Newfoundland & Labrador Association of
Social Workers

SOCIAL WORK
&
DECISION SPECIFIC CAPACITY ASSESSMENTS

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INTRODUCTION

The social work profession in Newfoundland and Labrador (NL) continues to grow and expand. There are currently over 1400 social workers working in diverse fields of practice throughout the province. Social workers continue to practice at the clinical, management, community and policy levels. By the very nature of our work, social workers exemplify leadership qualities and work with individuals, families, groups and communities to enhance their overall health and well-being.

As social workers, we are keenly aware of some of the provincial trends that are impacting on, and will continue to have an impact on, the people and communities with whom we work. As with other Canadian jurisdictions, NL has an aging population. Social workers are also experiencing an increase in clients with complex medical, cognitive and behavioral needs. Therefore, social work practice will continue to bring unique challenges and opportunities; particularly as it relates to capacity and the assessment of decisional capacity. As our demographics continue to change, the assessment of decision specific capacity will also become a heightened role for the profession.

Social workers across all fields of practice are involved in the assessment of capacity in their work with individuals and families. This is not a new role for the profession. As part of the informed consent process, social workers continuously strive to ensure that individuals have all the information they need to make informed decisions, that they understand the information, and can appreciate the risks and benefits of their decisions. This is the essence of social work practice.

While there may be legal considerations pertaining to capacity and capacity assessments, the purpose of this discussion paper is to outline and discuss the role of social work in decision specific capacity assessments, to provide an overview of some of the practice issues and ethical considerations, and to provide an opportunity for discussion, critical reflection, and practice analysis. Regardless of the area of practice, this discussion amongst the social work profession is timely and relevant.

CONTEXT OF PRACTICE

Social work practice with older adults is an area that will continue to grow and expand. According to demographic predictions as outlined in the Healthy Aging Policy Framework for Newfoundland and Labrador (2006), almost 20% of the population of this province will exceed the age of 65 by 2016. It is projected that this figure will increase to 27% by 2026. Statistics Canada (2005) projects that Newfoundland and Labrador (NL) will have the highest proportion of people over the age of 65 in the country within 10 years. In light of these statistics, it is probable that social workers in diverse fields of practice will work with and continue to work with seniors. While social workers have been involved with the assessment of capacity across all fields of practice, the assessment of capacity in relation to decision-making will become a heightened role for social work professionals.

CAPACITY AND SOCIAL WORK

Social work practice is grounded within the context of human rights. The CASW Code of Ethics (2005) outlines the values and principles of the profession including clients' right to self-determination, respect for the inherent dignity and unique worth of persons, and the right of clients to give informed consent. Social workers bring essential skills and expertise in assessing capacity and articulating the role of capacity in decision-making.

The role of social work in capacity assessments has been well established and is outlined in the CASW Code of Ethics (2005) and CASW Guidelines for Ethical Practice (2005) as evident in the following excerpts:

Code of Ethics: Value 1 - Respect for the Inherent Dignity and Worth of Persons

- *"Social workers respect the unique worth and inherent dignity of all people and uphold human rights"*
- *"Social workers uphold each person's right to self-determination, consistent with that person's capacity and with the rights of others"*

- *"Social workers respect the client's right to make choices based on voluntary, informed consent"*

Guidelines for Ethical Practice: Ethical Responsibilities to Clients

- *"Social workers promote the self-determination and autonomy of clients, actively encouraging them to make informed decisions on their own behalf"(1.3.1)*

- *"Social workers evaluate a client's capacity to give informed consent as early in the relationship as possible"(1.3.2)*

DEFINITION OF CAPACITY

Two terms used interchangeably by health care professionals are competency and capacity. While competency and capacity are related concepts, they are also very distinct. Competency is a term that implies a global ability to understand and appreciate, whereas capacity is decision-specific. While there is debate in the literature about these terms, the language of capacity is becoming more accepted and used by health care professionals.

As outlined in the CASW Code of Ethics (2005) capacity is "the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of choosing to act or not to act" (p. 26). Scott (2008) outlines four decision-making abilities that demonstrate capacity:

1) Ability to understand relevant information.
2) Ability to appreciate the situation and its consequences.
3) Ability to reason.
4) Ability to communicate and express a choice.

These decision-making abilities are consistent with the concept of capacity as outlined in the draft policy manual for the province's *Adult Protection Act* (passed 2011, not in force). As outlined in the draft Adult Protection Act Provincial Policy Manual, "capacity means an adult is able to understand, with support and accommodation, information relevant to the decision

where that decision concerns his or her health care, physical, emotional, psychological, financial, legal, residential or social needs or is able to appreciate the reasonable foreseeable consequences of a decision or the lack of a decision".

Capacity is not all or nothing, and according to Webb (2008) "capacity is situational to the decision in question" (p.1). Individuals may be quite capable of making some decisions (e.g., personal care) and not others (e.g., financial decisions). These decisions can range from the simple to the complex. As noted in the CASW Code of Ethics (2005) capacity can also change over time (p.26), and can fluctuate based on factors such as time, location, medications, or physical illness (Kapp, 2004); thus demonstrating the importance of the assessment of capacity across the continuum. Decisional-capacity must therefore be decision specific (Moberg & Rick, 2008; Kapp, 2004). This is also in keeping with NL's *Adult Protection Act (*not in force) which states: "where an adult is determined to lack capacity for decision-making referred to in subsection (2) in one particular context, he or she shall not be presumed to lack the capacity for decision-making in those other contexts or all of them unless the contrary is proven" (6.3).

CAPACITY ASSESSMENTS

Capacity can be assessed across different decisional domains including, financial, property, health care, nutrition, safety and shelter (Postoff, 2007). A decision specific capacity assessment can be completed to assess an individual's capacity to make a decision along one or more of these domains. However, it is important to note that these assessments should only be completed when there is an *identified need or valid trigger*, when it is in the best interest of the client, and with the consent of the individual. As outlined in the province's *Adult Protection Act (*not in force), "an adult is presumed to have the capacity to make decisions unless contrary is proven"(6.1). According to Scott (2008) "the assessment should not be performed to serve the interests of others" (p.9).

Risk becomes an important factor when deciding if a capacity assessment is needed. Therefore, the assessment of risk across the continuum becomes an important part of the

process. According to Soniat & Micklos (2010), including a risk assessment "helps the social worker determine whether the client has the capacity to function within his or her environment" (p. 73). Knowing and understanding the client's tolerance for risk is also important in completing the assessment of capacity.

When it is determined that a capacity assessment is necessary, there are several tools that can be used (i.e., Standardized Mini-Mental Health Examination, Capacity Assessment tool, MacArthur Competence Assessment tool, etc). Many of these tools have been developed to assess capacity in making medical decisions. When it comes to decisional capacity, questions will need to be tailored to the specific decision in question and a team approach is necessary. Molloy, et al (1999), provides numerous, specific examples of such capacity assessments in the domains of health, property, driving, sexuality and intimacy, as well as others. Although capacity tools may assist health care professionals in exploring capacity, the clinical interview is the key tool for assessing capacity and will need to be tailored to each individual situation.

ROLE OF SOCIAL WORK

Social workers bring essential knowledge and skills to the practice of decision specific capacity assessments, and play an integral part of a team based approach. The specific social work skill set includes assessment, collaboration, communication, conflict resolution, advocacy, and ethical decision-making. According to Soniat & Micklos (2010), "social workers bring a unique perspective to capacity assessment by holistically examining the person within the context of his or her social environment and by assessing both functional capacity and risks (p. 60). It is this 'person in environment' that allows for a comprehensive assessment of capacity beyond the traditional medical approach.

A major role for social workers in the assessment of decisional capacity is the coordination of the interdisciplinary capacity assessment process. This may include assessing and advocating for a decision specific capacity assessment, completing the assessment of risk, administering appropriate assessment tools, completing the assessment interview,

communicating with clients and family members, gathering collateral information, and educating and communicating with members of the interdisciplinary team.

ETHICAL DECISION-MAKING AND CRITICAL REFLECTION

Social workers are aware of the ethical challenges and dilemmas that can be present when considering issues around capacity and decision-making. Many social workers experience ethical dilemmas when working with clients who are perceived to make risky decisions. At what point does the risk become a factor in limiting a person's right to make decisions? What part does our own tolerance for risk play in our work with clients? Are there elements of ageism present? What about other 'isms'? Social workers do not want to see their clients put themselves in risky situations, but where is the balance between autonomy and beneficence, and from whose perspective?

Certainly, the assessment of decisional capacity is fundamental to working through many of these ethical dilemmas, along with a comprehensive risk assessment. Healey (2003) identified decisional capacity as a factor which influences social workers' support of client autonomy and self-determination.

On-going critical reflection is an essential part of social work practice and ethical decision-making. We must balance our own tolerance for risk with that of the client, and to explore our own values and beliefs about care. Are their times when our practices are paternalistic? Does our perception of risk impact on our work with clients and/or their families? How does our perception of risk differ in relation to the populations with whom we may be working? Are there cultural or other relevant considerations that may need to be explored? Antle (2005) proposed an ethical decision-making framework that can help guide social work discussion and reflection (see Appendix A). This model suggests that one must consider the policies/practices of the organization, professional ethics, relevant legislation, and the client's own priorities and needs when ethical issues and challenges arise in practice.

When considering ethical and practice implications, the following questions are meant as a guide to stimulate critical reflection:

1) Have there been situations in your practice where a decision specific capacity assessment would have been helpful?
2) Does your personal tolerance for risk influence your professional ability to assess risk and capacity?
3) What part of care can include risk? Does the idea of providing care mean removing all risk?
4) Is there a point at which care becomes paternalistic? Is this ever justified?
5) How do we educate families and society to understand an individual's right to make decisions that others may not agree with?
6) Do you see a link between decision specific capacity assessments and advocacy?

CASE STUDIES

The following case studies have been included to encourage practice analysis and discussion. The examples are based on actual client situations and have been modified to protect client confidentiality. As you reflect on the case studies consider the following questions:

1) What are the ethical issues?
2) What elements of risk are present?
3) Are there any elements of ageism? What about other 'isms'?
4) Are there assumptions being made?
5) How might a decision specific capacity assessment be helpful?
6) Is there anything that you would have done similarly/differently?
7) What supports would help you deal with these or similar cases?

Case 1 – Capacity Assessments & Financial Decision-Making

Helen is a 56 year old female who had been living independently in the community until she was admitted to the hospital following a fall. Helen has a diagnosis of Parkinson's. Her physical health has deteriorated to the point that she is not able walk independently and has trouble communicating. Her husband had passed away in the previous year. There was one son in the family but the relationship between the son and the mother had been strained for many years. Helen informed the staff that the son had caused much grief for her and her husband during their life time and only came around when he wanted money.

After being admitted to hospital, Helen developed a delirium. Due to the confusion and disorientation caused by the delirium, she was assessed as being incapable to make her own decisions. An application was completed on her behalf and she was admitted to a nursing home. During her absence, the son moved back into the family home.

After Helen was living in the long term care facility for a few months, her confusion started to lessen somewhat and she began to ask about her house, her possessions etc. In Helen's case, her cheques were being automatically deposited into her bank account. The son had access to this account and used the money himself, saying he needed the money to live on and refusing to pay his mother's rent or give his mother any money for her personal needs. Helen was able to identify what her sources of income were and wondered why she wasn't getting her cheque. She also began asking for some of her money.

Plans were being put into place to have Helen's capacity re-assessed but this would take some time to complete. Although there were still some obvious areas of concern, it appeared that Helen was able to express that she wanted some spending money and she wanted to pay her own rent from her own funds.

After consulting with the professional practice leader, the social worker and unit nurse completed a capacity assessment with this lady, solely around her ability to make a decision as to whether or not she wanted to change the address on her cheques to come to the nursing home. Through a series of questions (see Appendix B), the client was able to clearly state that

she wanted the address changed on her cheques to be sent to her at the long term care facility. The social worker documented each question and the resident's exact response. Based on the responses given, arrangements were able to be made to have the Helen's cheques sent to her at the facility. This decision was upheld when it was challenged by her son.

Case Example 2 – Christmas with Annie

Annie moved into a long term care facility in September of 2011. She had suffered a stroke a month previously that left her almost completely paralyzed and aphasic (unable to speak). She could make some utterances, but relied on a letter board to spell words and point at pictures of common items (like a glass of water or a toilet). Due to her physical challenges, Annie was placed on a diet of pureed food – blended to the point of being able to be consumed through a straw.

Annie's cognitive abilities never diminished after the stroke, and she often expressed frustration and great sadness at her physical limitations. One of the things she hated the most was her pureed food.

As Christmas approached, Annie explained to the facility's social worker that she would not eat a pureed meal on December 25th. She wanted, and was going to have, a turkey dinner with all the trimmings, "and not through a damn straw" she insisted (taking the extra time to spell out the expletive).

Understandably, this request posed challenges for the care team. The doctor and dietician had been quite clear in prescribing Annie's pureed diet, noting the risk of choking should she consume foods of an unmodified texture. Annie's husband and two sons were emphatic in their discussions with Annie, with the facility staff and with the facility administrator – "Annie *is not* to eat a regular Christmas dinner, or the facility will be held liable." They were genuinely concerned for Annie's welfare and saw the threat of litigation as one of the only means at their disposal to, as they described, 'protect' Annie.

Because Annie's decision caused such moral distress, a capacity assessment was undertaken with her permission to determine whether or not she understood the potential consequences of her decision. As suspected, the assessment indicated clearly that Annie still had capacity. With facilitated discussion led by the social worker, the care team came to realize that the decision was hers, as long as it was an informed decision, with all the risks outlined. Even after a frank discussion outlining the risks, Annie could not be swayed. A subsequent meeting with Annie and her family was very emotional, with her husband and children saying they did not want to lose her to something "as silly as turkey and gravy."

But it was Annie's decision. From a liability perspective, the facility asked Annie and her family to sign a waiver indicating that she was eating regular-textured food against the advice of her care team and that she understood the risks; for the family's part, the form said the facility would not be held liable should Annie suffer any ill effects from the meal. As for Annie, she enjoyed her Christmas dinner on her terms, and plans to do so again this year.

Case Example 3 – Community Perspectives

An 85 year old woman had been living alone in her own home since her husband passed away fifteen years ago. Two years ago, an assessment was completed with her consent (with assistance from her son as the woman was not literate) and 'self-managed' home care (private worker) was arranged by the son. The client was assessed as requiring 15 hours per week of support for help with meals, housework and medication compliance. The initial assessment suggested the client may have some 'mild dementia', as well as chronic obstructive pulmonary disease.

The son played a significant role with the organization of her care. However as the service evolved, the client began to express discontentment with her son and his 'bossy' approach. She kept insisting she did not want to have him as involved with her care, but he kept insisting on playing a role stating his mother could not make her own decisions. At one point, the son decided to fire the home care worker and hire another. This was not what the client wanted.

The social worker began to question the source of the diagnosis of 'mild dementia', and could not obtain confirmation. With the client's consent, the social worker collaborated with the client's family physician and a geriatric psychiatric assessment was arranged. The assessment process was explained thoroughly to the client – this assessment would help determine her right to make her own decisions about her care – the client consented.

The client was assessed, concerns re: her vulnerability due to low intellectual functioning were discussed BUT she was deemed capable of making her own care decisions re: her home care service. The fired home care worker was reinstated and the son was notified by the client that she no longer wished any involvement from him in her care-related decisions.

WHAT SOCIAL WORKERS NEED

1) Access to continuing professional education and training in the area of decision specific capacity assessments.
2) Access to tools and approaches in completing decision specific capacity assessments.
3) On-going access to supervision, consultation, and support to guide decision-making, including support from employers to be engaged in the work.
4) Opportunities for dialogue and discussions with social work colleagues and members of the interdisciplinary team.
5) Inclusion of capacity in the social work education curriculum.

CONCLUSION

Social workers have a professional, ethical, and legal responsibility to intervene in situations where there is a risk of harm to self or others. The purpose of this paper is to elucidate some of the key questions and issues for social work practitioners when the capacity of a client is called into question, either by a family member, or the system itself, and to generate dialogue and critical reflection. While the assessment of decisional capacity is not a new role for the social work profession, the discussion is important and timely given the changing nature of our provincial demographics.

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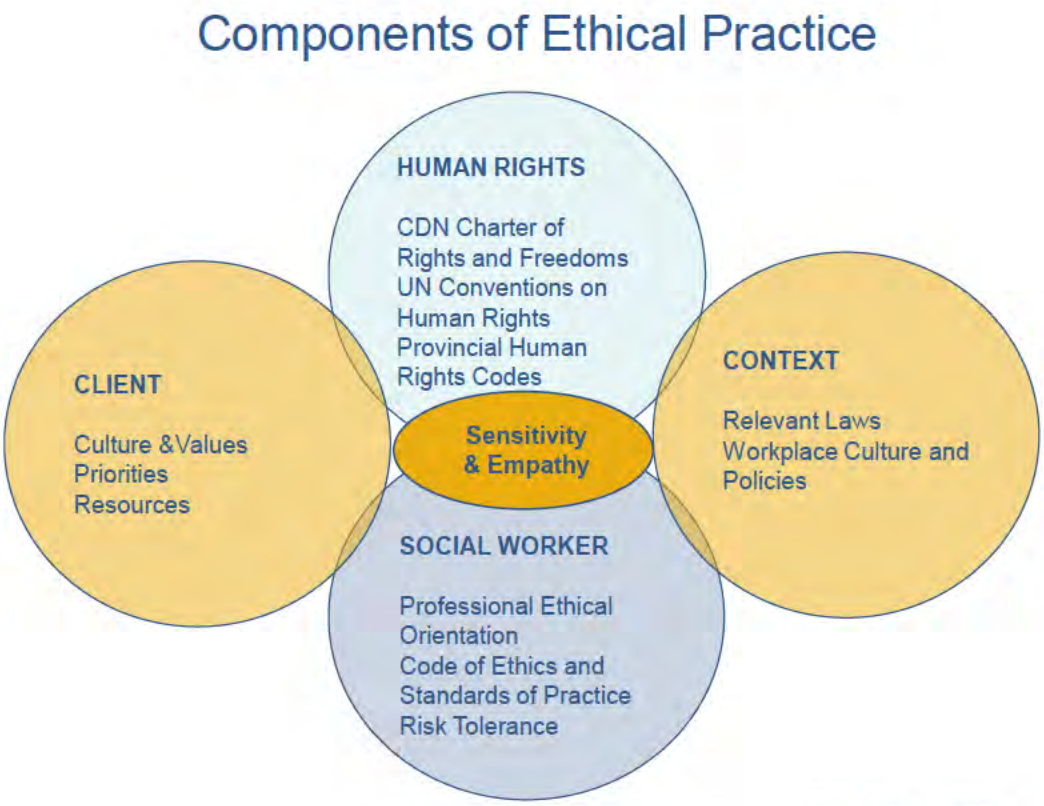
Appendix A


Components of Ethical Practice
HUMAN RIGHTS
CDN Charter of Rights and Freedoms
UN Conventions on Human Rights
Provincial Human Rights Codes
CLIENT
Culture &Values
Priorities
Resources
Sensitivity & Empathy
CONTEXT
Relevant Laws
Workplace Culture and Policies
SOCIAL WORKER
Professional Ethical Orientation
Code of Ethics and Standards of Practice
Risk Tolerance
B.J. Antle, 2005 2

Appendix B

Following is a list of sample questions used by the social worker and unit nurse in assessing the capacity of the resident in Case Example 1 in deciding where her pension cheques should be sent. It is important to highlight that this is not a list of exhaustive questions. The questions are meant as a guiding framework for the conversation which happens with the client, and are not meant to be prescriptive. There may be times that open and closed ended questions may be more effective depending on the individual needs of the client. Social workers must use their own clinical skills in individualizing questions to each client and client situation.

1. Do you know where you live now? (or what is your current address, can you tell me where you are living?)
2. Where did you live before coming to the Home?
3. Who lived there with you? What is your son's name?
4. Do you know what cheques/monies you receive each month? (or what cheques/monies do you receive each month)
5. Do you know that you get a Canada Pension Cheque each month? Do you know that you get a ****private Pension Cheque?
6. Do you know that you have to pay your cheques towards the cost of your care here at the home? (or do you know that you pay to live in this home, how much do you think it costs to live here)
7. Do you know where your cheques are being mailed each month?
8. Do you want your cheques to come here to the long term care facility each month so you can pay for your care? (or where would you like your cheques to be sent?)
9. Do you know that you son is keeping your pension cheques and not sending it to pay for your care?
10. Do you want your cheques to come to the long term care facility to be used to pay for your care?