family to say [to the patient] you have to stay here until you're feeling a little better and next week it...because the person is so confused and demented"*.

Another participant also described the process of acquiescence:

> *"if families and professional caregivers kind of agree on the outcome, and people truly are quite impaired, and who really have a lack of insight, often you can just gently lead them into care"*.

This participant explained that with acquiescence, the family and/or the social worker makes the decision regarding placement:

> *"if someone's completely demented and are not aware, and family are involved, close friends, we can just make those arrangements...and we're making the decision".*

The rationale, as suggested by several participants, for avoiding a formal assessment of competency in these situations was that acquiescence can avoid a lengthy and costly court procedure involved in obtaining committee of person, and can be less stigmatizing than using certification and the extended leave provision of the *Mental Health Act*:

> *"what [acquiescence] does is prevent a costly expense for the patient, which is a court hearing for committee of person. Its very expensive and very time consuming. The consequences of having that court hearing is such a stripping of their rights, that it takes everything from them. But if you sidle them in, they still are legally capable and can make decisions in other areas".*

Several participants pointed out that in some situations, patients agreed to services or placement when in actual fact, they were likely incapable of providing this consent. However, if it is consistent with the discharge plan developed by the social worker, with family involvement, this is not questioned:

> *"there must be many people in the community who have been waitlisted for facilities or who are now in facilities, not really fully appreciating the process. They are cognitively impaired, and they're there, you know by the grace of God they don't resist. They don't try to elope and so there's no big curfluffle"*

> *"very often family will sign it, or the patient will sign it [the long term care application*
>
> *form], without really fully understanding what they're signing".*

Another social worker concurred:

> *"we do a lot of things without that competency [assessment] in the sense we know that*
>
> *they may not be...when you're getting family to agree to sign on behalf of the family*
>
> *member...I mean we work around the language a lot to make choice for*
>
> *placement...you try to walk that really really fine line of, they've made the choice, but*
>
> *maybe they weren't that able to make the choice?"*

One participant did point out, that acquiescence is *"sort of side-door-ish"* and fails to incorporate due process to protect the rights of vulnerable adults. These patients have not been formally assessed or notified of a finding of incapability, and thus there is no formal avenue for them to dispute the removal of their decisional authority. However, most of the participants did not question this process, as it was felt to be in the patient's best interest.

Strategies of Persuasion

Several participants described situations where the patient initially expressed his/her wish to return home, but eventually agreed to placement. In one case, the individual was formally assessed as incapable, but:

> *"he would have gone because he was pressured into going, but was resisting it all the*
>
> *way...he, through our....strong encouragement...signed the [long-term care] form and*
>
> *was going to go [to a facility]. He consented, but it was not what he really wanted, but*
>
> *he was going along with it because he felt he had no choice".*

This social worker described her discomfort with this discharge plan (which was developed in her absence), despite a formal assessment of incapability:

"I was not comfortable with how that plan was going because we were pushing him to do what he didn't want. And even his home minister, his pastor came to the hospital and why, you know he doesn't want, he wants to go home, why won't you let him go home?"

In other situations, the patient is not formally assessed, and may or may not be capable of making the decision, but is "persuaded" by well-intentioned family members, social workers, or health care team members, to accept placement. Participants used words such as "bully", "cajole" "encourage", and "play hard-ball" to describe this process. As one participant stated, if the patient is very confused and demented, and

*"if you have family who are on side with you, then this doesn't become an issue very often. Because between you and the family, you can actually **bully** people in, or **bully** is the wrong term, but **cajole** them to move into care…"* [emphasis added]

*"generally, with the **encouragement**, with the **support** of the family, just with some time we're able to have people go into homes, especially extended care. Though they may want to go home, physically they're unable"*

Several focus group participants discussed how time can help this process:

"you kind of go in there, gentle, you kind of go in the back door….and often we just wait-list them, knowing its going to take months to get them somewhere and we'll just have to keep working at it. I've never had anyone yet who hasn't reached that point"

As one participant pointed out:

> "*the one thing with dementia is that if you keep them long enough on the unit, a lot of people actually forget about home, that becomes a very vague concept, and that helps [the transition to facility]*".

One participant described a strategy of persuasion which capitalized on the patient's desire to leave the hospital: "*This is a tactic I use quite often. Listen, do you want to get out of hospital? This is how you do it*". Another focus group participant elaborated on this point and stated:

> "*We play hardball with these people. We say, okay, you want to go home, great. But this is what you have to accept in order to go. You have to have your name on a waiting list, and you have to get this much homemaking, knowing they can just cancel it if they want to*".

The focus group discussed how the power and status of a physician was sometimes used to elicit the patient's agreement with a discharge plan. One participant advised the doctor of the discharge plan, "*and you give the doctor the script, and they parrot it back [to the patient], and you're standing in the room and the patient goes, yeah, okay, well that sounds great*". Another focus group participant shared this experience: "*the doctor went in and talked to them [the patient] for five minutes and [the doctor] states - 'agrees to placement'. After you've been working and working on them*". These participants described a variety of strategies used to persuade a patient to accept a discharge plan, which was not his/her expressed wish, but which was thought to be in his/her best interest.

<u>Balancing Risk versus Protection</u>

While some participants utilized these strategies of persuasion, all participants at the same time spoke of allowing a person to live at risk if she/he was capable of making this decision:

> *"you have to look at each case very closely and sometimes we have to let the person go home and live at risk. And see what happens"*

> *"she's at risk, that's for sure. But I believe that people have that right to be at risk if that is what they want"*

> *"people have of course the right to live at risk, to choose to live at risk, and she was at risk for falls, for break-ins. But she's not demented. And so she has the right to make decisions regardless of how poor they are. And that's the thin, fine line that you walk a lot of times"*

> *"we do advocate for the patient, because they have the right to live at risk if we think they understand the risks"*

> *"usually the role of social work is to let them risk, because you're really advocating for people...self-determination and all those things"*

One participant spoke of the challenge of allowing a person to make the decision to return to live at risk:

"The most difficult thing is watching people go home who you know are just going to

fall apart. And you have to think, well, that's their choice"

"the choice was made to send her back home and have her live at an incredible risk,

and the outcome was very bad, I think. She fired the mental health team, she refused

access to the home support people, continued to deteriorate, and she's fallen, and now

she's in the extended care unit"

There were differences among the participants in where they fell on the risk versus

protection debate, reflecting the notion that an assessment of risk is a subjective determination,

and that competency assessments and discharge planning are value-laden processes. The

emphasis on self-determination and allowing the patient to make the choice to live at risk, was

contrasted with statements which emphasized the desire of several participants to protect the

patient (presented below). Some of the contradictions arose within the participant's interview:

several participants began by explicitly stating the patient has the right to live at risk, thus

espousing the principle of self-determination, but then later presented examples from their

experiences in which protection prevailed over self-determination. One participant

acknowledged she was not a risk taker, but felt she had a responsibility to encourage the self-

determination of the patient, even if this was not what she was comfortable with herself. The

case example this participant presented was consistent with her stated approach.

The focus group did not utilize case examples for discussion, so it was difficult to

determine if the stated values of the participants were consistent with the values applied in

practice. The focus group participants appeared to speak equally about the patient having the

right to live at risk, while at the same time discussing their use of strategies of persuasion, as

presented above. In some situations, when the risk was felt by the social worker and the health care team to be too great, the patient's ability to decide appeared to play a secondary role:

"even if they do appreciate the risks, you proceed with what is, perhaps

paternalistically, what you believe is a care plan that needs to be tried, and see how far

you can go"

"I don't think we have an obligation to let him go home and keep doing that...he's

killing himself...I feel the man should be certified as incompetent and pinked to go to a

nursing home. Even if he's kicking and screaming - for his own protection"

"this lady was clearly not able to function, there was just no question, and so to send

her home to live again would be unconscionable...physically she could not be at

home...and that's the sad part is that that is what it had to come to"

In contrast, several participants discussed the corollary, in which a person may not understand the risk, but protection can be offered and their wishes can be respected. One participant stated that *"just because you find someone incompetent to manage their personal care does not necessarily mean that they can't still function independently with supports"* . However, the same social worker questioned how one could ethically or responsibly discharge an individual to live on their own when they have been assessed as being incapable.: *"how can you, once he's already found to be incompetent, then say he can go home and be on his own, so, its interesting..."*. Another participant elaborated:

"well, okay, maybe they don't appreciate the risk, so then the question is, can their

needs be met out there. And a lot of people go home, they don't have any idea what is

going on behind the scenes and what is needed to keep it all together...that can work if

you've got all of the formal supports, as well as the family ...and it will be safe and it is

okay. So its not just the risks, its can you also meet the needs".

Several participants also highlighted the challenge of discharge planning with individuals who

are competent to make decisions regarding place of residence, but the options are lacking in

order to address issues of safety:

"and often, they are capable of appreciating the risk, so they're competent, but its not

going to work at home, you can't meet their needs. And so those I find are the most

interesting ones".

Another participant discussed the gaps in services that would otherwise enable a questionably

competent or incompetent individual to have their choices followed:

"the timing and taking of her meds are so important to her function, and she's not able

to keep that straight in her head. And the community resources are such that there's no

way that we can send her out. Even if we had meals brought in to her, and homemakers,

there's nobody that's going to come in four times a day and make sure she gets her

Parkinson's meds at the proper time".

One participant eloquently summarized the challenges of balancing the patient's right to self-

determination and his/her right to be protected when he/she becomes incapable of making

choices for him/herself, especially with gaps in services:

"in the past I've heard it said that the hospitals and hospital social workers are

paternalistic and so on. But I feel that people have, as much as they have the rights to

be free and live at risk, they have the right to be protected. And that when people are

losing their ability to make sound decisions and they are subsequently being put at

risk....I feel I have a responsibility to offer them some kind of protection, and to engage

the system in the best way that we can to afford that protection. And its a really

imperfect system, that's for sure".

The Formal Assessment

When is a Formal Assessment Requested?

If acquiescence or strategies of persuasion were not options for discharge planning, the

social workers interviewed could then turn to formal assessments of competency. Formal

competency assessments were usually requested in order to determine the patient's ability

make decisions about their own discharge plans:

"when there's concern about where can this person go, then the number one things is,

lets get a competency assessment. Because that will give us our direction".

Another participant stated: *"I need to know, what am I dealing with here? Am I dealing with*

someone who is capable of being involved in this process?"

In some circumstances, formal assessments were used for other purposes. For some

participants, a competency assessment was requested to slow down the discharge process to

"give people a chance to bounce back, and give them time to repair". According to the

participant who worked on a surgical unit, there is often pressure by the attending physician to

discharge the patient from the hospital as soon as possible: *"just place them, get them out of*

our hair". However, levels of mental and physical ability may greatly fluctuate over the course

of a hospital admission, and this participant felt that, given time, some patients would improve

to the point that discharge plans could be dramatically different (i.e. the patient could return to

live at home rather than going into a facility). Requesting a formal assessment of competency

was used as a *"stalling tactic"*, one way of providing the patient the time and opportunity *"to come into his or her own"*. According to another participant, calling in the psychiatrist to perform a formal assessment of competency could take up to a week, and *"so its another little tool we have to slow down the process"*.

Another function of a formal assessment and a declaration of incapability was to *"give comfort levels"* for health care practitioners and family members when the decision making is taken away from the patient: *"it gives something documented that says, so if anyone comes back to us saying how could you have done that, and then you say, well, here, see?"* For some family members, they *"need someone to tell them, yes, its okay for you to make this decision"*. In the focus group, an implicit purpose of the competency assessment appeared to be to gain the co-operation of the patient, the family, or formal caregivers, with the discharge plan: *"its sort of the last ditch way that maybe the patient will get the message that you are, officially, declared, not competent, and therefore you need to take direction from us on it"*. However, a limitation of the formal assessment is that it does not always resolve these disagreements about discharge plans: *"if the family is split, even when a clear medical opinion is given on something like competency, it doesn't seem to help this family to have consensus, or help the patient themselves. It doesn't matter what you tell them, they're still going to be totally non-cooperative"*.

It is essential to clarify the reason for the assessment, and what a finding of incapability will accomplish. The focus group and individual interviews discussed that psychiatrists usually performed the formal assessment, and they were often reluctant to declare a person incompetent to make the placement decision. The first question the psychiatrist asks is *"what good would this assessment, and having the person declared incapable, accomplish?"*.

According to one participant, *"often, not much"*. As a result, formal assessments were done as a

last resort: *"we really really try everything before we declare people incapable"*. Another

participant concurred: *"its certainly not something you do willy nilly"*. As a result, *"95 to 98*

per cent of people who are actually, technically, probably not competent, are never actually

declared such. You don't need to", as in these situations, the patient acquiesces or concedes to

placement.

Three Legislative Frameworks for Formal Assessments

The participants identified three possible ways a formal assessment of competency was

used in discharge planning. Each process reflected a piece of legislation which attempts to deal

with the issue of capability to make decisions about place of residence. However, the

participants clearly identified a number of gaps in the current legislation: *"the provincial*

legislation is really lacking in how to deal with people who are demented and who don't have

the capacity to engage in discussion around a process of where you are going to go from

here". There seemed to be a sense of frustration with the lack of clear legislation and guidelines

to help social workers in these situations, with a corresponding optimism and hope that the new

adult guardianship legislation would provide more guidance.

The individual interview participants referred to *"the Mental Health Act and the*

Patients' Property Act – there's two pieces of legislation and they're the two most common

ones we used in this hospital". Under the *Patient's Property Act*, a medical doctor performs the

assessment. If the person is found to be incapable, the next steps possibly entail pursuing a

Committee of Person through the courts. If a family members apply for Committee of Person

through the courts, it *"is a really lengthy and costly process"* and was viewed as an impediment

to a timely discharge. If there was disagreement among family members about a placement plan, then a Committee of Person was seen as a protection for both the social workers and the facility: *"if there's ever a question that a family member might come back and say something about the placement, then the facilities are more likely to say the committee of person has to be in place for them to admit them"*. However, this participant explained that *"its very rare that we actually enact...a committee of person"*, in part because *"even with the committee of person, you cannot make the person stay wherever you choose to have them go"*. Due to these limitation, pursuing Committee of Person under the *Patients' Property Act* was rarely used in discharge planning.

Another option for discharge planning discussed by the individual interview participants was to have the patient formally assessed for committal under the *Mental Health Act*. Under the *Mental Health Act*, patients who are assessed as incapable can be certified into a designated facility to receive treatment for a mental illness. This option is used when a patient appears to be:

> *"exercising extremely poor judgement and placing themselves at risk because of a mental illness, and there is no committee of person in place, then the Mental Health Act can be used to fill that void, and then the Mental Health Act becomes the mechanism to decide where they go, whether they stop there, and what kind of care can be given to them while they are there".*

Utilizing the extended leave provision of the *Mental Health Act* was viewed as *"a safeguard for the facility, because they have the jurisdiction to keep them there. If they leave and they're confused then the police can be called to bring them back."*

To use the extended leave provision of the *Mental Health Act*, the patient must meet the criteria for involuntary committal, which includes a having a psychiatric diagnosis and being in need of psychiatric treatment. One participant presented the case of a patient who was considered capable when he was sober, but became incapable upon discharge from hospital and his return to drinking. However, the psychiatrist was unwilling to certify the patient under the *Mental Health Act*, because "*according to the letter of the law, he can made his own decisions. Except he can't - or he won't*". The extended leave provision was raised as an option only by those participants who worked in psychiatric units or departments (three participants). As one participant stated: "*again in acute care, it would be different in psychiatry, but I'm not aware of having committed anyone into a care facility. And I've worked here for over nine years and I know I personally have not done that. And my patient population is primarily the elderly*". Again, like pursuing Committee of Person under the *Patients' Property Act*, it appears that certification under the *Mental Health Act* has limited use and applicability with elderly patients.

The focus group did not discuss the use of the *Mental Health Act* in discharge planning, and Committee of Person was used only in rare instances, perhaps reflecting the options available in their particular practice setting. The third process for a formal assessment was raised only in the focus group, and followed the spirit of the new adult guardianship legislation. Rather than "*blanketing*" all of a patient's decision-making capacities by appointing a Committee of Person, some social workers requested a formal assessment solely of the patient's ability to make a decision about placement. The psychiatrist or geriatrician performed the formal assessment, and simply documented in the hospital chart the outcome of his/her

assessment. According to one participant, this then allowed the social worker to turn to family members to make the decision on the incapable patient's behalf:

> *"we just have this great feeling of relief when the psychiatrist said no, they're not competent, and we say great, sign this paper, we'll put them into this facility, and then we can work with the family, and we feel we've got some authority to do that. But in fact we don't have anything legal".*

This comment highlights the fact that the relevant sections of the new adult guardianship legislation were not yet in force at the time of the interviews.

The Current and Future Role of Social Workers in the Formal Assessment

Although a medical doctor performs the formal assessment of competency, the social workers interviewed saw themselves as continuing to have an important role through the provision of collateral information, and through *"strong suggestions"* to the geriatric psychiatric or geriatrician who may be performing the assessment. Another stated that *"all we can do is recommend a finding of incapacity"*. One participant explained that *"we have a good working relationship [with the family physicians and the psychiatrists] and they listen to us"*. However, another participant described how in his experience, he provided collateral information to the doctor *"but I find that they pretty much go off on their own after that and just report back [the results of their assessment]"*.

Some participants saw their role as educating patients and families *"what the risks are, and what the legal realities of intervention are"*. This may involve helping families understand that at times *"we have to allow some people to live at risk. Because we do, in the end, say that they are competent to make this decision, and that's really tough for families to come to terms with"*. One participant described having the role of informing the patient of the need to do a

formal assessment, describing the assessment process, and explaining to the patient the consequences of a finding of incapacity: "*I actually tell them we need to do a formal assessment and I actually get them to sign to say that I've told them that. And I'm to tell them that the following assessment means that if we find you not able to manage then we will make sure that there is somebody who is appointed who is either a government agency or somebody that you choose*".

The participants held mixed feelings and opinions on their role as potential future incapability assessors under the new adult guardianship legislation, perhaps reflecting a lack of confidence in their skills and expertise in performing assessments of incapability, or perhaps reflecting some trepidation at taking on new roles and responsibilities when many participants already felt overwhelmed with their current workload. Most social workers interviewed felt they would be able to do a "*basic assessment [of capability]- it doesn't take a doctor to do that*", and if the incapability assessment was limited to that around placement issues: "*I don't need a psychiatrist to tell me this guy is a danger to himself*". However, for the complex situations where patients are in the grey zone of capability/incapability, the same social worker felt that psychiatrists should be the ones performing the formal assessment:

> "*we get lots of grey zones...we're lucky in that they can sort that out for us and we don't have to do it. And in many cases certainly I think psychiatry should be the ones who make the decisions you know. Like I don't think social workers should be the ones all the time to do that*"

This statement may reflect this social worker's belief that psychiatrists have the necessary expertise to perform the more challenging assessments, or her reluctance to assume such a responsibility as a formal assessor.

The focus group discussed how the medical model, which dominates a hospital setting, views the time and expertise of doctors as being much more valuable and respected than that of social workers: *"the fact that its done by a doctor or a psychiatrist...they're not challenged. Its efficient, it has authority"*. For many families, there is greater confidence in an assessment performed by a psychiatrist. According to a participant, when the psychiatrist is called in *"you can see its an enormous relief. I've never had anyone resist when you say to family I'm going to bring the psychiatrist in. Its like, oh thank God, you're actually going to assess them properly"*. In a medical model, doctors are

> *"so revered and their time is so scarce, we don't make many referrals because we don't*
>
> *want to do so inappropriately. I have to say I think that if social workers were to be the*
>
> *people to do these [assessments], we would be asked to do them all the time...our time*
>
> *is not viewed as valuable as the physicians...and the reality is we are stretched so thin*
>
> *that how on earth we could embark on a whole other mandate to do competency*
>
> *assessments, I have no idea."*

However, the focus group also pointed out that in many ways, if social workers were to have a role as assessors of capability, it would be *"just formalizing what we are already doing"*.

The social workers interviewed appeared to have great hopes that the new adult guardianship legislation would address current gaps and inconsistencies, but they also had some trepidation as to how this would play out in practice. One participant stated she attended the focus group because she had *"a lot of interest in adult guardianship and how that will affect competency and practice in the future"*. Another focus group participant expressed that she was *"hopeful that with the new legislation we will be seen as more integral in making that assessment and that it shouldn't be so heavily medically based"*. The first focus group

participant added *"whether this new legislation gives us more opportunity in that, still has to be seen"*.

The focus group participants felt that social work's perspective lent itself well to assessing competency to choose place of residence. The social work perspective *"looks at so many different aspects, not just competency at one level…and so our assessment of competency has more facets to it, and its probably a truer one in many ways"*. This holistic perspective of social work was also felt to be compatible with the new adult guardianship legislation: *"we see this legislation as much more fitting within our philosophy system"*.

CHAPTER FIVE

DISCUSSION

The purpose of this exploratory research project was to generate a description of how social workers discharge plan with elderly, hospitalized patients, when they have concerns regarding their competency to make decisions regarding their place of residence. Analysis of the data led to the process described in the findings chapter, and summarized in Figure 1. These results will be related to the existing literature, and the implications for social work practice will be discussed.

Perceiving Competency as Mental Capacity and Functional Ability

The findings reflected a perception of competency which appeared to be held by the social workers interviewed. For these social workers, competency to make decisions regarding place of residence included both the mental capacity to make the decision, and the ability to function within the chosen discharge destination. This finding is consistent with the literature, which suggests that competency to choose place of residence following discharge from hospital includes: "both their ability to choose the place where they will live (choice of residence) and their ability to function in the place they have chosen (ability to thrive). Although these two kinds of competency are conceptually distinct, in practice they are often connected" (Silberfeld and Fish, 1994, p. 11).

Mental capacity has been defined as the "mental ability to understand the nature and consequences of one's acts" (Glass, 1997, p. 6). A higher level definition of mental capacity includes not only an understanding of a situation, but an appreciation, or a critical judgement of the information or the situation (Browne, 1999; Glass, 1997). Appreciation suggests that an individual has insight into a situation, making the connection between causes and effects. The

social workers interviewed appeared to include both understanding and appreciation within their perception of mental capacity. The participants' questioning of a patient's insight into his/her situation suggests the use of a critical judgement, rather than simply an understanding of the situation.

The challenge of assessing an individual's ability to understand or appreciate a situation is that understanding is a mental state which is invisible to others and difficult to test (Browne, 1999). Understanding usually occurs in degrees, rather than being an all or nothing phenomenon, and yet a competency assessment requires an either/or determination. Understanding alone is not a sufficient measure of capability: as the findings suggest, a person can understand a situation but still be incapable of making the decision. Checkland and Silberfeld (1993) confirm that the most challenging cases arise when "understanding, at least as manifested verbally, appears intact, but inappropriate or no action ensues" (p. 455). As a result, "you have to be a behaviourist when judging competency" (Browne, 1999).

Other authors on the subject of competency assessments concur. Abramson (1989) describes the autonomous person as someone who "not only deliberates about and chooses...plans but also is capable of acting on the basis of the deliberation" (p. 102). Competency, according to Glass (1997) should examine the ability of the person to function in a particular situation, and thus is determined by both the situation and the individual's understanding of it. Donnelly (1996) emphasizes that decisions regarding competency should be based on function, not only on a diagnosis, and that competency is interactive in nature: "the patient's external environment and changing personal skills influence capacity at any point in time. Thus the patient's use of resources, external and internal, should be considered in determining competency status" (p. 485).

The findings suggest that the individual's capability to function within a particular environment may at times be more important than the individual's ability to understand the risks involved. The social workers discussed how a person with a dementia can be supported in his/her own home with access to the appropriate resources, and at the same time be unaware of all that must be in place to sustain him/her there. Given an appropriate environment, many people who perform poorly on mental status exams can actually care for themselves (Winograd, 1984). This highlights the importance of not relying simply on mental status exams (such as the MMSE) when assessing incapability, especially with respect to the decision of choosing place of residence.

Schogt and Sadavoy (1987) confirm that even though someone may not be competent in a particular area, they may be functional in the same area with external supports to compensate for the disability. However, if these external supports or resources are available to safely support the individual in their own home, the question would revolve, not around the placement issue, but whether the individual will consent to having these supports in place, and if he/she is capable of refusing consent (under Part 3 of the *Adult Guardianship Act*). Another social worker questioned how a person who was assessed as being incapable of making the decision about their place of residence, can be returned to the community, suggesting there may be concerns about responsibility in such situations.

A risk of a functional approach to competency is that a person may be capable of making the decision to return home, but not of performing the task: this situation was raised in the cases discussed by the participants when a patient reaches an extended care level. In these situations, it appeared to be the assumption that an individual who was unable to function in the community, but who had the mental capacity to choose their place of residence, would then

logically choose to move to a long-term care facility. If the person did not choose facility

placement, it would likely lead to a questioning of the patient's competency. The alternative

appeared to be that the patient would be strongly encouraged to accept placement, in some

ways suggesting that his/her ability to make a decision was no longer significant. In other

situations, it is the lack of appropriate supports which results in the inability to meet the

person's needs in the community. Checkland and Silberfeld (1993) point out that mental

competence should not be treated purely functionally, i.e. a person requiring supervision and

help in self-care should not be declared mentally incompetent because such help is not

available. The possible risk of a functional approach to competency is that someone may be

found incapable due to structural/system limitations.

How competency is perceived clearly has a significant impact on the assessment

process. According to Gordon and Verdun-Jones (1992), including a functional component in

the assessment of competency suggests a need for comprehensive, multi-dimensional

assessments of an adult's ability to function independently in his or her own environment. A

focus on the mental capacity of the individual would result in an emphasis on a medical

assessment of the individual's mental processes, and could include neuro-psychological testing,

cognitive function tests, and psychiatric assessments. However, these findings suggest that a

focus on mental capacity alone is not sufficient for the decision of choosing place of residence,

but that a functional-psycho-social assessment must be included. Utilizing a functional

perspective of competency suggests a multi-disciplinary assessment, with input from social

workers, occupational therapists (to assess the individual's ability to function at home), and

nurses, in addition to the contribution of the medical practitioner. This is a significant shift

from a historically medically dominated view of competency and competency assessments.

As a result, social workers who perform assessments of incapability, should make explicit how they perceive competency, and be aware of the differences and implications of assessing mental capacity to make a decision versus the functional ability to perform the necessary tasks. If social workers become formal assessors under Part Three of the *Health Care (Consent) and Care Facility (Admission) Act*, they will need to be aware of the differences in their current view of competency, and how it is defined under this Act. Under the new adult guardianship legislation, the definition of capability tends to focus on an understanding, rather than appreciation, of risks, and does not explicitly contain a functional component. The social workers interviewed in this research also included an appreciation of the consequences of the decision or lack thereof, and thus this definition of incapability does not appear to reflect current practice or perceptions of competency assessments.

It is difficult to demonstrate understanding unless the behaviour or functioning of the individual is explored. As the findings highlighted, there are some situations where a patient can appear to demonstrate an understanding, but cannot implement the actions required to function safely at home. The guidelines for the assessment of incapability under Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* will need to make explicit how to deal with these types of situations, as well as how incapability is to be defined and assessed. Ideally, social workers from various practice settings will become involved in the development of practice, and with their input and expertise, hopefully the practice guidelines will be relevant, applicable, and appropriate to the needs of the assessor, and the person being assessed.

Balancing Self-Determination and Protection

The findings highlighted the challenge of balancing the self-determination of the client, if this involved a decision which contained risk, and the desire of the social workers to protect the client from harm and to develop a discharge plan in the patient's best interest. This challenge has been discussed in the social work literature, as self-determination is fundamental, not only to an empowerment model of social work practice, but to the profession of social work itself:

> these obligations are often in conflict, because the plan that the social worker considers the safest, may be the least desired by the client...the social worker may then act in a paternalistically benevolent way in order to protect the client (Abramson, 1989, p. 101).

Abramson (1989) found in her research that when there was a conflict between client safety and self-determination, the desire of the social worker to protect the client often prevailed over client autonomy. While my study cannot comment on the frequency with which safety prevailed over self-determination, it did highlight that in certain cases, the social worker's desire to act in the best interest of the patient could override the patient's wishes, even if they were capable of making the decision. In these situations, the social workers used a variety of methods, from "encouragement" to "playing hardball". Clemens et al. (1994) called these "strategies of persuasion", methods which could range "along a continuum from providing information, through gentle persuasion, to tactics that were almost coercive" (p. 82).The participants did begin with an emphasis on enhancing self-determination in placement decisions, but later raised cases where it became challenging to do so, due to levels of risk or the patient being assessed as incapable. There appeared to be differences among the participants as well, as some participants spoke more strongly of the need to protect the patient

from risk than others, again emphasizing the importance of personal values on the assessment

process and the perception of competency.

The research by Clemens et al. (1994) was based on in-depth interviews with nurses

and social workers who were case mangers, working with the elderly in the community.

However, the specific strategies of persuasion found in their study were remarkably similar.

Strategies used for achieving acceptance of a care plan with frail but competent clients

included:

> (a) pressuring clients to apply to nursing home...to ensure placement if needed; (b)
>
> teaming up with family members, physicians, and other providers to convince clients of
>
> the need for placement; (c) giving clients lists of things they must do to stay home; (d)
>
> using the threat of nursing home placement...to encourage compliance with the care
>
> plan (Clemens et al. 1994, p. 82)

Abramson (1989) suggests that certain characteristics make an individual more

vulnerable to these strategies of persuasion. These characteristics are similar to those identified

in this research which often raised competency as a concern: elderly patients who live alone,

lack social supports, and who were showing signs of self-neglect. For these vulnerable

individuals, there is a great "potential...that caring could be distorted into coercive control".

This potential may be even greater for individuals in the hospital, as there is an associated loss

of power when the individual assumes the role of patient, especially in relation to the

professionals of the institution who are seen to hold the power (Fulbrook, 1994). As a result,

social workers in a hospital setting need to be conscious of the power differential between

themselves and the patient with whom they are discharge planning. They should also be

cautious in the use of this power, especially when working with vulnerable adults with questionable competency.

In addition to being aware of the vulnerability of these individuals for such strategies of persuasion, there is a challenge for the social worker to not assume that an older adult in the hospital is incompetent. The findings seemed to suggest that a link was often made between age, the presence of dementia, and the assumption of incapability. The elderly are "often presumed incompetent and denied their choices, without an adequate attempt to assess their competency" (Naglie et al., p. 698). As the same time, the majority of individuals who are referred for a formal assessment of competency are elderly: in one study, 75 percent were 70 years or older (Naglie et al., 1995; Verma and Silberfeld, 1997). Social workers who are discharge planning must also be aware that although refusal of placement may cause a social worker to question a person's capacity to make decision, refusal itself should not constitute evidence of incapacity: "most refusals are caused by factors other than incapacity" (Etchells et al., 1996, p. 659).

In some ways, a patient's refusal of admission to a long-term care facility and an assessment of competency speaks more about the lack of alternative, appropriate options available to support his or her wishes. As Gordon (2000) states:

a determination that an individual is mentally incompetent (or incapable) is often a function of the size and commitment of that person's network of human support, and the person's material resources. Those with extensive supports will not, as a general rule, need guardianship intervention, and hence, will not be candidates for determinations of incompetency. Those without supports are more likely to find

themselves declared incompetent and blessed with the services of a committee or guardian (p. 6).

Again, social workers should be aware of the broader context in which competency is likely to be questioned, and recognize some of the underlying reasons why competency arises as an issue. An awareness of the structural issues which can trigger an assessment of incapability can prevent an already vulnerable population from being further oppressed through being declared incapable and having decision-making ability removed.

This also suggests social workers need to advocate for a wider range of services to be available and accessible to support aging adults in the community and to provide alternatives to placement in a long-term care facility. For example, if an increased number of home support hours were available, perhaps placement in a facility would not become a necessity, and thus the capacity of the older adult to make the decision regarding placement may not arise as an issue, or may arise at a later stage in the dementia process. There is also a need for greater equity in services, so that those with a lower socio-economic status are not as limited in the options available to them, and are, as a result, then more likely to be assessed as incapable. Several of the social workers described their advocacy for the elderly client, by "fighting" the push for an early discharge, in order for the patient to improve enough that they are able to return to their own home.

In addition to understanding the structural factors behind issues of incapability, social workers must develop an increased awareness of the ethical aspects. A key component of the competency assessment was determining the level of risk in the discharge plan chosen by the patient. However, the findings illustrate that determining the level of risk, and whether it is tolerable, often reflects the values of the assessor. Those committed to maximizing self-

determination may argue for "less stringent tests of competence while those who give priority

to physical health and safety will support a more conservative approach, setting the threshold

for competence at a higher level" (Glass, 1997, p. 10). It is important for the assessor to

examine his/her own beliefs about risk and make them explicit.

The majority of the participants did not explicitly refer to the ethical aspects of

competency assessments and discharge planning, which perhaps suggests that use of an ethical

framework may not solve the challenging cases, particularly when social workers must act in

the client's best interest while also enhancing their self-determination. Social workers should

be aware of their personal and professional values and how they may impact the discharge

planning process. It would be helpful if the social work profession could develop clearer

guidelines about "when, how, and why paternalistic beneficence should take precedence over

autonomy" (Abramson, 1989, p. 105). Social workers should develop ethical self-knowledge,

and explore if they are more risk tolerant than risk-averse (as one participant made explicit),

and if self-determination is more important than maximizing the client's safety (Abramson,

1989). While courses on ethics may be offered as part of a BSW or MSW curriculum, ethics

should become an integral part of a social work education, and be integrated into all courses, to

highlight how personal, professional, and societal values influence all levels and areas of social

work practice.

The different ways competency can be perceived, as well as perceptions of best interest

and levels of risk, suggests that assessments should not be the decision of one individual but

rather a team decision. The findings did describe the information that was required from

various health care team members in order to assess competency. Verma and Silberfeld (1997)

recommend a multi-disciplinary model for assessing competency, such as that found at the

Baycrest competency clinic in Toronto, Ontario. The clinic "is a multidisciplinary enterprise

founded on the principle that competency is not simply a medical or legal concept, but rather a

complex phenomenon that has medical, social, legal, and ethical dimensions" (Silberfeld and

Fish, 1994, p. x). Silberfeld and Fish describe a multidisciplinary team which was used to

assess competency to choose place of residence: the competency team included a psychiatrist, a

social worker, a nurse practitioner, and a medical ethicist. The team worked together to review

the relevant information, discuss possible solutions, and reach a consensus about the

assessment outcome. The multidisciplinary model of competency assessments is achievable in

a hospital setting, as all the different health professions are represented. Utilizing a multi-

disciplinary model of competency assessments may be more challenging if the client is in the

community. Adopting this model may also represent a challenge to the authority of the medical

profession, which tends to dominate in a hospital setting.

The notion that competency to decide place of residence is best assessed within a

multidisciplinary model suggests a need for interdisciplinary educational opportunities in

which health care professionals can work collaboratively, develop team work skills, and

articulate professional roles, functions and values (Clark, 1994). The participants highlighted

some of the challenges of making decisions in an interdisciplinary context, and this could

potentially be improved by an increased familiarity with the value bases and orientation of the

other health care professions. Courses such as the interdisciplinary Health Care Ethics course

which has been offered by the University of British Columbia, bring together a wide range of

health disciplines to work collaboratively on health care dilemmas commonly found in

practice. Courses such as this allow students to develop the interdisciplinary team work skills

and knowledge prior to working in a multi-disciplinary setting such as a hospital. While this

course is a step in the right direction, more courses should be offered which incorporate an interdisciplinary approach to learning.

Role of Social Work as Assessors: Current and Future

The findings highlight that the social workers interviewed regularly performed informal assessments of competency. However, much of this work and the corresponding expertise has been unrecognized, not only by other professionals but by the participants themselves. One individual interview participant, prior to beginning the interview, actually questioned if she had anything useful to contribute. This was also reflected in the assumption of the social workers that the interview questions about competency assessments referred to formal assessments, rather than informal assessments, and this is where discussion of the topic usually began.

One component of the informal assessment identified by the participants was to explore the patient's history, and look for any significant changes. The literature terms this "sedimented life preferences" (Verma and Silberfeld, 1997; Weisstub, 1990), or the established patterns of behaviours and choices of the older person. In many ways, the informal assessment is a usual part of the discharge planning process, in which the

> social worker must complete a thorough psychosocial assessment of the patient or
> family needs, including a focused social history. This assessment pays particular
> attention to the person's previous ability to cope in the community and the resources
> that may have been used to support her/his functioning (Holosko and Taylor, 1994, p.
> 497).

Many of the components of an informal assessment of competency are present in a formal assessment, and as a result, the participants already have many of the skills necessary to perform a formal assessment.

The participants saw themselves as having an important role, not only in the informal assessment, but also through the formal assessment process. The contribution of the social worker in competency assessments appeared, to some extent, to depend on the particular hospital setting, although there were a number of roles that were common among all participants. The roles of advocate, information gatherer, educator, and problem solver are roles common to all hospital social workers (Holosko and Taylor, 1994). The differences can be attributed to variations in the hospital's perception of social work practice, the organizational climate, the competencies of the social work practitioner, administrative support, and interdisciplinary support (Holosko and Taylor, 1994).

Advocacy was seen as a key role of the social workers interviewed: advocating for the client to live at risk, or advocating for the patient to stay longer in the hospital to provide an opportunity for them to be discharged home according to their wishes. As several participants pointed out, when discharge planning, there may be heightened pressure to reduce the lengths of stay of patients, and there is often the perception of older adults as "bed blockers", holding up the flow of people through the acute care system. Social workers can advocate for the needs of older adults within the health care system, and lobby for changes to help meet needs of older adults in acute care. The lack of long-term care beds and other services in the community adds to the perception of older adults as "bed blockers", as they wait in acute care beds for appropriate placement options.

The multiple roles of the social worker in competency assessments can be seen as arising from the unique social work perspective or theoretical orientation. The participants highlighted the holistic focus of social work practice, which moves beyond the medical model to encompass broader determinants of health: "the social work orientation to health care is unique in its holistic focus" (Holosko and Taylor, 1994, p. 6). Bracht (1978) as cited in Holosko and Taylor (1994) states that "social work's uniqueness [in health care settings] comes from its persistent focus on the physical, social-psychological and environmental health needs of clients" (p. 5). The holistic perspective of social work practice was contrasted by the participants, with the medical perspective. Social work and medicine "have evolved from very different practice frameworks and, in some instances, may have competing ideologies" (Holosko and Taylor, 1994, p. 25). The social workers interviewed often found themselves challenging this medical model. It was suggested that a social work perspective of competency would result in a more realistic and comprehensive assessment. The holistic view would not medicalize and compartmentalize the issue, but would incorporate the individual, psycho-social, environmental, and structural aspects that impact upon the assessment process.

The findings suggest that the social workers interviewed had mixed feelings about their future role as possible formal assessors of competency, particularly under the new adult guardianship legislation. One reservation was due to the dominance of the medical model and the medical profession within a hospital setting, in which the authority and expertise of social workers may not be considered comparable to that of a medical practitioner. The social workers interviewed expressed concerns that an assessment by a social worker would not carry as much weight as one by a physician, as social work tends to be less valued than the medical profession. This is an area that needs to be addressed by social work profession as a whole,

perhaps through hospital social work department heads, or the British Columbia Association of Social Work (BCASW). The BCASW could promote the recognition of the expertise and value of social work in these areas, as is done with events such as social work week. Education of other health professionals, both in hospital and university settings, of the role and value of social work, can help promote the value of the profession. Social workers can also advocate and challenge the medical model which is dominant in a hospital setting, by encouraging a holistic perspective of the person/patient, as well as a recognition of the broader, structural determinants of health.

On the other hand, some of the social workers recognized that they already have many of the skills and expertise to perform a competency assessment, through their experience in informal assessments of competency. It was interesting that some reluctance to take on this new role was expressed by the participants. This could be attributed to: feelings of already being overworked and being unable to take on new tasks; fears of responsibility in making these types of determinations which can have the end result of depriving an individual of his/her self-determination; or fears of being able to make these assessments according to a social work perspective in a medical model which dominates the hospital setting. These issues could be addressed through the support and leadership of the hospital social work departments in order to give their staff the confidence in their abilities to perform these assessments, the time to participate in training opportunities, or by hiring extra staff to specialize in this role and assist other social workers.

The literature suggests that competency assessments are traditionally considered the realm of medical practitioners, but "while they may be the best professional to determine the presence of a condition or disorder, they may not be the best to actually determine the presence

and level of an impairment" (Gordon and Verdun-Jones, 1992, p. 3-51). Gordon and Verdun-Jones (1992) feel that assessors "should belong to a professional association and be bound by its standards and ethics...these requirements generally point toward the profession of social work...arguably, an entirely new field of social work practice should be developed to respond to this challenge" (p. 6-56). This should be addressed in social work education in BSW or MSW programs: competency and competency assessments should be included in social work practice courses in health, aging, or mental health, as the literature and the findings clearly suggest it will be an increasingly important part of social work practice.

The social workers interviewed did express interest about the new adult guardianship legislation, and were curious about the role of social work in this new context. The curiosity of the social workers in the new adult guardianship legislation suggests a need for training and information sessions within the hospital setting to address their questions. For example, the Public Guardian and Trustee is scheduling workshops at various locations throughout the province on the assessment of incapability under Part 3 of the *Adult Guardianship Act*. Gordon and Verdun-Jones (1992) confirm that "assessors require special training" (p. 6-56), and if social workers are to have a role in the assessing of capability, they would need to participate in such training. There is also a need for specific guidelines for assessing capability regarding choosing place of residence. Guidelines have been developed by the Public Guardian and Trustee's Adult Guardianship Implementation Project specifically for assessing competency to consent to health care treatment, and another set of guidelines to assess capability under Part 3 of *the Adult Guardianship Act*. These could be used as a starting point for the development of guidelines specifically to the placement decision.

Limitations of the Formal Assessment and Gaps in the Legislation

The findings suggested that formal assessments of competency were used in discharge planning in a small number of cases. The participants utilized other approaches when discharge planning, such as acquiescence or persuasion, to avoid the formal and legal consequence of removing the individual's right to make decisions on his/her own behalf. Formal assessments of incapability were used as a last resort, an approach consistent with the literature (Silberfeld and Fish, 1994). This is also consistent with the principles behind the new adult guardianship legislation, which stresses that the least intrusive option should be pursued, and decision making removed only as a last resort. The findings also highlight the challenge of intervening against a patient's wishes, even if he/she has been assessed as incapable. While a formal assessment and a finding of incapability may settle the issue of decisional authority, it does not address the issue of intervening against a patient's wishes (Checkland and Silberfeld, 1993).

Another explanation for the limited use of the formal assessment route was given by several participants: the gaps in the corresponding legislation and the options available for addressing placement issues with incapable adults. Pursuing a Committee of Person under the *Patient's Property Act*, for example, was not considered a useful tool for discharge planning with a person refusing placement. One participant questioned the ability of the Committee to ensure the person stayed in a facility, if admitted against his/her wishes. However, a recent British Columbia Supreme Court decision suggests that a decision of a Committee of Person may be enforceable. In Bowen and Dewar versus Clarke (May 31, 2000), a Committee of Person had made the decision, based on the recommendations of health care professionals, for Mrs. Clarke to be moved to a long-term care facility. When she was removed by another family

member, the Committee of Person appeared before the court, and the judge upheld the decision

of the Committee and ordered Mrs. Clarke to be returned to the facility. The judge also ordered

that the individual be restrained from removing Mrs. Clarke from the facility again. However,

in this case, Mrs. Clarke was living in the community prior to admission in a long-term care

facility. Pursuing a Committee of Person was not viewed as a practical or appropriate option

for the hospitalized patient and for facility admission as it was seen as being too costly, time

consuming and too intrusive for the patient.

Use of the extended leave provision of the *Mental Health Act* was seen as more

efficient and cost effective, but it was often not appropriate to meet the needs of the patient,

especially for the elderly (Silberfeld and Fish, 1994). As a result, the use of the *Mental Health

Act* for the protection of the person has been called "poor man's guardianship" (Gordon and

Verdun-Jones, 1992, p. 1-26). As the participants discussed, elderly patients requiring but

refusing placement may fail to meet the criteria for involuntary committal under the *Mental

Health Act*. Due to the shortcomings of the options available under the current legislation, the

Patient's Property Act and the *Mental Health Act*, it was not surprising that social workers

sometimes turned to strategies of persuasion to discharge plan with patients requiring facility

care or supports in the home.

The *Patient's Property Act* and the *Mental Health Act* contain many limitations which

affect social work practice with the elderly by serving to disempower an already vulnerable

population. However, as it is the legislation currently in force, social workers must do what

they can within this framework to enhance the self-determination of their clients. The

participants expressed their hopes that the new adult guardianship legislation would provide

more direction and appropriate options for discharge planning with questionably capable

elderly patients. Members of the focus group were already following the spirit of the new legislation when discharge planning with incapable adults, although this legislation was not yet in force.

The legislation that impacts the assessment process is another opportunity for social workers to become involved in social change. Social workers, individual or as a profession, should be actively involved in developing legislation and corresponding assessment guidelines which will meet their clients' needs, and enhance their self-determination. Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* is yet to be proclaimed in force, and thus there are opportunities for the legislation to be amended and improved. This knowledge of the relevant legislation can then be used to help the client and family navigate the maze of the legal system and the long-term care system, and enhance the advocacy role of social work.

If social work as a profession is actively involved in the development of practice guidelines under this Act, they will be well positioned to take on the role of formal assessors of incapability. Developing and promoting the role of social work as assessors of incapability under the *Adult Guardianship Act*, and the *Health Care (Consent) and Care Facility (Admission) Act*, can be a strategy to increase the recognition of the value of the social work profession, as some participants pointed out how the profession can sometimes be devalued, especially in a hospital or tertiary social work practice setting. This is where the leadership of the BCASW could be effective to spearhead social work's involvement in this area, increase the visibility of the current expertise, and to promote the role of the profession.

<u>Limitation of the Research and Areas for Future Research</u>

    This research project presented findings which are significant to the process of discharge planning with elderly patients, when there are concerns about their capability to choose their place of residence. It is important to remember there are several limitations to this research. In this research project, only one focus group was conducted. Ideally additional focus groups should have been conducted to provide diverse data and balance the idiosyncrasies of one group (Krueger, 1994). However, the triangulation (i.e. two data collection methods) strengthens the research and provides corroborating evidence from different sources (Creswell, 1998).

    The qualitative nature of the research design, and small sample size limit the generalizability of the findings to other practice contexts and to other social workers. (Krueger, 1994). The participants came from three different hospitals within Vancouver, and as a result, the findings may be particular to this geographic or organizational region. Findings can be cautiously generalized, or transferred to similar practice settings with similar types of social workers, such as other hospitals in urban settings in British Columbia. As this research was limited to urban hospital settings, further research with additional participants is needed to ensure that the findings are broadly applicable to social work practice. Recruiting participants from other hospitals, such as those in rural communities, could provide a different perspective. Each health region may have different policies and procedures, as well as different organizational contexts (such as different pressures to reduce hospital lengths of stays), which may influence the discharge planning and competency assessment process.

    My research focused on assessing competency in older adults, with the most prevalent mental impairment being that of a dementia. Further research with other populations, such as

adults with brain injuries, or chronic mental illness is necessary to identify any differences or commonalties among these groups which may affect the discharge planning and competency assessment process. Different community support options may be available to these different populations, which may affect when competency arises as an issue. This research suggested ageism played a factor in the questioning of a person's capability: it would be interesting to explore the circumstances under which competency is questioned in these different groups. It would also be useful to explore the impact of culture on the defining of competency, competency assessments, and the discharge planning process. Different cultures may have different views of self-determination or acceptable risk, for example, which may conflict with that of the dominant cultural group. Cultural differences may then affect the way social workers discharge plan, or assess an individual's capability.

This research, while giving voice to the experience of some social workers, does not expose the experiences of the individuals and families dealing with issues of incompetency, which is a key area for further research. Each group may have a unique perspective about issues of competency, what competency means to them, and how it should be defined and assessed. It would also be useful to explore the impact of the adult's location on the assessment process and outcome, to see if differences unfolded if the person was assessed in his/her own home, versus being assessed in hospital. This research suggests that pressures to discharge patients as quickly as possible may influence the assessment of competency, as well as the foreign, institutional, hospital setting, which can affect a patient's performance during mental status exams, or even functional assessments.

Competency is a complex phenomenon, and this research only provides an overview of the issue as it relates to social work practice, and specifically to discharge planning. However,

this exploratory research does provide a rich description of the process by which social workers discharge plan with questionably competency elderly patients. The challenges and issues raised by these participants when dealing with issues of competency point to the need for appropriate legislative options, practice guidelines, and training. The findings identify a number of implications for social work practice, from the individual to structural level. These findings can be used as a starting point for further research into competency assessments and this important aspect of social work practice. This research also makes explicit a social work perspective on the defining and assessing of competency, and demonstrates the extensive knowledge of these social workers on this issue, expertise which appears to have gone unrecognized.

CHAPTER SIX

CONCLUSION

While this research provided me with an opportunity to explore my interest in the issue of discharge planning with questionably competent older adults, it also suggests a number of areas which warrant further exploration. An area which continues to intrigue me is that of the ethical dilemma inherent in issues of competency, and the conflict between the social worker's responsibility to enhance the client/patient's self-determination, while at the same time protect them from harm. This research suggests an easy or clear resolution to this dilemma may not exist, and social workers will continue to grapple with this issue. The subjective nature of the competency and risk assessment also suggests that social workers should explore their personal and professional values, and make them explicit during an assessment of competency.

Another challenge social workers address in discharge planning is the lack of options available to support the choices of older adult, such as increased publicly funded home support or supportive housing options. These structural limitations often force competency to be raised as an issue, and formal assessments and guardianship pursued. However, the research also highlights the gaps in the current legislation with respect to issues of placement. While the new *Health Care (Consent) and Care Facility (Admission) Act* was eagerly anticipated by the participants, it may not fully address the issues raised by the social workers unless changes are made, or detailed regulations are developed. Social workers have a key role in advocating for the changes necessary to enhance the well-being of their clients.

This research highlights the expertise of these social workers in the assessment of competency to make decisions regarding place of residence, and their appropriateness as assessors. However, this expertise appears to often go unrecognized, even by the participants

themselves. Involvement in the development of the relevant legislation, as well as specialised training, can help develop the confidence and recognition of social workers as skilled assessors of competency. Issues of competency will increasingly become relevant to social work practice, and developing this area of expertise can improve the value of the social work profession.

This description of the process by which competency unfolds as an issue in discharge planning can act as a starting point for developing guidelines for the assessment of capability, and points to the key role of social work in the development and testing of these guidelines. Guidelines can help ensure that those being assessed receive equitable treatment, and minimize the risk that the assessment outcome reflects the biases of the assessor, rather than the characteristics of the individual being assessed (Naglie et al., 1995). The goal of developing guidelines, and in fact, of this research, is to ensure that issues of incompetency are addressed in a way that is most empowering to the lives of older adults. It is my hope that this research is a step in that direction.

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APPENDIX E: Individual Interview Guide

The Role of Social Work in Assessing Competency in Hospitalized Older Adults to Make Decisions Regarding Discharge Destination

Interview Guide

1) Discuss the meaning of "competency".

2) How does competency relate to social work practice?

3) Walk through a case from your past experience in which competency played a role. What were the issues, challenges, outcomes?

4) What factors or information may influence the assessment of competency? What should be considered in an assessment?

5) Any other information you wish to add?

APPENDIX G: Focus Group Guide

COMPETENCY ASSESSMENTS AND SOCIAL WORK PRACTICE WITH THE ELDERLY

FOCUS GROUP
December 7, 1999

INTERVIEW GUIDE

1) How are competency assessments relevant to discharge planning and social work practice in a hospital setting?

2) What have been your experiences as a social worker in assessing the competency of elderly patients to decide place of residence following discharge?

3) What is or should be considered when assessing the competency of elderly patients to decide place of residence after discharge from a hospital?

4) What can social work, as a profession, contribute to the competency assessment process?

5) Anything else that you would like to add? Anything that has not yet been mentioned?