

**ABANDONMENT OR AUTONOMY:  
HOW DO SOCIAL WORKERS KNOW THE DIFFERENCE?**

by

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### Abstract

The Adult Guardianship Act proclaimed in British Columbia in 2000 was a legal response that provides a mandate for designated agencies to look into reports of vulnerable adults who are abused, neglected, or self neglected. Important guiding principles are embedded in the legislation intended to safeguard the principal of autonomy. This legislation requires designated agency staff to be simultaneously responsible for the mandate to care for vulnerable adults who are experiencing abuse, neglect, or self neglect and to uphold the principle of the right to autonomy. This qualitative research study describes the experiences and decisions social workers encounter in adult guardianship practice with older adults, particularly as it relates to the ethical dimensions of the practice. Results suggest that social workers look for and find ways to balance support for both autonomy and care by improvising “ethical jazz.” Questions were raised about the viability of integrating adult protection and health care.

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## Chapter One

### The Research Problem

#### Introduction

It has been my honour and my privilege to work with older adults in northern British Columbia. I have met men and women whose lives are remarkable for sheer hard physical work. They spent their lives fishing, logging, mining, trapping, building, raising children, and keeping house: a generation who by making their living and their homes here have changed the face of the North. I have entered into stories of spirited independence and survival. Many times these life stories were tales of tangled grief, sorrow, and anger whose final chapters were concluding in inevitable illness and self-destruction. Sometimes the part I played was one of witness and intervener in ongoing narratives of abuse and self neglect. I was the social worker who was hired by the Northern Health Authority as a result of the new adult guardianship legislation proclaimed in 2000; my role was to develop expertise and act as a consultant to other Health Authority staff.

The adult guardianship legislation was a legal response created to address the issue of abuse, neglect, and self neglect of vulnerable adults. The law was intended to provide for support and assistance for adults who have a physical handicap, or an illness, disease, injury, or other condition that affects their ability to make decisions about the abuse or neglect (Adult Guardianship Act, R.S.B.C. 1996, c.6). The legislation provides a mandate for designated agencies to look into reports of vulnerable adults who are abused, neglected, or self neglected and legal tools to assist in the fulfillment of this duty. Examples of these tools are the power to investigate, the right to information, court enforced support and assistance,

and emergency measures to preserve life and prevent harm such as the right to enter a premises without permission.

Important *guiding principles* were embedded in the legislation intended to safeguard the principle of autonomy (Adult Guardianship Act, R.S.B.C. 1996, c.6). The Act states that adults are *entitled to live as they wish* as long as others are not harmed, and they are capable of making decisions. Adults are to be *presumed capable* and should only receive the *most effective, least restrictive* form of assistance which refers to the idea that an individual's autonomy should only receive minimal interference. In other words, this legislation requires Health Authority staff to be simultaneously responsible for the mandate to care for vulnerable adults who are experiencing abuse, neglect, or self neglect and to uphold the principle of the right to autonomy. Right from the outset, staff mandated with this responsibility are set up for ethical quandaries from the oppositional principles built into the foundation of this legislation. The legislation, however, merely mirrors a universal paradox: that is the dialectic, the irresolvable tension between separation and connection that is at the heart of all human relationships and society as a whole.

Self-determination is a moral principle, fundamental to the profession of social work (Ewalt & Mokuau, 1995; Furlong, 2003; Healy, 1999; Manning & Gaul, 1997; Sasson, 2000). However, both the literature and the social work Code of Ethics support the notion that there are important exceptions to the principle of the right to self-determination. The Canadian Association of Social Workers (CASW) Code of Ethics states that social workers are obligated to uphold "each person's right to self-determination consistent with that person's capacity and with the rights of others" (CASW, 2005, p. 4). The literature also

reflects a general consensus that it is justifiable and morally acceptable to interfere with autonomy so long as an adult is declared incompetent (Kelly, 1994; Sasson, 2000).

The social work profession concerns itself with responding to those in our society who suffer from abandonment or abuse. If, when, and how a society chooses to respond to suffering is shaped by cultural beliefs and attitudes. The choices we make as a society in how we respond to abandonment and abuse have been conceptualized as two opposing moral visions. The moral vision termed an ethic of justice prescribes acting fairly toward others; the moral framework called an ethic of care supports responding to those in need (Gilligan, 1982). The debate on the merits and drawbacks on these ethical models has been considerable. The ethic of justice was criticized for its blind adherence to abstract principles and lack of compassion (Clement, 1996). Feminists questioned the ethic of care model, because the premise that autonomy was “illusory” threatened the right of women to determine their own lives and contradicted a basic standpoint of equality (Clement, 1996). However, it is possible to forge a path of possibility through the antagonism of the two extremes. These different ethical perspectives “should not be seen as competitors, but as allies...in our attempt to create a better world” (Clement, 1996, p. 109).

Seeking the balance between these two ethical frameworks is what social workers are called to do every day in adult guardianship practice. Social workers are responsible for applying these principles in real life practice; decisions must be made that uphold the principle of self-determination without violating the ethic of care (Bergeron, 2006; Healy, 1998; Rothman, Smith, Nakashima, Paterson, & Mustin, 1996). It is the dance between abandonment and autonomy, and it lies at the heart of social work practice. Each social worker looks for the steps between the rules and caring in their own way. In my own

experience, I found the practice to be enormous, complex, and provoking. I wondered how other social workers experienced this work. Did they ever think they were abandoning individuals to their own autonomy?<sup>1</sup> A social worker's acceptance of a client's refusal of services may not differ from abandonment, which would be a violation of social work ethics (Bergeron, 2006; Moody, 1998). Does the right to self-determination justify the risk of abandonment, of tearing the fabric of the interdependent web?

Dorothy, an older woman who was a victim of emotional, financial, and sexual abuse refused services until she collapsed and was transported to hospital (Bergeron, 2006). She was asked if her right to self-determination outweighed the health care professionals' responsibility to intervene; she said, "How dare you professionals speak of self-determination when I was obviously suffering?" (Bergeron, 2006, p. 89). She explained that her inability to understand her choices was due to shame, isolation, and the belief that she did not deserve anything better. Bergeron (2006) argues that law that requires us to investigate and substantiate abuse and then permit the victim to choose to remain in life threatening situations deserves our attention and "threatens our humanity as professionals" (p. 100).

## **Theoretical Framework**

### **Autonomy.**

Self-determination has been described as a principle, a task, a need, and a right (Furlong, 2003). Barker (2003) defines self-determination as, "an ethical principle in social work that recognizes the rights and needs of clients to be free to make their own choices and decisions" (p. 387). According to Clark, the term self-determination is used interchangeably with the term autonomy in the literature (as cited in Furlong, 2003). Autonomy refers to the

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<sup>1</sup> The author is indebted to Charmaine Spencer, an academic in this field from the Simon Fraser University Gerontology Research Center, for her use of this expression at various educational presentations

idea that an individual is capable of independent action and able to provide for one's own needs (Barker, 2003). Beauchamp and Childress (1989), renowned in the field of biomedical ethics, provide the following explanation of autonomy: autonomy comes from the Greek word *autos* (self) and *nomos* (rule or law) and was used to describe states with citizen self rule (as cited in Kelly, 1994). Autonomy for an individual is the right of a person to rule the self without interference from others (Kelly, 1994).

Most laws pertaining to adult guardianship maintain that competent adults in situations of abuse, neglect, or self neglect have the right to refuse services if they are considered capable. The adult guardianship legislation in British Columbia states that:

All adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters (Adult Guardianship Act, R.S.B.C. 1996, c.6, pt.3, s.2 (a)).

The language of capacity in this paragraph reflects the legal recognition that there are important exceptions to the principle of self-determination. Limits to self-determination are ethically permissible when individuals lack capacity and are living at risk (Rothman et al., 1996; Sasson, 2000). In fact, the social work literature argues for the need for practitioners to be directive when harm is threatened (Rothman et al., 1996). The CASW (2005) Code of Ethics states, "Social workers uphold the right of society to impose limitations of the self-determination of individuals, when such limitations protect individuals from self-harm and from harming others" (p. 5). In Beauchamp and Childress' (1989) view, health care professionals must not interfere with individual autonomy unless there is a competing moral principle such as *beneficence* (as cited in Kelly, 1994). Beneficence is a central principle in medicine and is considered to be the duty to benefit, the obligation to prevent harm (Kelly, 1994). *Paternalism* is the principle that justifies interfering with autonomy in order to

prevent harm for an individual's "own good" (Kelly, 1994, p. 76). Beauchamp and Childress state that paternalism may be justified if the benefit outweighs the loss of independence and if the person's ability to choose is seriously limited and would be universally justified under similar conditions (as cited in Kelly, 1994). The decision to intervene against individual choice in order to prevent harm risks violation of an important ethical and legal principle; however, the decision to respect an individual's right to refuse services risks abandonment of the client. Abandonment has been defined as the "premature termination of services or being unavailable to a client when needed" (Barker, 2003, p. 1).

The right to autonomy and the limits to that right are concepts subject to interpretation according to a wide variation and intersection of belief systems. The context of ethnicity, gender, and culture shape the individual and shared meanings that constellate around a social construct. This thesis will explore and examine the construct of autonomy and its various meanings and implications as it is manifested in elder abuse practice. The contrasting moral frameworks of the ethic of care and the ethic of justice will be used as theoretical lenses in the consideration of this subject.

### **Ethic of care.**

In 1982, Gilligan articulated a perspective that challenged theories of moral development that found women to be deficient and lacking maturity. With Kohlberg's scale of moral development women rarely reached the higher stages, because this model subordinated relationships to universal principles of justice (Gilligan, 1982). The characteristics of sensitivity and caring that some argue are women's strengths were seen as weaknesses that contributed to a less developed morality (Gilligan, 1982). Gilligan argued that theories of human development that failed to account for women's different ways of

relating in the world were deficient. While the ethic of justice emphasizes rights and rules, Gilligan proposed an alternate vision she called an ethic of care, a moral framework that emphasized responsibility and relationships. Within the framework of the ethic of justice, individuals are considered to be independent agents who consent to their obligations to others (Clement, 1996). In contrast, the ethic of care model assumes that individuals are connected and responsible for one another (Clement, 1996). The ethic of care views individuals not as “opponents in a contest of rights, but as members of a network of relationships on whose continuation they all depend” (Gilligan, 1982, p. 30).

### **Balancing autonomy and care.**

The right to define oneself is central to the ethic of justice, while the value of autonomy is questioned within the ethic of care framework. The interpretation of the meaning of autonomy varies with how *self* is conceived. Within the ethic of care model the self is socially constructed and cannot be defined by the individual, thereby making autonomy a problematic concept (Clement, 1996). The very idea of autonomy threatens the web of relationships that the ethic of care seeks to maintain. “Illuminating life as a web rather than a succession of relationships, women portray autonomy rather than attachment as the illusory and dangerous quest” (Gilligan, 1982, p. 48). This view of autonomy resulted in criticism from some feminists; for example, MacKinnon stated that the ethic of care is nothing more than the “voice of the victim speaking without consciousness” (as cited in Clement, 1996, p. 45). However, Clement (1996) argued that not only is autonomy compatible with an ethic of care, but also that the ethic of care framework is deficient if it is not integrated into the perspective.



## **Researcher Standpoint**

In this era in which researchers appreciate that the knowledge construction process is a collaboration between the researcher and the participants to co-create meaning and understanding, it is important for this researcher to make her own views explicit (Kirby, Greaves, & Reid, 2006). While previous research paradigms required the researcher to occupy a privileged stance of objectivity, the literature on research methodology calls for high standards of reflexivity (Kirby, Greaves, & Reid, 2006). Reflexivity is an interrogative process through which the researcher considers the implications of how his or her location and experiences are influencing the research process (Kirby, Greaves, & Reid, 2006; Lincoln & Guba, 2000).

My standpoint is that of a white, lesbian, middle aged, middle class woman. I came to the research project as a form of an insider in that I am an educated, professional social worker with several years of experience working with older adults who have experienced abuse, neglect, and self neglect. I am not unaffected by the contemporary society that I live in, that “enshrines individualism” (Furlong, 2003, p. 186) in the same way that the older adults that I have worked with have been influenced by the grand narrative of indomitable pioneer spirit associated with rural and remote areas. In other words, both my position as a social worker and my middle class status in Canadian society might be said to predispose me to value the right of the individual to their autonomy. However, for me personally, the need to uphold the principle of autonomy was deeply troubling at times; the ethical principle sometimes seemed a hollow theory, inadequate and superficial in the face of the breadth and depth of complex need. The question at the core of this thesis springs from the researcher’s assumption of a relational ontology that coincides with the belief that as a society we are

interconnected and interdependent and that this is a vital value for inclusion when examining the subject of compassionate care for vulnerable adults.

Another assumption of this researcher that should be made explicit is that opposing dichotomies are unhelpful frameworks for understanding the social world, which is consistent with postmodern and feminist orientations (Moosa-Mitha, 2005). The personal stance I bring to the subject matter is openness to multiple perspectives and balance. Openness to multiple realities allows for recognition of contradictory mutualities that may exist which may not otherwise be discovered. For example, embedded in the adult guardianship legislation is the belief, foundational to guardianship reform, that the construct of competence has a social component and is a function of an individual's social supports (Gordon, 2001). In other words, competence can be seen as a quality not just related to individual pathology, but also as a social construct. Individuals with disabilities can function independently and competently in the community, if they are provided with adequate and appropriate supports. This concept arises from the social model of disability that assumes that interdependence is normal and necessary for all individuals, including the disabled (Mackelprang & Salsgiver, 1999). It is an interesting contradiction that the law in this case, a manifestation of the ethic of justice's emphasis on abstract principles, also legitimizes the value of the personal, of interdependence, and the ethic of care in the public domain. No matter how this law actually works in practice, at its heart there existed the intention to recognize the need to balance independence with support.

The stance of balance works hand-in-hand with the idea that dichotomies can be misleading. Similar to Clement (1996), I see strengths and weaknesses in the opposing perspectives of care and justice and believe balance to be both necessary and desirable. The

ultimate goal for a vulnerable individual is neither independence nor dependence, but a pivot point somewhere in between that cannot be universally prescribed. Finding this balance point is in part the goal that social workers attempt to achieve. Elsewhere I have described this process as a dance in an attempt to convey the intricacies of balance that cannot be achieved with adherence to rigid rules, managed by a linear sequence of steps. To borrow a metaphor used by the theologian Richard Holloway (1999), this dance or balancing act may also be described as ethical jazz. Jazz music is not dependent on the written notes; it is an artful improvisation of the musician's knowledge of notes and chords, resulting in a new composition, never committed to paper, never played the same way twice. It is a talent that requires knowledge, versatility, and comfort with taking risks. Social workers perform ethical jazz when they balance important principles and complex needs in the world of practice where the harmony between theory and policy, and reality and resources is discordant.

### **Rationale**

If the ultimate goal of research can be as Freire has suggested, community transformation, with the facilitation of a mutual awareness of a truth (Kirby, Greaves, & Reid, 2006), then the subject of abuse, neglect, and self neglect of vulnerable adults is most suitable for community consideration. There is a critical need for research to support practice in this field. Many authors in this field loudly criticize the lack of empirically based research knowledge that makes it difficult to design and develop effective interventions (Acierno, Rheingold, Resnick, & Stark-Riemer, 2004; Bergeron, 2006; Healy, 1999; Macolini, 1994; Rothman et al., 1996; Schlesinger & Schlesinger, 1999; Thompson & Priest, 2005). Schlesinger and Schlesinger (1999) state: "We do not need more studies that define

elder abuse. We do need a greater understanding of the micro and macro interventions and preventions” (p. 291). Practitioners in the field are expected to respond, but they do not have the tools they need to identify and intervene; research is needed to identify effective interventions (Beaulieu & Leclerc, 2006). Research into practice where potential for coercion exists will further highlight the complexity of practice decisions that are required (Taylor & Bentley, 2006). Bergeron (2006) believes that retrospective research from the older adult’s viewpoint would be valuable and that an appreciation of how practitioners interpret the ethical principles in practice would enhance the profession’s overall understanding of the subject.

Thus, there is an essential need to map the contours of the practice terrain. How do social workers make decisions when balancing the need to protect autonomy with the need to protect the individual? What are the effective strategies and barriers encountered in adult guardianship practice with older adults? Insight into how social workers balance these ethical principles outside the textbook will assist the profession’s understanding of how social workers succeed (and fail to succeed) in their service to humanity.

Furthermore, the potential for social workers to experience moral distress as a result of the ethical dilemmas they experience is enormous (Healy, 1998; Kelly, 1994). Research findings that identify the issues, support the need for resources, or provide guidance for ethical dilemmas hold the possibility of reducing practitioner distress. The ethical dilemmas faced by mental health practitioners are similar to the ones identified in elder abuse practice as well. For example, Taylor and Bentley (2005) state that these workers are required “to formulate practice decisions that both protect society and maximize the rights of the individual – perhaps an impossible task” (p. 470). Therefore, the importance of describing

the challenge of this work extends beyond the practice area of elder abuse. Taylor and Bentley frame the ethical dilemmas encountered by mental health practitioners as value collisions and professional dissonance. Findings that describe how social workers reconcile this dissonance will contribute to practice.

Finally, the subject of self-determination is a concept so fundamental to the social work profession, perhaps even described as a piece of orthodoxy never closely scrutinized (Furlong, 2003), that a closer examination of its application to elder abuse practice could yield content and questions that demand further discussion.

## Chapter Two

### The Literature Review

#### Developing a Definition

Elder abuse was first identified as a social problem in the literature in the 1970s (Mcdonald & Collins, 2000) and thought to be an offshoot of the interest in the problem of family violence and spousal abuse (Gordon & Brill, 2001). The Canadian studies on elder abuse that followed in the 1980s supported the idea that elder abuse existed (Mcdonald & Collins, 2000). Elder abuse research in the 1990s extended to practice and policy issues and legislative reform (Mcdonald & Collins, 2000).

Defining what constitutes elder abuse and its causes has produced considerable controversy and presented methodological issues for research (Beaulieu & Leclerc, 2006; Macolini, 1995; Mcdonald & Collins, 2000). Much of the early research focused on the need to develop a common definition of abuse (Gordon & Brill, 2001; Thompson & Priest, 2005). The lack of a consistent definition has resulted in difficulty with collecting accurate data and making data comparisons and stands in the way of answering the question of what constitutes elder abuse (Mcdonald & Collins, 2000; Podnieks, 2008). Definitions vary in scope from specific to broad; some are related to the outcome of the behaviour, some arise from the theoretical cause (Mcdonald & Collins, 2000).

Three broad categories that appear to have general agreement in the literature are: domestic abuse, institutional abuse, and self neglect (Mcdonald & Collins, 2000). Domestic abuse is meant to indicate the type of abuse behaviour that happens in a trusting relationship in the community as opposed to the abuse that occurs in an institution (Mcdonald & Collins, 2000). These types of abuse can cause physical, psychological, or financial harm (Mcdonald

& Collins, 2000). Self neglect refers to action, or lack of action, by an older adult that creates potential harm for him or herself (McDonald & Collins, 2000). The inclusion of this last category of abuse has been a matter of debate due to the lack of an abusive third party (McDonald & Collins, 2000). More recently, the World Health Organization adopted a definition that reflects some of the consensus that has developed in the field and cited by researchers (e.g., Beaulieu & Leclerc, 2006). For example:

Elder abuse is a single, or repeated act, or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect. (World Health Organization, 2002)

### **Prevalence of the Problem**

A systematic and comprehensive review of international elder abuse prevalence research concluded that the best evidence suggested that over 6% of the older general population, a quarter of older adults who were dependent on caregivers, and a third of family caregivers reported involvement in abuse (Cooper, Selwood, & Livingston, 2008). However, prevalence rates reported in the global literature varied from 3 to 27% (Cooper, Selwood, & Livingston, 2008). Reasons suggested for this wide variation are thought to be possibly due to methodological differences in defining and measuring the issue, and actual differences in the issue across cultures (Cooper, Selwood, & Livingston, 2008).

A recent American study found that 1 in 10 participants in a random sample of adults 60 and over reported experiencing emotional, physical, or sexual mistreatment or potential neglect in the last year (Acierno et al., 2010). Only a fraction of abuse is thought to be reported (Acierno et al., 2010; Cooper, Selwood, & Livingston, 2008); difficulties in collecting sensitive information and excluding the cognitively impaired from research are

two reasons thought responsible for preventing full representation of the problem (McDonald & Collins, 2000).

In Canada, a national telephone survey of older adults was conducted by Podnieks, Pillemer, Nicholson, Shillington, and Frizell (1990) which found that 4 % of the sample reported experiencing some form of abuse, with financial abuse being the most common (as cited in McDonald & Collins, 2000). A study by Spencer (1996) in British Columbia that focused on financial abuse determined that 8% of a random sample had experienced some form of financial abuse after turning age 60 (as cited in McDonald & Collins, 2000). O'Connor, Hall, and Donnelly (2009) suspect that financial abuse is the most common form of abuse, partly because it is the most easy to recognize when compared to the other forms of abuse. In Ontario, a College of Nurses study (1993) on institutional abuse surveyed registered nurses and nursing assistants and found that one half of the participants reported observing one or more incidents of abuse (Podnieks, 2008).

### **Explanations of Elder Abuse**

Explanations of elder abuse in the literature have varied. The phenomenon has been likened to both child abuse and spousal abuse (Gordon & Brill, 2001; Harbison, 1999; Macolini, 1995). Psychopathology of the abuser, intergenerational transmission of violence, dependency of either the older adult or the abuser on the other, stress, and ageism are risk factors the literature has suggested are linked to elder abuse (McDonald & Collins, 2000). McDonald and Collins (2000) point out that theory building in the elder abuse field has been limited, relying on identifying risk factors for abuse without providing a framework for the relationship between the risk and the abuse, a result of the lack of incidence data where



mechanisms for abuse could be better examined. These authors go on to describe the four main theoretical perspectives that have evolved in the literature.

One widely accepted model is the situational model, where it is theorized that stress causes the caregiver to abuse an older person (McDonald & Collins, 2000). Variables in this model relate to the older adult, to the caregiver, and to the social and economic context of both individuals (McDonald & Collins, 2000). This model has been criticized for its potential for blaming the victim and lack of supporting evidence (McDonald & Collins, 2000). This model cannot explain findings such as those of Pillener and Finkelhor (1988) where it was suggested that it was the caregivers who are the older adults most at risk from abuse from the family members for whom they provide care (as cited in Brownell & Heiser, 2006). In Acerno et al.'s (2010) study, low social support and previous exposure to traumatic events were the most consistent correlates across all types of mistreatment. The authors point out though that functional impairment in the older adult just predicted emotional and financial mistreatment, which provides only limited support for the caregiver stress theory.

The social exchange theory views the older adult as powerless and dependent in a relationship with an abusive caregiver where the reward of having one's needs met exceeds the punishment of the abuse (McDonald & Collins, 2000). This theory has been criticized for the assumption that aging automatically means dependency and the fact that many abusers are dependent on the older person (McDonald & Collins, 2000).

The symbolic interaction perspective considers not just the behaviour of those involved in the abusive situation, but the meanings that people attach to the behaviour in certain situations (McDonald & Collins, 2000). This view suggests that individuals who observe and experience abuse in their families learn to replicate this behaviour (McDonald &

Collins, 2000). Arguments with this view include the idea that not all caregivers who have experienced child abuse become elder abusers, and research that suggests that parents who are abusing children are more likely than caregivers who are abusing older adults to have been victims of child abuse (McDonald & Collins, 2000).

Feminist models of elder abuse have focused on the abuse that occurs between spouses who are older adults, a function of the patriarchal system where the lower power status of women causes them to be vulnerable to violence (McDonald & Collins, 2000). The difficulty with this theory is that it limits the focus to physical abuse of female victims (Gordon & Brill, 2001) which is only one aspect of a larger problem and it does not account for the research suggested by Podnieks (1992) that older men are as likely to be abused as older women (as cited in McDonald & Collins, 2000). There is some suggestion in the literature that power imbalances between individuals might be a more valid theoretical framework for elder abuse than gender based theories, prompted by the gay and lesbian domestic violence research (McDonald & Collins, 2000). However, it has been argued that critical feminist theory is applicable to the field of elder abuse, because it concerns itself not just with gender, but also with power inequities inside and outside of personal relationships and is therefore a useful lens for the consideration of how persons who are aging and have disabilities may be oppressed and marginalized in society (O'Connor, Hall, & Donnelly, 2009). Ristock (2005) points out the limitations of using a dominant gender and structural lens, as it tends to oversimplify and fail to account for the diverse patterns of interpersonal relationship violence that were uncovered in her research into lesbian domestic violence.

Harbison and Morrow (1998) discuss the lack of theory and research to support many of the claims about elder abuse and neglect. They identify three central constructions of

elder abuse and neglect that include: abused and neglected older adults who require protection; abused and neglected older adults who are experiencing family violence; and abused and neglected older adults who are victims of criminal acts. They point out that these constructions are based on paternalistic assumptions of older adults as in need of protection and incapable of making decisions. An additional construction is the acknowledgement that the older adults themselves can act as agents for their own interests (Harbison, 1999). The discourse on elder abuse and neglect has by and large arisen from professional experts and not from older adults; a suggested reason for this may be the unwillingness of older adults to be associated with the negative identity of ageing that is implied by the inherent assumptions of the constructs (Harbison, 1999; Harbison & Morrow, 1998).

### **Towards an Integrated Theoretical Model of Elder Abuse**

Gordon and Brill (2001) call for a different approach, for a model that can include the multitude of factors that might give rise to elder abuse. They state, “No single theory of elder abuse and neglect can account for all situations” (p. 187). They propose an integrated theoretical model that accounts for interactions between different social, psychological, and cultural variables that can be used to guide policy and practice. In their discussion of what should be included in an integrated model of theory and abuse, they refer to Ansello’s (1996) framework that categorizes risk factors for abuse according to the characteristics of the victim, the abuser, and the environment (as cited in Gordon & Brill, 2001). These risk factors include history of substance abuse or mental pathology in the older person or the caregiver, a previous history of abuse in the caregiver context, the abuser’s dependence on the senior, and a chronic illness that exceeds the caregiver’s ability (Gordon & Brill, 2001). They contend that these risk factors are the key elements that form the essence of a

theoretical model for elder abuse. While no combination of variables can absolutely predict abuse, the ascendancy of a particular component will shift according to the context of the situation; it is only through time and trial that the utility of an integrated model of elder abuse can be demonstrated (Gordon & Brill, 2001).

### **What are the Interventions?**

Theories that practitioners and policy makers hold about the causes of elder abuse have shaped the interventions and services designed to address the problem (Brownell & Heiser, 2006). For example, caregiver stress hypotheses have led to interventions that support caregivers such as respite services (Brownell & Heiser, 2006). The approaches that have been developed to address elder abuse have included legislated adult protection programs, adaptations of domestic violence programs, advocacy programs, networks, and community based multi-disciplinary teams (McDonald & Collins, 2000).

Protective services programs ideally provide a combination of legal, health, and social services but have been criticized for their infantilizing treatment of older adults and inadequate provision of services in some locations (McDonald & Collins, 2000; Podnieks, 2008). Harbison and Morrow (1998) state there is substantial evidence that for the tangled complexity involved in abuse and neglect cases, legislation is an ineffective tool. A case in point is the difficulty legislation encounters when dealing with differing levels of mental competence for differing levels of decisions (Harbison & Morrow, 1998).

Examples of adaptations of domestic violence programs are the creation of elder specific shelters (McDonald & Collins, 2000; Podnieks, 2008; Solomon, 2006), developing support groups (Brownell & Heiser, 2006; Hightower, Smith, Ward-Hall, & Hightower, 1999), hotlines, legal clinics, and family and individual counselling programs (Podnieks,

2008). Criticisms of these programs point out that the existing problems with police response, such as restraining orders and lack of follow up services, apply equally to older adults. Furthermore, some of these types of services are not always well equipped to serve the special needs of older adults (Hightower et al., 1999; Podnieks, 2008). Also, these types of services have been viewed as unhelpful for cases of neglect (McDonald & Collins, 2000).

Using a rights-based model, advocacy programs work to educate individuals about their rights and available services (Podnieks, 2008). Independent of the system, advocates ideally support an older adult to make change based on the individual's own values (Podnieks, 2008). The formation of elder abuse networks, drawn from a cross section of the community, are promoted as a community strategy where members "act in an advisory capacity to consult, collaborate, and cooperate in developing intervention strategies and prevention options for vulnerable adults" (Podnieks, 2008, p. 144).

Several community based multidisciplinary teams who work together to assess, consult, and intervene in complex cases have been developed across Canada (Podnieks, 2008). Furthermore, the community based multidisciplinary teams across Canada that provide mental health services for older adults would not be unfamiliar with the adult protection client. Research has shown that older adults experiencing abuse and neglect are referred to geriatric psychiatry services (Vida, Monks, & Des Rosiers, 2002). One particular study examined the interventions of a home-based geriatric assessment team for adult protection services clients. The study identified five categories of interventions that were used that included: home health care agency services, institutional placement, guardianship actions, urgent medication initiation, and acute hospitalization (Heath, Kobylarz, Brown & Castano, 2005).

Harbison (1999) argues that the positivist approach to researching the problem of elder abuse has resulted in framing a multilevel and multidimensional social problem as a disease that can be identified, diagnosed, and treated. This curative view has led to the development of individualistic solutions and tools that are limited by the individual's right to choose (Harbison, 1999). This has resulted in a set up for a conflict between the contrasting approaches of forcing an intervention versus a minimalist "wait and see" attitude (Harbison, 1999). Harbison (1999) makes the observation that the minimalist approach is contrary to the culture of some professional organizations and can also create a sense of defeat for the professional.

The lack of fit between services and older adults experiencing abuse and neglect has been noted in the literature. On the part of older adults, there is a general reluctance to accept services (McDonald & Collins, 2000). Research has shown that older adults refuse assistance and tolerate material abuse for a multitude of reasons such as a need to maintain relationships, a fear of institutional placement, or feelings of guilt or shame (Harbison & Morrow, 1998). Spencer (1995) stated that up to one third of older adults decline services which may reflect a disconnect between need and service (as cited in Podnieks, 2008). Innovative services appropriate to different cultures are needed for First Nations communities and the many different cultures that make up Canada's population (Podnieks, 2008). Harbison (1999) discusses the dominance of professional expertise in the entire enterprise of abuse and neglect and suggests that professional involvement is not required in all cases and that the older adults themselves may be the ones "who are most likely to be effective in producing positive outcomes" (p. 13).

## **Social Work and Self-determination**

The discussion in the literature on the subject of social work's relationship to the principle of self-determination provides considerable material for reflection. The political, ideological, and professional factors of different historical periods have influenced the social work profession's attitude about self-determination (Freedberg, 1989). According to Freedberg (1989), the concept of self-determination arose in the eighteenth century period of enlightenment when ideas such as a belief in the human capacity for reason and the ability to direct one's own life are thought to have taken root and flourished. In the 1920s and 1930s, reaction to totalitarian regimes, the desire to uphold democratic values, the powerful emphasis of Freudian theory with its emphasis on diagnosis, treatment, and individually directed choices, and the profession's desire to establish legitimacy were all strong influences. The 1940s and 50s were a time social workers struggled to solve social problems caused by the war. Freedberg states, "During the New Deal Era, social work became more accountable to society. As a result, the goals of social work became institutionalized; their social purpose reflected community needs for individual self-maintenance and social contribution" (p. 36). Reynolds, a social worker from the 1950s, is seen by Freedberg as a maverick and the only voice of that time to recognize the contradiction of self-determination in the social environment; she stressed the idea that self-determination exists in "a sense of common humanness between worker and client and not in the procedures and methods that called for the modification of personal attitudes" (Freedberg, 1989, p. 34).

The climate of the 1960s was political and controversial; social work aims of self-determination for the marginalized and the promotion of empowerment and community action were emphasized, but it was also a time when the paradox of self-determination

became more apparent (Freedberg, 1989). The application of the principle of self-determination by actualizing the human potential of clients was argued by some as not credible, when those clients lived in an economic system controlled by a propertied class that marginalized and disenfranchised certain individuals (Freedberg, 1989). The reaction of the civil libertarians to the conservative periods of the 1970s and 80s transformed the *need for self-determination* to the *right to self-determination*, thus imbuing it with a sense of morality (Freedberg, 1989). However, Freedberg (1989) notes that in this period, self-determination belonged to the individual, and not the group, as it was seen in the 1960s.

### **Self-determination and Culture**

The meaning of self-determination is related to how the *self* is conceived which varies across cultures; social work's present emphasis on self-determination could be argued as culturally biased (Ewalt & Mokuau, 1995; Furlong, 2003). The concept of self can range from a unitary to a relational construct (Furlong, 2003). In a culture where the ability of the individual to stand alone from the group is seen as a sign of strength and maturity, the capacity for a relational self to contribute to the collective well-being is not as highly valued (Ewalt & Mokuau, 1995). Barnett reported on an example of a different culture's value of independence; a rehabilitation team working in Australia wanted to teach techniques to enable a visually impaired elderly Aboriginal individual to shop independently, however the community was horrified at pursuing the goal of making an elder walk around alone (as cited in Furlong, 2003).

### **Self-determination and Relationship**

The nature of autonomy can be conceptualized as both an internal psychological state and a social construct. Clement (1996) argued that autonomy results when social conditions



exist that permit individuals to critically examine their roles and make free choices. She concludes that paradoxically, self-determination cannot be separated from relationship as individuals learn autonomy within relationship (p. 24). Manning and Gaul (1997) use this notion of autonomy being connected to relationship in their discussion of informed consent. Legislative and organizational policies on informed consent are a concrete expression of the principle of self-determination in health care practice (Manning & Gaul, 1997). Manning and Gaul (1997) state, “It is the process of interacting with others that helps people get in touch with themselves and what is meaningful to them as individuals” (p. 114). Therefore, the nature of the relationship between the health care provider and the individual will affect the degree of self-determination that is expressed (Manning & Gaul, 1997).

The idea that the relationship of the health care provider cannot be separated from the autonomy of the individual is echoed in Bergeron’s (2006) work in the area of adult guardianship. Bergeron suggests that the context of the relationship between the health care provider and the older adult will affect the process that leads to the determination of the individual’s capacity: the questions that are asked, the information that is received, the choices that are weighed will shape the picture of the older adult’s decision making and functioning. Bergeron states, “It is unlikely that anyone, once they have entered into a relationship, can autonomously decide anything. Within any relationship, voluntarily or involuntarily, one ceases being totally autonomous and is influenced by the exchange” (p. 90).

### **Ethics of Dignity**

Elsewhere in the literature, other ways of conceiving the meaning of autonomy have emerged. Moody (1998) put forward an interesting argument that challenged current notions

about self-determination, which he refers to as an ethics of dignity. He points out that the contemporary emphasis on autonomy, honesty, and explicit (versus tacit) actions are not necessarily ethically sensitive. He argues instead that ethical care for the elderly needs to have room for courtesy and dignity. Compromises in truth telling that maintain the illusion of autonomy, such as not drawing attention to the fact that an individual does not remember what day it is, are protective of individual dignity (Moody, 1998). Furthermore, Moody (1998) expresses concern that respect for individual autonomy risks abandonment; he states that total non-interference can also equal indifference and is as undesirable as total intimacy. He contends that an ethics of dignity could reframe and balance the debate between autonomy and paternalism and believes the debate to be a reflection of the ongoing dialectic between intimacy and detachment that is fundamentally present in all human relationships.

### **Autonomy as a Continuum**

In the area of biomedical ethics, Beauchamp and Childress' work is a significant contribution to the development of a more comprehensive understanding of the concept of autonomy. Beauchamp and Childress (1989) contended that autonomy should be conceptualized, not as having a binary quality, but as a continuum (as cited in Kelly, 1994). They state:

Autonomous acts are actions when the actor acts with intentionality, understanding, and without controlling influences that determine the action. All three components of an autonomous act can occur on a continuum, therefore actions can be autonomous by degrees (as cited in Kelly, 1994, p.72).

Furthermore, they differentiated autonomous persons from acts; that is, autonomous persons can have temporary acts that are not autonomous due to illness, but individuals who are not autonomous due to impaired functioning might be able to make autonomous choices (as cited

in Kelly, 1994). Beauchamp and Childress also formulated guidelines to assess lack of competency; an individual determined to be incompetent must be unable to state a choice, understand information, appreciate their situation, and to demonstrate a reasoned decision (as cited in Kelly, 1994).

### **Autonomy and Dependency**

Consideration of how the concept of self-determination is modified by the context of dependency has also been discussed in the literature. Collopy et al. (1998) state that the meaning of autonomy is difficult to describe in isolation of the context in situations of dependency (as cited in Healy, 1998, p. 33). For example, by definition autonomy concerns itself with independence and must redefine itself when applied to individuals in a nursing home (Reinardy, 1999). Collopy et al. (1991) suggest that autonomy can coexist with dependency by framing the meaning of the idea as living within a setting consistent with one's identity (as cited in Reinardy, 1999). Control over decision making is key to the definition of autonomy and enhancing the capacity of older adults to make decisions constitutes support for autonomy (Galambos, 1997; Healy, 1999, p. 29).

### **Capacity and Vulnerability**

Discussion in the elder abuse field in the 1980s and early 90s included the concept of vulnerability (BC Adult Abuse/Neglect Prevention Collaborative, 2009). Vulnerability was a term that encapsulated the many other factors, other than a person's age, that would indicate an adult's need for support and assistance (BC Adult Abuse/Neglect Prevention Collaborative, 2009). The concept of vulnerability was intended to avoid paternalistic and erroneous assumptions about increased age equalling increased dependency (BC Adult Abuse/Neglect Prevention Collaborative, 2009). Although this construct has provoked

criticism because of its vagueness and the belief that it still limits autonomy, some have argued for its continuation and re-conceptualization (BC Adult Abuse/Neglect Prevention Collaborative, 2009). The BC Adult Abuse/Neglect Prevention Collaborative (2009) state that the concept of vulnerability is valuable for highlighting adults who are at risk of abuse and neglect which allows for the possibility of prevention instead of reaction. They suggest that vulnerability be understood as a social condition that is subject to change and not reducible to an individual's inherent disability or medical condition. Furthermore, building on the understanding of capability on a continuum, they propose a matrix model of risk assessment that links the constructs of capacity and vulnerability. The capacity axis is a measure of the individual's capacity to make decisions. The vulnerability axis is an indicator of the "many socially constructed challenges that adults may face" (BC Adult Abuse/Neglect Prevention Collaborative, 2009, p. 20). Examples of these challenges include: isolation, lack of a support network, low income, language barriers, mental health diagnosis, addiction, homelessness, and culture of origin. This matrix model is meant to be a broad tool that can be used to provide an overall picture of an individual's circumstances and is proposed as being useful for portraying the complex correlation between the two constructs (BC Adult Abuse/Neglect Prevention Collaborative, 2009). While there is a strong link between incapability and vulnerability, it is also true that a highly incapable adult in a certain environment may not be very vulnerable (BC Adult Abuse/Neglect Prevention Collaborative, 2009). Conversely, a very capable adult may be extremely vulnerable depending on the social circumstances (BC Adult Abuse/Neglect Prevention Collaborative, 2009).

### **Capacity and Complexity**

To summarize the discussion thus far, autonomy is a quality exhibited by an

individual that refers to their ability to take independent action to meet their needs.

However, autonomy is a multidimensional construct that can be shaped by the social context of a relationship, can be viewed as existing along a continuum from very capable to very incapable and many shades of grey in between, but also can be understood as an action isolated from typical functioning of an individual depending on the circumstances. The implication of conceptualizing autonomy in this non-binary and multifaceted way is that the complexity of assessing individual incapacity is considerably increased. When a multidimensional lens is used to assess incapacity, the more likelihood there is that an individual's capacity will be viewed as neither absent nor present, but marginal. Questions of paternalism are most difficult when competency is marginal (Kelly, 1994). When there is no question that an individual is incompetent, the ethical issues are straightforward; when the question of competence is uncertain, the moral certainty of the right action becomes less clear (Kelly, 1994).

### **Assessing Incapacity**

The task of the social worker engaged in collecting the puzzle pieces to construct an overall picture of the older adult in a setting, that may or may not be abusive, is not for the faint of heart. The social worker must enter a home, interview an adult, collect information (that may be contested either by the adult or the alleged abuser), offer support and assistance (if it is determined to be needed), and formulate an impression of the adult's capacity to choose. If the reception is hostile, the worker may not have more than one opportunity to establish a working relationship to gain enough understanding of the situation to make a knowledgeable decision about whether the adult is capable of choosing to live at risk. The assessor must consider the adult's ability to "receive, assimilate, and integrate the relevant

information” and understand the risks and benefits of a decision (BC Adult Abuse/Neglect Prevention Collaborative, 2009, p. 10). Furthermore, the incapability assessment process is not “culturally neutral” (BC Adult Abuse/Neglect Prevention Collaborative, 2009, p. 92). For adults who come from a different culture from that of the assessor, the quality of the assessment depends on the understanding of the information that is exchanged (BC Adult Abuse/Neglect Prevention Collaborative, 2009). The accuracy of understanding is contingent not just on any interpretation services that are used, but also on the very meaning of abuse and neglect that does not necessarily translate across cultures in the same way (BC Adult Abuse/Neglect Prevention Collaborative, 2009).

Bergeron (2006) has written extensively about the complexity and perils of this incapability assessment decision making process. A major risk of this practice is to accept an individual’s refusal of services without examination of the reasons and emotional features that may lie beneath the surface. Bergeron states, “Honoring client choice may not necessarily mean honoring the overt refusal for intervention” (p. 99). She goes on to argue that the capacity to make choices is comprised of many elements that include individual factors such as a person’s cognitive ability, health conditions, locus of control, cultural belief systems and contextual factors such as the relationship with the helper. For example, refusal of intervention may mask learned helplessness, health issues, depression, or hopelessness (Bergeron, 2006). Or an older adult may have an external locus of control, and it is not realistic or reasonable to expect them to suddenly actualize self-determination (Bergeron, 2006). Assessing an individual’s capacity to make decisions requires comprehensive knowledge and critical thinking (Bergeron, 2006). It begins with building a relationship, because the approach that is used has the potential to affect the client’s decision making

(Bergeron, 2006). The assessment of the client's decision making needs to go beyond what the client states in an initial interview to comprehensive knowledge about the client's history and competency (Bergeron, 2006). Superficial assessment of an individual's incapacity may result in inaccurate determinations that may lead to abandonment of the client (Beaulieu & Leclerc, 2006; Bergeron, 2006). Furthermore, if the client's capacity to engage with the social worker is impaired, this may also influence the process, risking premature disengagement (Bergeron, 2006).

O'Connor, Hall, and Donnelly (2009) state that the literature on assessing decisional capacity has paid scant attention to the influence of the context of abuse and neglect. Using the lens of critical feminist theory, they contend that assessments of capacity are limited if they focus on intellectual functioning and do not consider issues of power and gender. They argue that the usual rules cannot be applied, such as involving family and friends to reduce the adult's anxiety when abuse and neglect are factors. They point out that safety issues such as how to ensure a safe environment for the adult before and after the assessment must be considered. Similarly to Bergeron (2006), they make a case for the influence of disempowerment on an individual. For example, is the adult not demonstrating the ability to make a decision, because they are refusing to make a decision, because they are not experienced in making decisions, or because they have a long held belief that making a decision will not change their circumstances? The idea that a woman's sense of self and well-being may stem from their relational connections and not a sense of independence must also be understood in the overall analysis of the decisions and consequences (O'Connor, Hall, & Donnelly, 2009). Furthermore, these authors propose that the legal concept of *unconscionability*, where a court can overrule a transaction, if it is believed that a person

would have been unable to make a decision due to *undue influence*, may be a useful framework for examining this subject. They suggest that a framework of “equitable analysis” (p. 166) would shift the focus of an assessment from the person to the situation and perhaps allow for the possibility that an assessment of decisional capacity could include the context of an individual’s relationships.

### **Self-determination Presumes the Existence of Choices**

The broader environmental context also shapes the potential for an individual to act with autonomy. For example, Bergeron (2006) suggests that the culture of a helping agency will influence how a social worker interprets refusal of support and assistance. Furthermore, the extent of agency services will affect the practical choices that are available to the adult. The capacity to express self-determination rests on a presumption that choices are available in one’s environment. Older adults need a range of choices that reflect their community and culture; often the only available choice is a nursing home (Bergeron, 2006). Wolf and Pillemer (1989) note that many older adults prefer abuse and neglect to the choice of the nursing home (as cited in Bergeron, 2006). Lack of funds may necessitate a choice between two unsatisfactory options for an older adult who requires care when the home environment is no longer appropriate (Cummings & Cockerham, 1997). When choices are limited or appear equally aversive, it is difficult to construe the choice to remain in an abusive situation as a free and conscious one. Furthermore, the guiding principle of least intrusiveness implies the existence of a continuum of choices. The lack of this continuum of resources has been observed (Bergeron, 2006; Thompson & Priest, 2005); Mathews (1988) pointed out that when options are unavailable, the hopeful intention implicit in the idea of least restrictive measures is defeated (as cited in Macolini, 1995). Harbison and Morrow (1998) argue that a



requirement of addressing abuse and neglect is for older adults to experience a true autonomy, that is authentic choice and control instead of the limited choices offered by home and community care programs which reinforce the powerlessness of aging individuals.

### **Helping or Harming**

The idea that intervening in an elder abuse situation might result in the need for an older adult to be placed in a nursing home brings up the idea that action intended to help may produce consequences that older adults experience as harm. In fact, the very act of investigating suspicions of abuse can produce harmful consequences. An initial visit intended to seek substantiation of reported facts may result in a damaged relationship with the caregiver that prevents the agency from delivering necessary health services to the older adult. This last idea leads to the need to recognize that the informal care provided by friends and family are an essential source of labour in our elder care system and must be recognized in care planning (Healy, 1999). The potential for conflict is great when the needs of the older adult and the caregiver are competing; mediation techniques are suggested as helpful, but the answers are not always clear (Cummings & Cockerham, 1997; Healy, 1999). The reality that the caregiver might need to be regarded as part of the equation also leads to the fact that planning support and assistance for an adult in abusive circumstances needs to take into consideration, not only the needs of the abused adult, but also the needs of the perpetrator (Beaulieu & Leclerc, 2006; Thompson & Priest, 2005).

### **Negotiated Consent and Accompaniment**

In acknowledgement of the complexity and multidimensional nature of autonomy, intervention approaches have been put forward in the literature that extend beyond the binary choices of taking over or walking away. Bergeron (2006) has expressed her support for the

concept of *negotiated consent* as proposed by Moody (1998) where degrees of assistance are offered that provide relief to the victim or assistance to the perpetrator that reduce the harm of the abuse and neglect (as cited in Bergeron, 2006). She states, “The challenge, of course, is to find and create those alternatives that reflect a range from a minimal safety net to the maximum net for the victim” (p. 99).

This concept of negotiated consent is similar to the practice continuum model proposed by Beaulieu and Leclerc (2006). These authors propose that intervention in elder abuse situations can range from negative autonomy to accompaniment to extreme measures. Negative autonomy is described as what happens when the client refuses services and the practitioner withdraws from the case. Extreme measures are when the professional is forced by the risk of the circumstances to take actions without the consent of the individual or the collaboration of the perpetrator. Accompaniment, the middle ground between the two extremes, is thought to be the ideal balancing point. This is the place where there is time for the practitioner to build relationship and seek negotiated solutions. The degree of intrusiveness along the practice continuum that is used depends on the variables of autonomy of the victim, the level of risk, and the collaboration between the parties; changes in any one of these variables may occur slowly or suddenly and will influence the intervention process (Beaulieu & Leclerc, 2006).

### **Attitudes of Social Workers**

A small number of studies have set out to examine social workers’ actual attitudes towards autonomy and applications of autonomy in practice (Healy, 1998; Healy, 1999; Reinardy, 1999; Rothman et al., 1996). Rothman et al.’s (1996) study of self reports of social work practice concluded that social workers used a range of directiveness in their

practice and were willing to be directive “in the face of overriding consequence factors involving risk” (p. 403). Findings from Reinardy’s (1999) study with social workers in nursing homes described the actions of social workers that supported the autonomy of the residents; their practice included measures such as advocacy for residents’ choices, assisting individuals to consider their choices, and supporting consistency in the individual’s goals and values. Healy (1998) found in her research with social workers that cognitive deficits, safety risks, and high caregiver burden were associated with lower levels of support for autonomy. The research that demonstrates that social workers do support directive intervention and act accordingly, “seems to be a well-kept secret of social work practice,” which is contradictory to the emphasis on self-determination and makes the lack of practice guidance in this area problematic (Rothman et al., 1996, p. 404).

### **Lack of Guidance**

Overall, the literature lacks substantial material to assist or provide direction to social workers when confronted with ethical dilemmas (Cummings & Cockerham, 1997). The principle of self-determination is emphasized as essential to the profession without guidelines for when directive intervention is appropriate (Rothman et al., 1996). Hasenfeld notes that social work technique tends to neglect involuntary interactions, as it assumes the right to self-determination will always be respected (as cited in Bergeron, 2006). Determining capacity is an important component of knowing when autonomy must be respected, but some authors feel that guidelines for assessing competency are unclear (Bergeron, 2006; Cummings & Cockerham, 1997; Kelly, 1994). Standards are further complicated by the idea that the fluctuating nature of dementia results in the need to apply the ethical principles differently over time (Cummings & Cockerham, 1997). O’Connor, Hall, and Donnelly (2009) agree

that standards need to be clarified, but feel that currently health professionals are focusing their assessment on the risks in the situation and not on the individual's capacity to choose and that it is probable that interpretations of any standards will continue to be diverse.

### **Practice Wisdom**

Assertive mental health practice holds parallels to adult protection practice.

Assertive mental health outreach work was developed in an effort to reach clients that are difficult to engage with office based service models. This type of practice can be viewed as similar to elder abuse practice, because the professionals are required to reach out and engage with individuals who have difficulties with insight and judgment regarding the need for those services. One study of an assertive mental health team articulated the style and technique of their type of practice (Rowe, Frey, Bailey, Fisk, & Davidson, 2001), which may offer insights to practitioners in elder abuse. Their approach included: team discussion of options and associated potential risks, developing comfort with the choice not to intervene and to increase monitoring instead, and also the choice not to intervene if the risk could be addressed. Rowe et al. (2001) believe that this type of practice requires the clinician to accept a certain amount of ambiguity and risk. They state, "This entails living on the cusp of a dilemma, erring at the last moment on the side of clients' safety from harm and death but pushing the envelope of clinical comfort in acknowledgment of their autonomy and proven ability to survive on the street" (p. 406).

Helpful offerings of attained wisdom for this practice found in the literature are more in the nature of abstract approaches than practical techniques and have included calls for moderation and integration and avoidance of polarizing the extremes. For example, Healy (1998) argues that framing the duty to protect in opposition to self-determination will not aid

in a resolution to an ethical dilemma. She contends that concerns about risk are relative and that one needs to balance degrees of support for both principles, instead of treating it as an either/or process. Similarly, Kelly (1994) contends that there is a middle ground in the debate about paternalism and that practitioners should avoid the extremes. Kelly also stated that if consistent guidelines regarding assessing capacity such as Beauchamp and Childress are practiced, then not only are directive interventions morally appropriate, they are obligatory. Loewenberg et al. (as cited in Taylor & Bentley, 2005) suggested that rank ordering ethical principles (deciding what was most important) may assist practitioners to resolve ethical dilemmas.

Other aspects of practice wisdom mentioned that relate to coping strengths for the professional were: accepting complexity, willingness to sit with dilemmas, and recognizing good enough practice (Taylor & Bentley, 2005). Furthermore, in their research on how self-determination might contribute to professional dissonance in mental health settings, Taylor and Bentley (2005) suggest that reframing existential anxiety and burn-out to the more positive state of potential for change is more helpful for practitioners. They state, “This spirit of ‘becoming’ can enliven the concept of professional dissonance in a way that moves it from a pathological problem needing a cure to a practice process that signals avenues of change” (p. 479).

### **A Proposed Model**

Cummings and Cockerham (1997) proposed a 5 step clinical model to assist social workers with adult protection scenarios. Step 1 is the identification of the basic facts relevant to the situation such as degree of impairment and functional ability of the individual and their relationship with the caregiver. Step 2 is identifying the abilities and roles of each of the

decision makers in the situation. Step 3 is the stage where the different courses of action are examined, and the costs and benefits of each course of action considered. Step 4 consists of making the value system of each party explicit to contribute to developing understanding. Step 5 is the final stage where the decision is made, and the consequences are monitored. It is interesting to note that despite their suggestion of this methodical model, these authors also comment that in the final analysis social workers should realize that ideal solutions might not exist and that resolution may not be possible. However, this model was still thought to be useful for enhancing social worker confidence and reducing stress.

### **Education and Skill Development**

Many sources emphasized the importance of better preparation and education for practitioners working in situations that involve these ethical dilemmas (Bergeron, 2006; Cummings & Cockerham, 1997; Healy, 1998; Rowe et al., 2001). Professionals need an understanding of the available legal remedies and are required to use critical thinking to understand the range of factors that obstruct choice (Bergeron, 2006). Improving skill in evaluating capacity to make decisions would increase competency (Healy, 1998). Furthermore, Healy (1998) also suggests that improved training will aid in consistency of clinical judgment, which in turn will increase practitioner confidence. Practitioners in this line of work need opportunities to discuss their ethical dilemmas with colleagues (Bergeron, 2006; Healy, 1998). Findings have suggested that peer support and quality supervision are valuable for supporting practitioners (Taylor & Bentley, 2005).

### **A Role for Social Work**

The area of adult guardianship practice should be considered important territory for the profession of social work to prove its value in the health care setting. “Social workers

who develop skill in identifying and articulating the complex ethical dimensions of practice on interdisciplinary teams will demonstrate the competence needed to provide their agencies with leadership in the development of policies and procedures concerning these dynamics” (Healy, 1998, p. 35).

### **Legislation in British Columbia**

Each province in Canada has developed its own legal framework for addressing abuse and neglect; each set of laws reflect an underlying belief about the importance of focusing either on protection or autonomy (BC Adult Abuse/Neglect Collaborative, 2009). The categories of legislation that have been identified are: comprehensive adult protection regimes, deliberately limited regimes, protectionist regimes, and patchwork regimes (BC Adult Abuse/Neglect Collaborative, 2009). The BC legislation is considered a newer example of a comprehensive regime, because it is a specific piece of legislation that identifies a particular class of adults who are protected from abuse and neglect that has been defined in the law (BC Adult Abuse/Neglect Collaborative, 2009). The newer comprehensive regimes are characterized by their wide scope and reflect a least restrictive and rights-based approach (BC Adult Abuse/Neglect Collaborative, 2009)

The *Adult Guardianship Legislation* is a package of interrelated legislation enacted in British Columbia in 2000 that included the *Representation Agreement Act*, the *Health Care and Consent Act*, and the *Adult Guardianship Act* (Gordon, 2001). The new legislation was the culmination of many years of effort on the part of individuals in the community and within the government to reform adult guardianship law (Boyce et al., 2001; Gordon, 2001). A reading of the history that led to this achievement unravels the many interests and influences that converged to create new law. In the 1980s, changes in thinking about the

meaning of disability and the Canadian Charter of Rights and Freedoms led many to realize that there was a need for changes in existing laws (Boyce et al., 2001). The *Patients Property Act*, written at a much earlier time, did not reflect the reality that more and more individuals with disabilities were living in the community and not in institutions (Boyce et al., 2001). In 1989, the leadership of the British Columbia Association for Community Living, an organization for individuals with intellectual disabilities, recognized an opportunity to spearhead a movement for law reform that would consider the views of individuals with disabilities; they were instrumental in forming the Project to Review Adult Guardianship, a loosely structured coalition of individuals who worked together to develop a consensus on key principles and a framework document for change (Boyce et al., 2001). Despite the recognition that change would not occur without a broad based coalition of interests and the efforts that were made to include everyone in the community of concern, it was noted that gaps existed in this coalition (Boyce et al., 2001). Interest groups for older adults were not actively involved in the reform process prior to implementation of the law, and the relevant groups advocating for individuals with mental illness failed to ever reach consensus (Boyce et al., 2001). The Project to Review Adult Guardianship group joined with an inter-ministerial committee for guardianship reform to form the Joint Working Committee which eventually produced a discussion paper in 1992 entitled, *How Can We Help?: A New Look at Self-determination, Interdependence, Substitute Decision Making and Guardianship in British Columbia* (Boyce et al., 2001). The work and the recommendations from this Joint Working Committee led to the law that was eventually drafted and passed in 1993 (Gordon, 2001). Disagreements and tensions that existed throughout this process appeared to escalate in the implementation phase of the legislation, and significant shifts in the key players in the



movement occurred. A Coalition to Implement Adult Guardianship Legislation formed in 1994 which:

...went beyond making claims for individual human rights and sought powers of policy implementation driven by consumers. It took the discussion out to non-institutional groups in the community and fed information back into power structures, either bypassing structures that were not helpful or forcing them to recognize the pressures for change (Boyce et al., 2001, p. 123).

The goal of the Coalition was “to develop ‘circles of friends,’ to provide support to those in need, and to exclude or at least limit, the extent to which bureaucrats and professionals would be able to intervene in family and community affairs” (Boyce et al., 2001, p. 123).

The Adult Guardianship Act, finally proclaimed in 2000, was intended to address the specific issue of vulnerable adults who are experiencing abuse, neglect, and self neglect. Part 1 of the Adult Guardianship Act sets out the definitions of abuse, neglect, and self neglect. Abuse was defined as “the deliberate mistreatment of an adult that causes the adult physical, mental, or emotional harm or damage to or loss of assets” (Gordon, 2001, p. 171). Neglect was defined as “any failure to provide necessary care, assistance, guidance or attention to an adult that causes...serious physical, mental, or emotional harm, or substantial damage to or loss of assets” (Gordon, 2001, p. 172). Self neglect meant “any failure of an adult to take care of himself or herself that causes or is reasonably likely to cause...serious physical or mental harm or substantial damage to or loss of assets (Gordon, 2001, p. 172). The law applies to all adults, anyone aged 19 years and over (Gordon, 2001).

Embedded in the legislation were guiding principles that were intended to assist with interpretation of the legislation. The *Act* states that adults are *entitled to live as they wish* as long as others are not harmed, and they are capable of making decisions (Gordon, 2001). The guiding principles also affirm that adults should receive the *most effective, least*

*restrictive* form of assistance (Gordon, 2001). Adults are to be *presumed capable*, and ways of communicating are not grounds for determining incapacity (Gordon, 2001).

Part 3 of the legislation provided the legal framework for the provision of support and assistance for adults experiencing abuse and neglect “who are unable to seek support and assistance because of physical restraint, a physical handicap that limits their ability to seek help, or an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect” (Gordon, 2001, p. 217). In this legislation, there is no legal duty to report a case; however, there is a duty to look into a report. Specifically, a designated agency that receives a report of an adult experiencing abuse, neglect, or self neglect and is unable to seek help must look into the report (Gordon, 2001). Community Living BC, the agency in British Columbia that provides services to individuals with IQs 70 and under, was designated as an agency for the adults eligible for those services; Health Authorities were designated to receive reports for all other vulnerable adults (Gordon, 2001). Designated agencies have the power to investigate and the right to ask for information when looking into reports of abuse, neglect, and self neglect (Gordon, 2001). The function of right to information overrides confidentiality privileges, as the Act states that agencies in control of information must disclose that information to a designated agency when requested (Gordon, 2001). The legislation states that designated agencies are required to report criminal offences to the police, if they become aware of a reportable offence in the course of their investigation (Gordon, 2001). Designated agencies have the potential to use broad emergency powers under the legislation to protect an adult from serious physical or mental harm (Gordon, 2001). Emergency measures include actions such as the right to enter a premise without a warrant, use of reasonable force, conveying the adult to a safe place, and

providing emergency health care (Gordon, 2001). After looking into a report, a designated agency may do one or more of several things that include: determining that no further action is needed, assisting an adult to receive support and assistance from a combination of health, legal, or social services, informing the Public Guardian and Trustee, or investigating further (Gordon, 2001). After further investigation a designated agency may also decide to take actions similar to the above list, or additionally may decide to prepare a support and assistance plan, or apply for a restraining order on behalf of the adult (Gordon, 2001). The agency must explain the support and assistance plan to the adult who may agree to or refuse the support and assistance that is offered (Gordon, 2001). If it is determined that the adult is incapable of refusing the support and assistance, the designated agency may apply to the court for a support and assistance order to enforce the plan (Gordon, 2001). Grounds for determining incapability are to be based on determining whether the adult understands the support and assistance services, why the services are being offered, and the consequences of refusing the services (Gordon, 2001)

### **Other Legislation Relevant for Adult Guardianship Practice**

In order to understand adult protection practice in this province, it is necessary to know that despite the advent of the adult guardianship legislation, for reasons which are many and varied, the current context involves and requires the use of several other laws. In other words, while the adult guardianship legislation may require staff of designated agency to respond to vulnerable adults, the support and assistance that is offered may or may not entail one or more other pieces of legislation. These laws reflect a transitional composite of historical and outdated thinking about disability and modern guardianship reform.

### **Patients Property Act and Bill 29.**

The Patients Property Act (Patients Property Act, R.S.B.C. 1996, c.349) still in effect, governs the appointment of decision makers for financial and personal affairs and reflects the thinking of an earlier time when incapacity was considered in global, binary terms. Under this law, the court appoints another person to become either a Committee of Estate, or a Committee of Person, or both to make decisions for an incapable adult. A Committee of Estate makes decisions for an individual about their financial affairs; a Committee of Person makes personal decisions for an adult. By what is referred to as the statutory or certificate method, a Director of Mental Health (or their designate) signs a Certificate of Incapability in order for the Public Guardian and Trustee to take on a Committee of Estate for an incapable adult who has no family or friends to act for them. The appointment of decision makers for financial and personal affairs works hand-in-hand with adult protection practice, as appointing decision makers for adults who are incapable are potential solutions for adults who are abused, neglected, and self neglecting.

The Patients Property Act was to end with the advent of the Adult Guardianship Act; however, this could not occur when Part 2 of the Adult Guardianship Act was not proclaimed in 2000. In November 2007, when Bill 29 received royal assent it was thought that a comprehensive legal framework for modern guardianship would finally be created (BC Adult Abuse/Neglect Prevention Collaborative, 2009). Bill 29, the Adult Guardianship and Planning Statutes Amendment Act, was meant to amend the Adult Guardianship Act and repeal the Patients Property Act (BC Adult Abuse/Neglect Prevention Collaborative, 2009). The provisions set out in Bill 29 reflect a more nuanced conceptualization of capacity and specify a process that reflects the principles and higher standards associated with

guardianship reform (BC Adult Abuse/Neglect Prevention Collaborative, 2009). However, to date, this legislation has not been proclaimed.

### **Personal planning tools.**

Bill 29 promoted personal planning tools such as Powers of Attorney and Representation Agreements as potential solutions to address the issue of abuse, neglect, and self neglect (BC Adult Abuse/Neglect Prevention Collaborative, 2009). Personal planning tools allow an adult to plan for a time of future incapability. A *Power of Attorney* is a legal agreement where a capable adult confers their authority to make financial decisions to another adult (Power of Attorney Act, R.S.B.C. 1996, c.370). A *Representation Agreement* allows a capable adult to assign personal, health, and financial decisions to another adult of their choice (Representation Agreement Act, R.S.B.C. 1996, c.405). The changes in Bill 29 were intended to promote Representation Agreements as a tool for health care and personal decisions and focus on Powers of Attorney as being the central instrument for financial decision-making (BC Adult Abuse/Neglect Prevention Collaborative, 2009). A thorough discussion of these planning tools, which is an intricate and complex subject in itself, is beyond the scope of this thesis, but is mentioned here to aid in understanding the range of tools that are available for a social worker to consider when developing a support and assistance plan. Ironically, these personal planning tools that can protect vulnerable older adults from abuse also represent an opportunity for abuse when they are in the wrong hands (BC Adult Abuse/Neglect Prevention Collaborative, 2009).

### **Health Care Consent.**

In the course of developing a support and assistance plan, the need for health care treatment may arise, to which the older adult must consent. When an adult is considered

incapable of making informed consent, this circumstance falls under the purview of the *Health Care (Consent) Act and Care Facility (Admission) Act* (Health Care (Consent) Act and Care Facility (Admission) Act, R.S.B.C. 1996, c.181). If a health care provider deems that an adult is incapable of making a health care decision, and there is no appointed Committee of Person or a Representative, then a *temporary substitute decision maker* can be appointed from a hierarchal list of family members that is set out in the law. The temporary substitute decision maker must be over 19, willing and able to make the decision, and not known to be in dispute with the adult. The authority for the temporary substitute decision maker is specific to that particular health care decision or course of treatment. This law reflects the idea that incapacity is not necessarily global; an adult may be capable of making simple types of health care decisions, but not ones with more complexity. This law was not fully proclaimed; currently, a decision to consent to care in a facility is not covered by this act.

### **Mental Health Act.**

Adults with mental illness sometimes require mental health treatment, but do not have the insight to understand they are ill and in need of treatment. Adults who require treatment and care for their own protection or the protection of others can be involuntarily admitted to a hospital under the auspices of the *Mental Health Act*, if it has a unit that has been designated as a mental health facility by the Minister of Health (British Columbia Ministry of Health, 2005). The aim of the Mental Health Act is to set out a legal process to ensure that the authority to involuntarily admit adults with mental disorders is carried out appropriately (British Columbia Ministry of Health, 2005). The law contains safeguards intended to ensure

individual rights are protected such as notification of rights and access to review panels (British Columbia Ministry of Health, 2005).

Some overlap exists between the Adult Guardianship Act and the Mental Health Act in that both laws may be applicable to an adult who is self neglecting and unable to make decisions due to a mental illness such as schizophrenia or dementia. The Mental Health Act has extended leave provisions which allow for the discharge of an involuntary patient to the community under conditions set out by a physician to which the adult must comply (British Columbia Ministry of Health, 2005). Currently, it is not uncommon for the Mental Health Act to be used by health care providers when an incapable older adult who is living at intolerable risk is refusing admission to facility care. The older adult is certified under the Mental Health Act, admitted to hospital, and discharged on an extended leave under the condition that the adult will reside in the facility. The many reasons for this use of the Mental Health Act are somewhat beyond the scope of this discussion; however, a basic explanation was necessary as this particular aspect of practice is mentioned in the results.

In summary, this literature review has described the definitional challenges and the varied theoretical causes for elder abuse, neglect, and self neglect. Interventions put forward to address the problem have included legislation, adaptations of domestic violence programs, advocacy programs, community networks, and multidisciplinary teams. The construct of autonomy, fundamental to the profession of social work, was examined according to historical, cultural, and relational perspectives. As autonomy is conceptualized as existing along a continuum and shaped by the social environment, the task of assessing incapacity in the context of abuse, neglect, and self neglect requires comprehensive knowledge and appreciation for the many elements that underlie choice. Superficial assessments risk

determinations that result in abandonment. Furthermore, the capacity to realize autonomy depends on the existence of choices which the literature points out is often limited.

Negotiated consent and the practice continuum model are two ideas that have emerged in practice and research that reflect a continuum of response that correspond to the continuum of capacity. The current legislation in British Columbia relevant to adult guardianship practice represents a mixture of old and new beliefs about individuals with disabilities.

Research suggests that social workers are willing to be directive in circumstances where there is risk, but guidance to assist social workers to resolve ethical dilemmas is lacking.

Acceptance of ambiguity and complexity, willingness to take time with the issue, and recognition of good enough practice are practitioner coping strengths that were identified.

Finally, the need for better prepared and educated practitioners in this field was recognized by many authors.



## Chapter Three

### **Methodology and Methods**

#### **The Research Question**

The purpose of this qualitative research is to describe the decision making process of social workers in British Columbia who look into reports of older adults in situations of abuse, neglect, or self neglect as they make decisions about interventions which have varying levels of intrusiveness. Particular sub questions will examine the following: How do social workers support the principle of self-determination? How do social workers demonstrate an ethic of care? How do social workers decide the degree of intrusiveness of the interventions that are used? What ways do social workers find to create compromises and balance the two extremes? What are the barriers that stand in the way of balance?

#### **Methodology**

A methodology is a set of beliefs about the meaning of the research methods that are used by researchers when seeking answers to research questions in order to contribute to building knowledge (Kirby, Greaves, & Reid, 2006). Different than methodology, the specific research data collection techniques and analytic procedures are the tools or methods that are used across the range of research paradigms (Kirby, Greaves, & Reid, 2006). Attached to the methodologies of the various research paradigms are implicit and explicit assumptions that shape the construction of knowledge (Kirby, Greaves, & Reid, 2006). It is therefore appropriate for me as a researcher to consider and articulate the values and assumptions that guided my choice of methods that were used in this thesis research journey.

#### **Borrowing and Bricolage**

In the field of research inquiry a number of disagreements and controversies have

emerged in the literature over the meaning of differing assumptions associated with traditional paradigms. Postmodern perspectives have declared truth to be socially constructed and relative to context, thus making the truth claims of absolute generalizations vulnerable to criticism (Patton, 2002). The idea that the social world is too complex to reduce to a single verifiable reality has taken root and flourished and points to the impossibility of having a “single ‘conventional’ paradigm to which all social scientists might ascribe” (Lincoln & Guba, 2000, p. 185). Furthermore, the once distinct borders of differing paradigms and methodologies have become permeable, allowing a fluidity of ideas. The literature supports the “borrowing or bricolage” of ideas and concepts across paradigms where the fusion seems to make sense or is seen to be useful (Lincoln & Guba, 2000, p. 167). According to Lincoln and Guba (2000), “Inquiry methodology can no longer be treated as a set of universally applicable rules or abstractions” (p. 164).

### **Qualitative Tradition Values Lived Experience**

In qualitative traditions such as phenomenology or constructivism, it has been argued that the preferred approach for human science, versus natural science, is to describe and deeply understand the meaning of the social world rather than to explain causation of social phenomenon (Van Manen, 1997). The social world makes itself known, not through verifiable observable fact, but through lived experience. Lived experience is interpreted and understood, retroactively, mediated by the language and meanings through which individuals understand their social reality (Van Manen, 1997). As researchers, it then becomes our job to engage in a mutual and collaborative process that seeks to understand the subjective experience of all research participants equally (Kirby, Greaves, & Reid, 2006). The sense-making story that individuals write from the raw materials of their lives represents glimpses

into the architecture of larger meaning that structures the social world.

### **Objectivity and Subjectivity are Important**

Whether or not the bones of an objective reality exist outside the meanings that individuals construct to interpret the world is still a matter of some debate. For example, the degree to which social factors are understood to shape interpretation of knowledge can range from weak to strong (Schwandt, 2000). Code (1991) has rejected the arguments that objectivity or subjectivity can claim more truth, reasoning that it represents a misleading dichotomy (as cited in Kirby, Greaves, & Reid, 2006). Code contends that knowledge includes elements of both objectivity and subjectivity and that while she agrees that all knowledge cannot be considered an object, separate and distinct from the knower, there still remain objective elements that can be discovered (as cited in Kirby, Greaves, & Reid, 2006).

### **Re-interpreting Validity**

Given that the conventional academic standards used to evaluate the credibility and value of a research project have been based on assumptions dissonant with the qualitative paradigm, many in the literature have called for a re-interpretation of the customary criteria (Lincoln & Guba, 2000). For example, Schwandt (1996) calls for social inquiry that supplements the exploration of social problems, enhances the ability to engage in moral critique, and enables “the capacity for practical wisdom” (as cited in Lincoln & Guba, 2000, p. 179). Additional characteristics of commendable qualitative research discussed in the literature include: authenticity, fairness, rigour, capacity to promote social action, substantive contribution, aesthetic merit, reflexivity, impact, and apparent expression of a reality (Creswell, 1998; Lincoln & Guba, 2000; Richardson, 2000). Furthermore, Richardson (2000) has proposed the metaphor of the crystal to capture a deeper, more complex view of

validity. Instead of the two dimensional metaphor of the three pointed triangle, she suggests the image of the three dimensional crystal. Crystals are intricate structures where the light of knowing can be reflected and refracted in a multiplicity of ways, which embodies the idea of multiple forms of truth (Richardson, 2000).

### **Feminist Research: A Critical Paradigm**

Kirby, Greaves, and Reid (2006) describe three broad research paradigms: instrumental, interactive, and critical. Critical paradigms examine the role of power relations and the ways that the social structure has contributed to marginalizing oppressed members of a society (Kirby, Greaves, & Reid, 2006). “Theory is used to attempt to explain underlying structures that influence phenomena” (Kirby, Greaves, & Reid, 2006, p. 14). A feminist orientation has been described as a critical theory that challenges dominant constructions of gender (Kirby, Greaves, & Reid, 2006). For example, Minnich said, that while most have been excluded from knowledge making, the dominant few have “created root definitions of what it means to be human that, with the concepts and theories that flowed from and reinforced those definitions” (as cited in Patton, 2002, p. 130). A strength of feminist research that has been recognized is its use of multiple theoretical lenses; as an anti-oppressive theory, feminism is not viewed as being alternative, but as engaging in a reciprocal conversation with other social theories (Moosa-Mitha, 2005). Another key feature of feminist research is the implication that the knowledge will be used for action, to work toward creating change in people’s lives (Kirby, Greaves, & Reid, 2006).

### **Ontological and Epistemological Assumptions of the Study**

The ontological and epistemological assumptions of the feminist orientation have the best alignment with both the personal standpoint of the researcher and the theoretical

framework of this thesis. Gilligan has been described as a relational feminist that belonged to the group of feminists that preferred to emphasize and celebrate women's differences, rather than arguing against differences between men and women (Moosa-Mitha, 2005). Ontology refers to the assumptions or beliefs about the nature of what can exist and be known (Kirby, Greaves, & Reid, 2006). Epistemology relates to theories about how knowers obtain knowledge of what can be known (Kirby, Greaves, & Reid, 2006). A central epistemological assumption in feminist approaches to theory is that knowledge is subjective and grounded in lived experience (Moosa-Mitha, 2005). Furthermore, embedded in the assumptions of this study will be what Mauthner and Doucet (2003) refer to as a relational ontology. In a relational ontology a view of self is exchanged for that of a relational being. Individuals are seen as belonging to an interdependent and relational web (Mauthner & Doucet, 2003). This is resonant with ideas emerging from the new science of quantum physics and complexity theory where there is discussion that the universe is relational, not mechanistic (Bai & Banack, 2006). It is my contention that the assumption of a relational ontology is exceptionally consonant with the theoretical framework of the study, given that a relational concept of self is so fundamental to Gilligan's ethic of care theory, where individuals are seen to have connection, and the right to separateness is not assumed.

In sum, the methodology for this study has drawn ideas from a number of qualitative traditions and paradigms. The values, the very choice of the research questions, and the methods all assume the existence of multiple contextual realities and that access to and understanding subjective experience is a viable and valid route to constructing knowledge. Features of the study that are aligned with basic principles of a critical feminist paradigm include: the significance placed on lived experience, the concept of the relational self, the

importance of theory that challenges dominant ideologies, and the belief that the work of knowledge construction is a contribution to social change.

## **The Methods**

### **Thematic analysis.**

This thesis project uses the technique of thematic analysis, which is a flexible tool that can be used across a range of paradigms that allows for a detailed and complex portrayal of the data (Braun & Clark, 2006). Analysis of textual data typically collected in qualitative research includes a wide range of techniques that are used by researchers with differing epistemological positions to identify salient concepts in the data, uncover relationships among the concepts, and build theoretical models that link the concepts (Ryan & Bernard, 2000). Braun and Clark (2006) reason that thematic analysis is particularly appropriate for novice researchers and does not require a commitment to an entire package of theoretical assumptions associated with a paradigm. What is considered necessary though is for the researcher to clearly articulate the values and assumptions that underlie the work (Braun & Clark, 2006), which is what I have attempted to accomplish in this discussion.

The transcribed text will be treated in the sociological tradition where text is considered a window into human experience (Ryan & Bernard, 2000). The researcher will adopt the perspective suggested by Mauthner and Doucet (2003) that while subjective accounts cannot be assumed to be completely transparent, and it is not possible for subjects to be fully known, it is still possible in the research relationship to reflexively construct a representation of a subject's experience that has at least some relationship to their reality.

A number of criteria, guidelines, and principles have been suggested in the literature as enhancing the quality of a thematic analysis (Braun & Clark, 2006). Systematic attention

to data transcription, coding, and analysis; making the theoretical position of the researcher visible; congruency between the assumptions, method, and analysis; confidence that the data has not been severed from its context; consistency between data and analysis; defensibility of resulting concepts; and going beyond a level of description are some of the considerations that have been proposed (Braun & Clark, 2006; Kirby, Greaves, & Reid, 2006; Silverman, 2000).

### **Recruiting participants.**

A combined purposive and snowball sampling method was used to locate social workers currently or previously employed in British Columbia by Health Authorities and required as part of their job role to respond to reports of older adults in situations of abuse, neglect, or self neglect. The study sought out participants who had at least two years of experience looking into adult guardianship reports. Explanatory materials about the study and invitations to participate were sent to key informants and to the British Columbia Psychogeriatric Association for further dissemination. Respondents were asked to participate in a telephone interview that took from one to two hours to complete.

The reason for broadening the geographic area of the sample to the entire province was that the primary researcher is in a supervisory relationship with the majority of social workers who do this practice in the local area who would therefore be unsuitable for participation in the study. If the study had been confined to the northern region, this would have represented a serious limitation for the research. The choice to avoid accessing social workers through Health Authority organizations was related to the practical difficulty of obtaining ethics approval from 5 separate Health Authorities.

**Ethical considerations.**

This study complied with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Medical Research Council (MRC), the Natural Sciences and Engineering Research Council (NSERC), and the Social Sciences and Humanities Research Council (SSHRC), n.d.) and received approval from the UNBC Research Ethics Board. The principles of right to privacy, confidentiality, and free and informed consent were all respected. The project did not require any harmful procedures or involve deception. Participation in the project was voluntary, and the participants were informed they were free to withdraw at any time. Risks and benefits of participating in the study were explained to every participant. Written informed consent was obtained from the participants who were all competent to provide consent. Pseudonyms were used in the data collection and analysis; the actual names of the participants and their consent forms were stored separately from the interview data to ensure anonymity. Audio recordings, hard copy transcripts, and written notes were kept in a locked cabinet. Computer files were saved in password protected files.

**Data collection.**

Over a three-month period, semi-structured interviews were conducted over the phone with 10 participants. A guide (see Appendix 3), which had been piloted on one volunteer as well as the researcher, was used for the interviews. In order to prepare and enhance the respondents' reflection about their practice, a brief preamble (see Appendix 4) that provided a summary of academic background material intended to promote discussion, and a copy of the interview questions was sent to the respondents prior to the interview. The researcher documented observations about the interview in a journal. Interviews were



recorded with a digital recorder that was wired into the phone, which increased the quality of the recording. The primary researcher transcribed all the interviews but one; a paid assistant who signed a confidentiality agreement (see Appendix 5) transcribed the remaining one. After transcribing the interviews, every interview was re-played and crosschecked with each transcript. Participants were offered the opportunity to read and verify the transcript, but only two participants accepted.

### **The participants.**

Ten social workers volunteered to participate in this research study. There were 8 females and 2 males; 5 of the social workers had Bachelor of Social Work degrees, 5 social workers had Master of Social Work degrees. Their years of social work experience ranged from 4 to 28. Their years of experience working for a designated agency under the Act varied from 2 to 10. All 5 geographical health regions in the province were represented; two social workers were interviewed from each of the Northern Health, Interior Health, and Vancouver Island Health regions, three from the Vancouver Coastal health region, and one from the Fraser Health region. Four of the participants described themselves as working in a small town or rural area, four of the participants described working in a large urban area, and the remaining two said that they had worked in a mixed urban and small community environment. Education specific to adult guardianship received by all the social workers consisted of various workshops conducted by the Public Guardian and Trustee and the Health Authorities.

### **Analysis of the data.**

As only one researcher was involved in interviewing, transcribing (except for one interview which was later verified against the recording), and coding the data, the

consistency and quality of the data analysis was enhanced. The data was coded manually, which is still preferable to computer-assisted analysis for some qualitative researchers (Charmaz, 2000). A systematic 5 stage process was employed for the data analysis. A data-driven or inductive approach was used, which means the themes were derived from the data itself versus using a pre-existing coding frame (Braun & Clark, 2006; Charmaz, 2000). This type of analysis is sometimes referred to as open coding (Patton, 2002).

The researcher made notes in a journal throughout the entire process to document the development of ideas about the meaning of the data. The researcher believed it was important to provide a thematic analysis of the entire data set that was obtained, but as the focus of the research was about the ethical dimensions of the practice, particular attention was paid to discerning themes on this topic. Also, the researcher's standpoint with respect to relational ontology would have influenced the recognition of the themes of *Engagement* and *Relationship Building*.

The first stage of analysis involved the development of the initial themes and began with re-reading all 339 pages of data. The data was then read again and concepts were identified and named and noted in a journal. When the open coding was finished 21 themes had been identified. The second stage of analysis involved the development of a thematic structure. The researcher used a visual process to map and cluster concepts with logical links. This process reduced the 21 themes to 17. The third stage of analysis was the application of the thematic structure to the data; the data was re-read and electronically cut and pasted into the separate themes.

Open coding continued throughout this stage of cutting and pasting as labels continued to be assigned to selections of text within the themes. Chunks of text were used in

more than one thematic category as multiple meanings were usually embedded. In order not to lose the context, individual meanings were not separated from the surrounding text. At this stage of the analysis some of the themes were quite specific, because the meaning stood out right from the beginning, such as the interpretive sub-theme of *Facilitating Flexibility*. Other themes were more general and semantic, such as *Non Intrusive Interventions* and required further analysis to discover the meaning.

The fourth stage of analysis was the re-reading and comparing of text within each theme in order to establish sub-themes. The fifth and extended phase of the analysis process involved a constant and repetitive cross comparison of themes and sub-themes. Meanings of the data evolved and developed; themes collapsed, expanded, and merged. Although thematic analysis is explained and presented in the literature and in this thesis as a linear and step-by-step process, it is also the application of an iterative and interactive process, which is argued by Tobin and Begley (2004) to be an “overarching principle of ‘goodness’ ” (as cited in Fereday & Muir-Cochrane, 2006).

The analysis process concluded with the identification of 13 themes. This final thematic structure was compared with the original text to ensure that the final themes had not drifted from the original meaning of the data and that significant themes had not been missed. Seven themes that originated at the beginning of the analysis process continued unchanged into the final version. The names and meaning of the remaining six themes shifted and evolved throughout the analysis process. For example, the original named themes of *Non Intrusive Actions*, *Intrusive Actions*, *Strengthening the Continuum*, *Balancing*, and *Social Workers Are* eventually merged together to become the final theme of *Ethical Repertoire*.

## Chapter Four

### **The Results**

#### **The Story of the Data**

Although it was not intentional, the data that was generated in this research study essentially took on a story shape; in other words, the quintessential narrative plotline of beginning, middle, and end revealed itself as the analysis formed. This was due in part to the interview schedule that asked social workers to tell about a time when a specific level of intrusiveness that was used which would naturally result in a descriptive story-like answer. But the narrative shape was also due to questions that focused on obtaining information about different stages of the process of responding to a report of abuse, neglect, and self neglect. For example, the questions that focused on the initial investigation phase elicited descriptions of the beginning phase of investigation, and questions that asked for the social worker's feelings about the conclusions of these cases resulted in stories of endings that provided a sense of closure.

The stories shared by the social workers portrayed a wide variety of accounts of older adults' experiences with abuse, neglect, and self neglect. The abuse that was reported ranged from verbal, to financial, to physical. The abusers that were described were spouses, children, grandchildren, and non family members. In one case, a social worker referred to a non-family member abuser who had a repetitive pattern of seeking out vulnerable adults for financial abuse.

The situations of neglect reflected both caregiver stress and need for caregiver education as well as caregiver pathology. Furthermore, in some cases the so-called neglectful or abusive caregiver also had to be considered as a vulnerable adult. One social

worker stated, “Now I’ve also ascertained that ironically...the abuser presents as less capable of seeking support and assistance than the victim.”

The self neglect circumstances that were discussed included unmet physical and health care needs, untreated Mental Health issues, inability to manage finances, squalor, and addictions issues.

Overall, thirteen themes were identified in the analysis which will now be described. The themes will be illustrated with quotations from the participants; details such as the gender and location of the participant speaking will not be included in order to ensure anonymity. Table 1 on the following pages provides a summary of the thematic structure.

Table 1

*Thematic Structure*

Theme	Subthemes	
	Level 1	Level 2
Looking into a Report	Collecting information	
	Preparation & planning	
	Decisions	Adult Guardianship or health needs? Who will respond? Level of risk Order of events Location of visit How to introduce self? Who to bring?

Table 1(cont'd)

*Thematic Structure*

Theme	Subthemes	
	Level 1	Level 2
Engagement	Clinical savvy & creativity	
	Relationship building	
	Use of health care provider role	
	Demand for spontaneity	
	Resistance	
Developing a Support & Assistance Plan	Assessing need	
	Getting to know the adult	
	Working with the family	Skills & Interventions Confidentiality Balancing viewpoints Family as less than noble
Assessing Incapacity	Lack of understanding	
	Capacity threshold	
	Last resort	
	Who assesses?	
	Degrees of assessment	
	Barriers with assessments	
	Assessment unit	

Table 1(cont'd)

*Thematic Structure*

Theme	Subthemes	
	Level 1	Level 2
Ethical Repertoire	Respecting autonomy	A high priority value A comfortable stance Respecting the inherent worth of the individual Rooting for the rebel Defending autonomy Autonomy side of the room
	Qualms about care	
	Avoiding intrusiveness	Health care role Avoid the all or nothing The middle ground Facilitating flexibility Tolerating risk Weighing the benefit of intrusiveness Least intrusive intrusiveness
	Recognizing need to intervene	
	When older adults refuse	
	Balancing	

Table 1(cont'd)

*Thematic Structure*

Theme	Subthemes	
	Level 1	Level 2
The Team	Team as benefit	
	Team in distress	
	The social worker and the team	
	The physician and the team	Status Physician as collaborative partner Physician as barrier
Responsibility & Distress	A distressing responsibility	
	A complex adventure	
	Non-voluntary clients	
	A grave responsibility	
	Responsibility & powerlessness	
	Coping strategies	
Addictions	Felt distress	
	Stigma	
	Complex solutions	
	Intense work	



Table 1(cont'd)

*Thematic Structure*

Theme	Subthemes	
	Level 1	Level 2
Comparisons to Child Protection	Easier & harder	
	Different standards	
	Transferable skills	
Success & Failure	Failure	
	Mixed success: the bumpy road	
	Success	
The Organizational Structure	Inadequate resources	
	Problematic structures	
	Dual role	
Participants' Recommendations	Resources	Education & training Specialist resources
	Better structures	Standards Policies & procedures Provincial forum Collaborative paths with physicians
	Separation vs integration	
Wisdom Gained	Helpful skills & tools	
	Helpful strategies	
	Helpful attitudes	

## **Looking into a Report**

The first theme encompasses the beginning of the social worker's story, consisting of the numerous tasks and decisions that may take place in the initial phase of responding to a report.

### **Collecting information.**

At the beginning, the social worker gathers information from the caller. For example, "It was just trying to get as much information as I could about what the person knew about the situation and how long...the problem had been occurring...and...what the details were around that." The information is assessed in terms of credibility and urgency. Whether the caller wishes to remain anonymous also needs to be established. Frequently, further information about the adult is gathered from inside the health care system. One social worker described it in the following way:

There's a certain amount of assessment you can do...without...breaching any kind of confidentiality issues. You can check data bases. That kind of thing. You know, do a bit of a file medical record history search and stuff which can help you get some info right after the caller gets a hold of you.

Other sources of information may also be contacted such as the physician if they are known, or a home support worker, or the RCMP if the circumstances of the story warrant the caution.

### **Preparation and planning.**

After collecting information from the reporter and collateral sources, a social worker must make a number of decisions in order to plan a way of approaching the older adult that will have the best chance of success. It is a process that requires assessing risk and anticipating the challenges that might arise. Multiple unknown possibilities must be considered for which potential solutions must be planned. One social worker referred to this

process as simulating how “a few different scenarios are going to work.” Here is a description of one participant recollecting the forethought and multiple factors that would have been necessary to consider when preparing for a number of contingencies prior to making contact with an individual.

...this was something where we didn't know this person, so we weren't sure whether for instance this person had a physician and whether there was anyone who had any knowledge of this person. This person was in a room and board situation. So if we took him out of there... we didn't know where we were going to put them. We didn't know...was this guy going to be able to manage independently? Or was he going to be a meaningful care kind of person? So I needed to look at anything in that range. If the guy needed to live independently, then he could go to a motel. But did he have any money to pay for a motel? I have no way of getting money to pay for a motel... So okay, so if he can live in a motel, well then I need money for a motel. If he can't live in a motel and he needs support...then you have the time crunch involved in getting an assessment done to get support services appropriate for this guy so that you can make that happen. ...you may need to take him to the hospital to have him assessed. But if he's not acute then the hospital isn't going to admit him. So you're still then going to look at...maybe he needs to go in a place where he gets some care. But if you don't happen to have a place with an opening and generally you don't, because there's a waitlist for everything. Then where are you going to stash this fellow? ...one of the options for this fellow was maybe I could put him in the men's shelter as a place to sleep, but it's only open from four in the afternoon until eight in the morning. So I might have been able to put him in the men's shelter. I might have been able to get a long term care assessor...to put in some home support if he needed assistance with...bathing, dressing, medication – any of those sorts of things. That might have been possible. But then what was going to happen to him from eight o'clock in the morning til four o'clock in the afternoon? Particularly if he was a guy who maybe needed a little bit of supervision.

One reason put forth as an explanation for the need to put considerable effort and energy into developing a thorough strategy for the first contact is that there may only be a “best one time opportunity to visit with somebody.” It was put this way:

Because if we think we're going to get one shot at it ...then we might do it slightly differently. And it might be a little harsher because we're thinking ...this looks like it's going to be a difficult thing...and so we're going to have to pull out everything just to get one chance at visiting the person.

### **Decisions.**

From the moment a social worker receives an adult protection report, a number of decisions must be made.

#### ***Adult guardianship or health needs.***

One of the first decisions that must be made is whether the situation is a health care referral or meets the criteria for an adult guardianship situation. It was suggested by one participant that as health care providers are predisposed to receiving health care referrals, it was important that the individual receiving the report had the ability to recognize an abuse, neglect, or self neglect situation embedded in a health care referral.

#### ***Who will respond?***

The next decision that must happen is determining who in the health care system is going to respond. This decision is dependent on multiple variables such as where the referral arose, from which program the adult may already be receiving health care services, and the informal or formal response systems that have developed within that particular Health Authority structure. Most of the participants in this study described the social worker as having a lead role in responding to reports, but this was not the case for everyone.

#### ***Level of risk.***

The social worker uses the information to assess the level of risk to the adult and the level of risk to self. The situation may be urgent and require immediate attention. Consideration must also be given to how an investigation may or may not increase the adult's risk. There may also be information that indicates risk to potential investigators. For example, in a case where the presence of weapons has been noted then appropriate cautions must be taken. In high risk situations, decisions must be made about contacting the RCMP

for background information and whether or not they are needed to accompany the social worker.

***Order of events.***

The social worker must determine who else should be contacted to collect information and the best order of events. In some cases, the adult is the first person who is contacted, but in other cases the physician, other family or friends, or other service providers may be contacted for further information. One social worker stated that the first choice is to talk to the adult, but if there was a reason such as risk, other collateral sources may be contacted first. One social worker recounted an example of creative allegiances where members of the faith community who had a relationship with the adult were contacted in order to collect further collateral information; this strategy was necessary for determining if the situation warranted a higher level of intrusiveness to interview the adult, as he or she was resistant even to an introductory conversation.

***Location of visit.***

Often the first visit is in the adult's home, but other locations may be chosen in order to speak to the adult privately, away from the individual who may be abusing them. In this study, one social worker described meeting with the adult in the physician's office.

***How to introduce self.***

***Timing.***

Another decision that must be made is whether the social worker will contact the adult via an introductory phone call or whether the unannounced home visit is preferable. One participant mentioned that this decision was based on an intuitive sense about whether the surprise visit would be more beneficial than the usual least intrusive route.

*Health care or adult protection purpose.*

The decision that the social worker makes about when to introduce the adult protection purpose for a visit presented an interesting theme for discussion. Most social workers described the use of the health care provider role when they first met the adults about whom a report had been made. One social worker indicated that it was rare that they would “come out guns a blazing” and immediately identify the adult protection role. There was some recognition that this approach could be perceived as deceptive, but one participant felt that it could be considered a matter of timing. “How much do I tell the person about what I’m doing prior to what I’m doing?” is how the ethical question was presented. It appeared in most cases that health care issues were generally discussed at the outset, but the adult protection purpose would be introduced as rapport was built. An exception to this typical pattern that was pointed out by a participant who noted that immediate identification of the adult guardianship role was sometimes advantageous with some abusers.

***Who to bring?***

Social workers also discussed the decision about whether they go alone on the first visit or whether it is necessary to bring another colleague, a physician, or the RCMP. One social worker planned a family visit for a first meeting. A further example of the deception versus timing question came up in a social worker’s comment about how a physician may be brought on a visit, but that he or she may not necessarily be identified as a physician, at least not immediately if the adult is known to be particularly suspicious.

The decisions that the social worker makes in relation to any of the above subthemes will relate to the degree of intrusiveness that is deemed to be necessary and appropriate by

the social worker. Level of risk and level of resistance were two common factors that influenced the social worker's decisions across the categories.

## **Engagement**

### **Clinical savvy and creativity.**

The first step to engagement is how a social worker actually makes that first face-to-face contact. Social workers referred to doorway conversations with older adults and the different ways they used "clinical savvy" or "smooth talking" to enter a person's home. "I more talk around it and within the person's language parameters and their understanding of thing. ...and usually I can talk my way through things" was what one social worker stated.

Creativity was another component that was mentioned as helpful for engagement. One example of this was when a social worker described associating the first visit to a particularly suspicious older adult with a visit from a volunteer. The social worker arrived prior to the volunteer and the adult may have thought the social worker was the volunteer at first. "So it was a little sneaky," the social worker stated. But the strategy allowed an opening for the social worker to have a doorway conversation as her/his identity was made clear before the volunteer arrived, and the opportunity was used for a brief informal assessment of the adult's vulnerability.

### **Relationship building.**

After the initial engagement, the social worker must begin to build a relationship with the older adult. Within the structure of this analysis, relationship building is examined as one subtheme inside the theme of engagement. Gentleness and least intrusiveness were considered key ways of building rapport with older adults. One social worker pointed out that the social worker's overall "demeanour" should be as "least intrusive" as possible and

needed to convey gentleness and respectfulness with tone of voice, eye contact, and possibly touch in some cases and that an effort was made “to connect as much as I can with my being.” One particular participant used the words “softly, softly” twice in the interview in reference to the need for slow and gentle approaches. Related to this theme of building rapport with gentleness and softness was one social worker’s comments on the understandable anxiety of adults who have been reported to a designated agency. The participant remarked that adults “are panicked that...the world is just going to come crashing down,” and it was necessary to spend time calming the individual’s anxiety.

Another facet of the slow and gentle approach was the necessity to take time to build rapport over a number of visits. Spending time with the adult having conversations about matters of interest to the adult not directly related to the problem such as music and books was another strategy that was mentioned. One social worker pointed out the benefit of relationship building and referred to a case where there was considerable “front end investment” done in relationship building that eventually facilitated the client agreeing to the addition of other community partners, including the RCMP.

Some of the examples demonstrated how relationship building was also accomplished with the provision of practical help such as buying groceries or bringing a functioning telephone. Finally, the remarks of one social worker highlighted the reciprocal nature of relationship building. The participant was commenting on the charm and likeableness of an older adult who was the recipient of a complex and intensive community care plan involving both formal and informal care providers. “This gentleman...he was a very likeable charming man. And a very good heart. So it was easy to do eh?”



### **Use of health care provider role.**

Using the health care provider role to engage with an older adult was brought up by all the social workers in this study. From introducing themselves as a health care provider, to using internally collected health care information to discuss the adult's health issue as a starting point for an initial conversation, to offering health care services such as meal support or home care services to support the adult, the health care provider role is used to build rapport. The health care provider role is considered less threatening, not as stigmatizing, and therefore less intrusive for an older adult. The possible disadvantage of the health care provider role is demonstrated in the need to be seen as a support person and not "accusatory." Some of the comments expressed concern that alienating a caregiver or adult could possibly lead to refusal of health care services. For example, "I don't want to come in, in a way that's going to make it difficult for me, for the person to accept supports from me after I get in."

### **Demand for spontaneity.**

Several comments from social workers related to the importance of an open minded and inquiring stance without preconceived assumptions. For example, one social worker said, "and I don't go in with a set idea of how things are going to go." The implication of the open minded stance is the demand for spontaneity that is required from the social worker. Indeed, the same social worker stated that after developing a strategy the next step was to make the visit and "wing it from there." Other participants also referred to this part of the process in similar ways. One social worker pointed out that there was uncertainty about how "things are going to go"; another social worker referred to the course of events in an initial visit as "evolving" and "part of the fun."

### **Resistance.**

The general consensus from the social workers in this study was that most of the time the least intrusive, supportive health care provider role engagement strategy was successful. However, when resistance to support and assistance was encountered, there were examples of methods social workers used to overcome barriers. Using other members of the team to engage or creative improvisation were some of the ways that were mentioned. A couple of social workers pointed out that even in the midst of active resistance where an older adult may be responding with outright hostility, it is still possible for the social worker to use observational skills to assess basic indicators of risk and the adult's capacity.

### **Developing a Support and Assistance Plan**

#### **Assessing need.**

The first step in developing a support and assistance plan is the social worker's assessment of the adult and their circumstances. One social worker put it this way:

I am going to go in and ask questions and find out what I can... about the situation...there's a general path and again that path for me is all about offering supports. ...So it is going in, asking questions, getting the lay of the land, figuring out what we've got. Trying to figure out what the needs are. What are the holes in this situation? ...and then trying to match that up somehow with whatever supports are around. ...what is it you can put in there to prop that person up?

#### **Getting to know the adult.**

Several social workers spoke specifically about the significance of getting to know the adult. It was considered very important to really "get a full sense of who a person is." A deep understanding of a person was thought to be vital for balancing autonomy and care. One participant said that until there was a "sense of knowing" that the social worker wasn't "there yet." Another participant put this notion slightly differently and stated that it was the

social worker's responsibility to speak to the client's world view and that this could be gleaned from:

...what the person says to you. How they say it. The language they use. ...the pressure in their voice. Their intensity. The way they look at you. The way they move about the house. All that presents something. ...you need to digest it for yourself so you can speak to it and feel comfortable speaking to it.

### **Working with the family.**

#### ***Skills and interventions.***

In this study, social workers discussed the various ways they worked with families as part of their efforts to provide support and assistance to older adults. As family members are frequently care partners in providing support and assistance, they are often key recipients for social work interventions. Listening, validating feelings, educating families about dementia, care options, and the responsibilities of legal authorities (e.g. Power of Attorney) are some of the different interventions that were described. For example, one participant described a situation where a caregiver attributed the behaviour of their spouse to being deliberately difficult, rather than the result of dementia, and required education about the disease. Sometimes social workers put their efforts into involving the family in providing support and assistance. Details of service plans have to be worked out and refined with family members. A social worker spoke at length about a situation where a periodically neglectful caregiver was resistant to formal service provision and needed to put considerable effort into facilitating the acceptance of services through education and relationship building. Another social worker described the lengthy work that was involved in attempting to facilitate a family to assist their family member with their finances without success until an unexpected family member stepped forward who was capable and agreeable to taking on the responsibility.

There were also two examples of social workers educating family members about the principle of least intrusiveness and the right to autonomy. One social worker in particular spoke about advocating with a family to consider the older adult's values when using their authority to make financial decisions. Another social worker expressed concern that the authoritative nature of the legal committee process under the Patients Property Act encourages a family to be overly intrusive, as if a family feels obligated to act to the full extent of their authority due to having the legal responsibility.

***Confidentiality.***

The specific challenges around confidentiality that arise when working with family were discussed. One participant mentioned the complexity of needing to respect client confidentiality while listening to the concerns of interested family members. Another example was when a participant described the need to be very cautious about not alerting an abusive family member, who may have been in the next room or monitoring telephone calls, when conversing with the older adult about the plans to leave the house to go to a shelter.

***Balancing viewpoints.***

Another intricacy in working with families that the social workers described was that of the need to balance differing viewpoints from the client and their family about the client's situation. "They often have a different take on what's going on than maybe the client does," was one comment. There was also an example of including the family viewpoint along with a multitude of other factors when deciding not to take intrusive measures for an adult, because the family members would not have supported such an action.

***Family as less than noble.***

The conversation with the social workers in this study also reflected their awareness that the motives of family members are not always based on a desire to benefit the older adult. For example, one social worker commented about the work involved in enlisting family members to manage the financial affairs of an older adult: “I wish for that family that they would...stop bickering among themselves and truly put the best interests of the client at the forefront. ...And they didn’t. I mean, they all said they did. But they – they really didn’t.” Another social worker noted that family concerns for an older adult might not necessarily be an act of beneficence, but a means to accomplish a change in the family system. For example, the efforts of a family to have their mother placed may not have been about their concern for their mother’s welfare, but about their desire to displace an adult sibling from the family home.

**Assessing Incapacity**

The following comments from social workers about the incapacity assessment process reflect the critical crossroads that an opinion of incapacity can play in the entire process. Often, there is very little meaningful action that can be taken for an older adult refusing service until an adult’s incapacity has been declared. Assessing for incapacity is often not related to just the adult guardianship legislation, as a number of other laws in existence are applicable in these cases. The following is a description of the participants’ amalgamated comments about all different types of incapacity assessments. Observations about different types of assessments that had ideas in common were grouped together; ideas about particular types of assessments were specifically differentiated.

### **Lack of understanding.**

Participants commented on the general lack of understanding about the concept of incapacity and the lack of consistency in assessing incapacity. One social worker referred to the lack of shared understanding across disciplines; another social worker mentioned the lack of understanding about required standards for incapacity assessments under specific acts.

### **Capacity threshold.**

One participant made particular mention of differences in interpretation of the capacity threshold in reference to the obligation of the Designated Agency to respond to a report of a vulnerable adult under the Adult Guardianship Act. In the opinion of this social worker, when a report is received by a Health Authority, the perception that an adult was capable was sometimes used as a reason to refuse to look into the situation. This was felt to be a wrong interpretation of the obligation to respond, as it was possible that an older adult who has difficulty organizing support and assistance may still have the capacity to consent to a plan. The same social worker also pointed out that as formal incapacity assessments are only required for obtaining support and assistance orders under the Adult Guardianship Act, and as support and assistance orders are not being sought because of their lack of practical benefit, the result is an absence of formal process for health care providers to use to determine when to act intrusively. This participant remarked that the ensuing lack of guidance for when to raise the threshold on assessing an adult's incapacity causes significant uncertainty and clinical distress.

### **Last resort.**

This category refers to the general understanding among the social workers that assessing incapacity should happen at the end of the process, after all other avenues are

explored. One social worker said, “always assess the risk and mitigate those risks” before considering the need to assess incapacity. One of the participants lamented the need for such drastic action and said, “I hate the incapability thing!” and talked about how one should always try and find another way to solve the problem. Another social worker said that deciding to assess incapacity means, “you failed at the sales job” which signifies the weight that is placed on the need to encourage the adult’s acceptance of services. Several participants referred to how the pressures of bed utilization in the hospital can rush the process and pressure staff to assess too quickly.

Many of the social workers’ stories about their cases included comments about the complexity of assessing incapacity and the difficulties encountered when the individual’s incapacity was marginal or fluctuated. Lack of certainty about incapacity raised the level of clinical concern, and changing capacity highlighted the problem of when to time assessments.

### **Who assesses?**

The question of who has the power and status within the health care system to assess incapacity became an interesting theme in the research conversation. All the comments directly or indirectly referred to the power that the physician carries in their somewhat exclusive role of assessing incapacity. One participant remarked that although the law<sup>2</sup> did not specifically name physicians as having the sole authority to assess incapacity, within the health care system the opinion of a social worker does not hold weight in comparison to the physician. Another social worker described his/her frustration when the information that was obtained for a psychiatric assessment did not appear to be considered in the formulation of the final opinion. Interestingly, given the large role the physician plays in this process, one

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<sup>2</sup> This is true for some, but not all of the legislation currently applicable to adult protection practice.

social worker commented that in his/her experience physicians appeared to avoid making determinations on incapacity.

Another participant called the incapacity assessment process “inter-subjective” and pointed out that it was a collective team process where the different team members put their views together for someone else’s deliberation: “What do you see? And what do you see? And what do you see? And you know we put that together and somebody has to make a final decision.”

### **Degrees of assessment.**

Some of the discussion differentiated formal capacity assessment from informal capacity assessment. For example, one participant mentioned that a social worker would do an informal cognitive assessment before proceeding to using a cognitive screening tool. This information would then be combined with additional information regarding the adult’s functioning and provided to a physician for a formal assessment, if it was determined that this was necessary.

### **Barriers with assessments.**

While not true for all the participants in this study, significant concern was expressed about lack of access to physicians for incapacity assessments when needed. One social worker said, “it’s so difficult here that I just cringe,” when it becomes apparent that an assessment for incapacity is necessary. Two participants referred to problematic relationships with Mental Health which was perceived as a source for assessments. Another participant described the frustration experienced when an adult experiencing financial abuse from a family member could not be adequately assessed due to a psychiatrist refusing to reassess the adult. As this social worker explained, the continued financial abuse of the adult



could be better accepted if it had been determined that the adult was capable of understanding. Without a physician's opinion, there was a sense that an injustice may have been allowed that should have been stopped. Particular mention was made by one social worker about how he/she would feel more supported if there were access to a geriatrician who could provide specialized in-home assessments.

#### **Assessment unit.**

Related to the desire to have a clear understanding about an adult's capacity in order to support the decision making process and the difficulties that can arise in assessing day-to-day functioning in the community, one social worker expressed a desire to have an assessment unit, a location "where we would have the luxury of doing a nice assessment on a person" in order to get a "better picture of the whole person."

#### **Ethical Repertoire**

The degree of intrusiveness of the interventions discussed by the social workers in this study ranged from non intrusive interventions such as assistance with housing and health care services, organizing utilities, and informal assistance with banking to extremely intrusive interventions such as use of the Mental Health Act for facility placement, or facilitating the Public Guardian and Trustee to take on a Committee of Estate for an individual. These interventions may have occurred singly, sequentially, or in parallel fashion within the same story. Intertwined within these tales by social workers, a variety of tangled ethical positions were revealed and displayed. A number of themes were teased out and identified. These themes were not mutually exclusive and overlapped; one or more strands may have been present in a story.

### **Respecting autonomy.**

#### ***A high priority value.***

Not surprisingly, all the social workers made comments in this study that exhibited the high priority that was placed on respecting autonomy. For example, “well, I value autonomy pretty highly. And so I’m probably slower to act to take somebody’s autonomy away.” Another participant pointed out that overriding autonomy was not a success even if the individual was making poor decisions. One social worker drew the connection between respecting autonomy and everyone’s desire to be accorded similar treatment in the statement, “I would like to live independently in this world or until the end of my life. ...I really don’t want to have somebody taking control over my life.”

#### ***A comfortable stance.***

One participant stated that respecting autonomy was an “easier” way of working with people and commented that it was a “relief” to work in this way after working in child protection. This statement was qualified by the recognition that the client must be considered capable. For example, “if she is capable then I’m feeling okay with supporting her decisions about leaving things as is.” A note of uneasiness and contrast to this stance was provided by another participant. “Sometimes it’s hard when it conflicts with my values. And also when there is a lack of support available for people.”

#### ***Respecting the inherent worth of the individual.***

Related to respecting the right to self-determination is the fundamental social work value of respecting the inherent worth and dignity of every individual. This value was apparent in one social worker’s comments on the abhorrence of judgments from other health care colleagues on individual lifestyles. For example:

I really do not like overreaction to – and I do not like judgment. I do not like people looking at – Oh he’s all dirty! His fingernails have dirt under them and he lives in a dirty bathroom and oh my god!

***Rooting for the rebel.***

One particularly interesting example of championing the right to self-determination value was reflected in the story from a social worker who reported feeling the need to applaud the escape of an individual from the network of care.

He had actually walked down to the local pub. He had a few dollars in his pocket...I don’t know how he got that money...and had six beer. ...All the staff are all, he’s come back and he’s drunk, eh? Smelling like booze and everybody was aghast eh? And I don’t know...I thought good for you. (Laughs) Anyways, that’s what I was feeling.

***Defending autonomy.***

The social workers in this study did not express a unanimous opinion that the non-social work members of the health care team were less protective of autonomy than social workers. Some of the social work participants stated that their medical colleagues understood the guiding principles and the need to respect autonomy, while others clearly expressed that in health care the “ethic of care...trumps autonomy.” Sometimes the social worker was described as a “lone wolf”, as a primary member of the team who was responsible for raising “questions around the issues of autonomy.” One of the participants who stated that the team generally understood the guiding principles of the legislation also stated that as the only social worker on the team, “it was really my role to really keep bringing up the self-determination of the person...that was challenging at times, I think.” Another participant talked about how it was necessary to talk about your “role and responsibility” when you enter someone’s “private world,” because there were professionals who “just believe they have a right to be there.”

Several social workers shared the notion that referring to the law and the guiding principles was an effective way of educating the team, including the physicians. One participant explained it this way. “And I’ll say under what act are you talking about? Under what piece of legislation do you want me to work under at this particular time?” Another participant’s statement that it was sometimes necessary to educate community members about the principle of self-determination who “want us responding with both barrels,” points out the educational role that social workers can play in the community as well as to other health care professionals.

***The autonomy side of the room.***

In an effort to describe the absence of a shared definition of the meaning of respecting autonomy, one of the research participants said that if a line was drawn down the middle of a room full of people with one side representing autonomy, and the other care, that everyone would stand on the side that represents autonomy. However, this social worker stated that the autonomy side of the room is not where he/she would position those professionals. This participant concluded, “In other words, there are a lot of people who think they’re doing the right thing. ... And...I would say. I wouldn’t do it that way.”

***Qualms about care.***

Many of the social workers in this study expressed reservations about the health care system’s tendency to prefer care to autonomy. “Health care does not necessarily hold autonomy as the highest ranked ethical principle,” said one participant. Another participant thought that the tendency related to the culture of the medical model where “you have to go in and fix it and here’s...our tool basket and you have to fix things this way.” One social worker stated the case more emphatically. “Excuse my expression but a lot of covering our

butts. ...God help us if we don't do all that we can do eh?" Two participants commented that care might sometimes be regarded as "arrogant" or "abusive." "If we override the rights to people's autonomy and we've become too protectionist, we if fact then become the abusers," one of the participants concluded.

### **Avoiding intrusiveness.**

Throughout the stories shared by the social workers, a multitude of examples illustrated the ways that social workers sought to avoid an intrusive approach to care.

### ***Health care role.***

The health care role appeared to be a significant aspect of being a less intrusive presence in an individual's world. One participant pointed out that collecting information from inside the health care system is least intrusive in itself and that health care services are perceived as less threatening. Furthermore, the actual provision of home support services often reduces or removes the risk and avoids the use of the legal tools. As one participant put it, "the whole point is to provide support and prevent the abuse...and that works really well," when the services are available.

### ***Avoid the all or nothing.***

One social worker expressed exasperation with the perceived tendency of health care to view answers to adult guardianship situations as "all or nothing" solutions; in other words, health care providers who command an acceptance of prescribed services from the client or will refuse to be involved. The attitude from this social worker exemplified the typical social work resistance to such solutions and preference for avoiding intrusiveness. "And it's very rarely an all or nothing," this social worker remarked.

***The middle ground.***

The alternative to the all or nothing is the middle ground, the many ways that social workers find the smaller, less intrusive solutions to address the issues. Comments from the participants in this study reflected the substantial effort that is made to find the middle ground solutions. For example, here is how one social worker described defending small change: “And I’ll say well everything can’t change. And we don’t have the right to change everything. We have the right to change a few things. ...and if those few things change then that might change something else.” This is how the same social worker described working with an older adult, negotiating degrees of assistance:

I say, let’s start somewhere. What will they accept? And if whatever they accept, then we’ll work with that...we’ll work our way up to...why don’t we try this? You don’t have to keep going like this...we sort of negotiate their anxiety about what I’m trying to do.

Social workers also commented that there was a need to take time, slow the process down to discover and develop the solutions. One participant commented that it was important to get to know the client, as “the more you know a person, the more you can find the middle ground.” Another participant commented that focusing the intervention on the abuser in one of his/her cases was, somewhat ironically, less intrusive.

***Facilitating flexibility.***

Much of the discussion highlighted the work done by social workers to facilitate flexibility of the system. System flexibility can be considered as an aspect of avoiding intrusiveness when it enables the provision of a less intrusive service that reduces the harm and prevents the need to use a more intrusive intervention. Facilitating system flexibility included the work to coordinate complex community care plans, working with members of the team to follow the detailed care plan, and advocating for service providers to stretch their

service mandates. One social worker stated, “It was really quite an uphill struggle actually to advocate on her behalf to get into an environment that would keep her safe.” Another social worker suggested that just the act of raising team awareness about the issues might assist to encourage flexibility and willingness to support the client’s wishes. One of the participants argued that increasing the flexibility of services is actually prevention for abuse and neglect. If “monitoring and following up with people” were considered a valid reason for an open file, then perhaps some circumstances involving untreated mental illness would not grow into adult guardianship situations.

***Tolerating risk.***

Implied in the reluctance to take intrusive action, is the necessity for tolerating risk. Many of the social workers discussed the sense that they were more comfortable with risk than their health care counterparts, willing to wait until a crisis brings an individual into the health care system in a different way. “We all have different perspectives on what is safe. ...they’ll say no that person is at risk big time and then I’ll look at it and I’ll think, oh... I...don’t...really think so.” Someone else stated, “There’s a difference in perhaps how I assess risk and how my colleagues assess risk.” Another participant pointed out that the price of tolerating risk might be devastating tragedies which could be considered to be the requisite cost of avoiding an overly protectionist society where individual rights are removed too quickly.

***Weighing the benefit of intrusiveness.***

When deliberating over whether or not to take intrusive action, social workers weigh the potential benefit. One social worker stated that it was important to “stop and think” and ask, “What’s the trajectory?” She/he suggested that a particular decision “may make the

moment easier, but the rest of the life needs to be lived.” Comments suggested that it was important to realize that in some situations appointing a substitute authority may not have a practical benefit or perhaps even result in an alternative more harmful than the original situation. As one participant stated, “What have we got to replace this with? Is that any better?”

*Least intrusive intrusiveness.*

It was clear from the descriptions of the social workers that even when they identified situations that required extremely intrusive interventions, they looked for ways to soften the impact. Some of the stories described the effort that social workers made to facilitate the client’s acceptance of services, even with intrusive interventions such as incapability assessments or Public Trustee involvement. “Because he was agreeable all the way,” said one social worker in reference to a case that started with small interventions, worked gradually toward Public Guardian and Trustee involvement, and avoided a forced placement.

When appointed decision makers were called to make decisions on behalf of an incapable adult, social workers pointed out the least restrictive principle. One participant suggested that when acting for an incapable adult that it was important to act “in the spirit of the person,” that is to consider what decisions the adults would have made when they were capable. Another social worker commented that it was important to “restrict liberty in the least amount possible...and allow for as much independence as possible.”

A further example of the principle of least intrusiveness is when social workers describe practicing non-intrusively, after the intrusive intervention is over. For instance, in a specific situation where acceptance of services had been enforced by using the Mental Health Act, a social worker described the following when working with the caregiver: “I actually



found...sort of later as we were looking after him that it was very important to have his spouse to be in control. And to be part of the decision making process...and when that happened...she became more responsible.” Similarly, another participant commented that it was important to remember that necessary emergency interventions can buy time, but that too often the adult was forgotten after the emergency was over; this social worker suggested that this was the time to finish “crafting a more appropriate least intrusive intervention.”

### **Recognizing need to intervene.**

Despite the participants’ emphasis and endorsement of respecting individual autonomy, there was also unmistakable support for intervening against individual wishes as evidenced by the comments and the examples described by the social workers. Intrusive intervention was seen as justifiable when there was client incapacity and intolerable risk. For example, “she didn’t appreciate the severity of the infestation of rats,” and “he was not in his right mind to make the decision.” Also, “we have to be really careful not to abandon people to autonomy when they’re so impaired that their autonomous decisions are not guided by realistic decision making.” In reference to a particularly complex circumstance, one social worker described the effort that was undertaken to “cobble together this clear gap in executive functioning,” in order to demonstrate the adult’s lack of capacity in order to proceed with an intrusive intervention. With regard to risk, social workers made comments such as, “it’s when the risk is just insurmountable,” and “if the person’s...trying to cut off his arm with a knife. Then we think this is intolerable. We better do something.” One social worker remarked that when the temporary loss of rights was necessary to assess capacity that this was justifiable.

I don't feel bad about the possibility that that person may be capable and the pink was all for naught. Because that's great. Then I'm sorry that I bothered you. But it just looked like you were in need of protection.

#### **When older adults refuse.**

There was general agreement among the participants in the study that when capable adults refuse support and assistance, the general response was to allow the adult to live at risk but to stay connected by various means such as monitoring, follow up, counselling about options, and involving other services. One of the participants stated that if someone refused services and the level of risk was low the decision would be accepted. However, "an open door" would be left for the individual "should they change their mind." This same participant also pointed out that while "no further intrusive action" should be taken, the key word was "intrusive," as other non intrusive actions may still be appropriate. One variation with this particular similarity between the participants was when one social worker elaborated that he/she might not accept the refusal without trying to "push a little harder and a little longer," if the adult presented as someone in more of a "victim role", i.e. as someone not thinking clearly due to being affected by years of abuse.

Some of the participants acknowledged discomfort with occasional cases where older adults had refused services and were living at risk. Discussing these types of cases with the rest of the health care team was mentioned as a possible source of support. Issues about the adult's risk, functioning, and options could be revisited. Referring to this type of conversation one of the participants stated that the discussions "just keep going on and on and on and on."

### **Balancing.**

In response to the question of how the participants managed to balance the oppositional ethics, social workers supplied a variety of answers such as, slowing down to do things differently so that the individual's needs are met, ensuring the information is accurate, knowing the client well, understanding the client's capacity, referring back to the law, recognizing that capacity is changeable, weighing the risk, and reducing the harm of the risk. The range of answers from the participants reflects the multiple factors that are taken into account and as one of the participants remarked, "A lot of juggling goes on." Another participant commented that there wasn't an "easy formula," and that one needed to look "at the whole person" and "balance that with the level of risk," which suggests that a holistic thinking is used where the parts and the whole are simultaneously viewed, where a variety of specific factors are considered in the context of an individual. Some social workers also remarked that it was helpful to use the team to find a group decision and "make it not just a personal decision."

### **The Team**

Many of the comments from the participants in this study highlighted the multidisciplinary cast of characters in health care that may be called to the stage who may or may not work together to achieve a common goal.

### **Team as benefit.**

The participants provided many examples of how the entire health care team can be viewed as a resource for supporting this difficult and complex work. For instance, there were stories of different members of the team collaborating and working together by doing joint investigations or creative problem solving. Discussing problematic situations and moral

dilemmas with the rest of the team was thought to be helpful, because sharing multiple perspectives facilitated a better understanding of the client. In the opinion of one participant, a collaborative team review should be a required standard for this practice.

### **Team in distress.**

In contrast to the positive view, diverse perspectives were also viewed as an issue that needed to be managed or a source of conflict and frustration. For example, “so you have different workers with different perspectives and making different judgment calls so you’re trying to balance that.” Another participant stated:

There’s a lot of distress in that continuum, because they get caught up in these battles of one team is suggesting they’re just not capable of managing the risk – so expose them to an incapability assessment which some will say that’s unethical, because they don’t need that.

One social worker described their strategy for coping with a difference of opinion:

And they believe they’ve got...the right answer...and it’s on their side.  
...The way I try and get around that is that I say, we need...just to make recommendations...and I’ll say, well I’ll give you my recommendation.  
And that’s...that’s where I’ll stand.

Another problem that was identified was the difficulties in team communication that can occur in the transfer of cases between communities or between community and acute care. “And it all fell down at the hospital” and “All our work was for nothing” are statements that exemplified the frustration social workers experienced when their counterparts did not appear to share or understand the needs of the client in the same way.

### **The social worker and the team.**

Some of the stories appeared to indicate that the social worker acts as a consultant to the rest of the health care team on adult guardianship issues, either unofficially or officially as part of the job structure. One participant commented that it was a worthwhile endeavour

for a social worker to work to “to build confidence and capacity in all of our health care colleagues” and reduce their “anxiety around abuse and neglect cases,” highlighting the potential contribution a social worker can make.

### **The physician and the team.**

#### ***Status.***

Several of the stories relayed by the social workers referred to the authority and control that is wielded by a physician in the organizational structure of health care. Here is how one social worker expressed it:

I mean I can stand with all my colleagues in arms and say through all our assessments and all our expertise and all our knowledge this is a client with incapability...and needs to be protected. But unless a doctor supports it, it really is meaningless.

Another social worker also spoke about the physician’s ability to veto and trump a care plan; another pointed out that a physician is required for key interventions such as “when you admit someone to hospital you need a most responsible physician.”

#### ***Physician as collaborative partner.***

Despite the concerns expressed with the physician role, there was a clear note of satisfaction that could be heard in those cases when the social worker and physician were able to work collaboratively. Social workers provided examples of when physicians were seen as educational resources or team members who invited or welcomed information from the social worker about older adults who were of concern. One participant indicated appreciation for the potential support that could be realized with a collaborative relationship with a physician, when the desire for an outreach geriatric specialist who understood adult guardianship practice was stated.

***Physician as barrier.***

There were also many instances when the physician was viewed as an impediment to the process. Whether the physician was unsupportive of the need for an assessment of incapacity or the support and assistance plan, others were unable to proceed with what they believed was a necessary course of action without the physician's cooperation. Here is an example:

Her doctor would not put forward to Mental Health for an assessment. The daughter-in-law believed that he didn't want to be in her bad books. I'm not sure what the reason was. But he said that he would not support an assessment, 'She was fine.' She was losing weight. She was a very slim and tiny woman to begin with. So she was down to some 80 odd pounds. And allegedly the doctor would talk to her about her weight, but that was the end of it. So it wasn't until this woman had a fall and still didn't want to go to the hospital. Wanted to be left alone. Let her son live there and do whatever - that the daughter-in-law was able to take her to the hospital and get her in. And from there...I tried to get an assessment through social work setting it up. And then the doctor found out about the request for the assessment through the hospital – stood in the way of that.

Discussions on this subject also touched on observations of physician's general lack of knowledge about adult guardianship and the challenges in educating a group who operate independently of other health care professionals.

**Responsibility and Distress**

***A distressing responsibility.***

In recounting the nature of adult guardianship practice, the social workers used descriptors that suggested the responsibility of this practice could be distressing. "Intense work," "stressful," and "pretty taxing work" are a few examples. More than one participant used the term "moral distress." One social worker referred to the idea that the lack of resources for providing support and assistance to vulnerable adults created "so much moral distress." Another participant made the point that as adult guardianship work has been

poorly supported within the health care structure and “left on the shoulders of individual practitioners,” the responsibility has been overwhelming for some social workers. Worry, losing sleep, burn out, and trauma were thought to be some of the effects for social workers from this kind of work practice.

### **A complex adventure.**

The enormous complexity of this practice may be one of the factors that increase the stress. Social workers said that the work was “complicated” and that it was “easy to really miss a piece.” The nature of adult guardianship practice was also described in terms such as “not black and white,” “shades of grey,” and a “judgment call” which gives an impression of its unpredictable, dynamic character and resistance to standardization. Events occur during the course of a case that cannot be foreseen which must be worked into the equation; sometimes there are circumstances where “everyone doesn’t know what to do.” This particular aspect of the practice was not always seen in a negative light and framed as an “adventure” or part of the “fun and the angst...because...it’s certainly not a cookie cutter kind of approach.”

### **Non-voluntary clients.**

Mention was made by one participant about the potential for conflict and hostility and added stress when working with non-voluntary clients. The social worker said, “Generally you weren’t going to be liked by the person and so it just made it...difficult. Right? More stressful for sure.”

### **A grave responsibility.**

The participants in this study recognized the gravity of the responsibility of this type of practice. The social workers commented in different ways on the responsibility of making

decisions that have critical impact on individual lives. A significant aspect of this responsibility was the realization that decisions could potentially lead to “devastating consequences.” Consider the comment, “If I had a magic wand to change one thing, it would have been that she didn’t die.” One social worker explained that it was important to practice competently in order to “avoid any kind of drastic mistakes.” Another social worker used the term “damned if I do, damned if I don’t” which touched on the anxiety expressed by more than one participant that is involved in making a decision when the potential for a bad outcome could occur equally for any action or inaction.

### **Responsibility and powerlessness.**

Somewhat ironically, along with a sense of responsibility, a strong sense of powerlessness was also expressed by a number of the participants. “I don’t know that we could have done anything differently” and “but there really isn’t anything I can do” were examples of statements made about situations where actions to improve or resolve the situation were not within the social worker’s reach.

### **Coping strategies.**

Further signs of social workers’ efforts to positively frame the responsibility of the practice could be seen in their recognition of the limitations of their position with comments such as, “I do think we do the best we can,” which could possibly be construed as attempts at feeling comfortable with the fundamental powerlessness of the role. One social worker appeared to balance the enormous responsibility of the practice by acknowledging the limitations set by existing cultural norms.



And I sometimes would like to do more. And I sometimes would like to do things differently. But because of the place I live, and where I live, and the laws that exist... I do what is the maximum amount and that's what I do. And I don't have any authority or any right or any reason other than my own initiative to go further. And...that's where it stops.

## **Addictions**

“Booze is such a complicating factor,” said one of the participants, evoking a note of intensity and frustration that was echoed by many others. Despite the interview schedule not having any questions aimed at addictions, 10 stories illustrating the impact of substance use in this area were elicited. The felt distress was palpable in such statements as “Home support were horrified” and “passed out in a pool of his own stuff. It was horrible!”

The stigma related to substance use issues was apparent in some of the comments such as a social worker needing to allay the concerns around an older adult with substance use issues moving to an assisted living residence due to “the stereotypes around alcoholics.”

Intervening in situations with addictions issues were considered more complicated as typical solutions were not appropriate. For instance, more than one social worker mentioned the refusal of home support to provide service due to substance related behaviours. One participant speculated on the potential advantage of having an innovative service where home support workers would purchase alcohol for clients as part of a harm reduction strategy, knowing that current rules would prohibit this idea. Furthermore, assessing capacity was seen to be problematic in these cases “because you know they’re capable when they’re sober, but in reality you know they’re never sober.” Success was considered possible, and examples of success were shared, but huge effort and intense work were clearly necessary on the part of the social workers.

### **Comparisons to Child Protection**

This theme was also not specifically sought, but appeared to naturally emerge in the conversation as social workers reflected on their work. One social worker felt that adult guardianship practice was easier due to the consent model, where the capable client must consent to services. Other comments referred to the idea that adult guardianship is more challenging, because there isn't the same automatic right to protect that there is in child protection. Comments also touched on the differing standards between the two fields, such as investigation and information transfer between communities. One of the social workers felt that staff with child protection backgrounds perceive adult guardianship standards as "soft," because there is a lack of understanding that the focus is not about assessing capacity, unless support and assistance is refused. There were a few remarks that the child protection field provides better training and that the assessment skills in that practice are transferable to adult protection.

### **Success and Failure**

During the course of the conversation, the participants were asked for their opinions about what was accomplished at the end of the day with their various clients. This is what they said.

#### **Failure.**

Cases where the intrusive action seemed too intrusive were considered unsuccessful. For example, actions that led to more harm such as when an older adult is placed in facility care, becomes agitated, and then chemically restrained were questioned as being successful, particularly if the sedation resulted in falls and subsequent death. Incidents and events were shared that were considered to be unfortunate or disastrous and possibly avoidable.

On the other hand, social workers also felt unsatisfied with the cases where there was a failure to take what they believed was the right course of action. Examples of these situations included: when the doctor refused to assess incapacity, when a social worker failed to follow up on financial abuse of an incapable adult, and when an adult was not certified under the Mental Health Act and placed in a care facility.

**Mixed success: the bumpy road.**

Some of the situations that were described were cases that were partially successful or eventually successful, but only after what felt like a monumentally huge and frustrating effort was exerted. These cases typically described problems and barriers in the course of events that required continual and ongoing problem solving, such as when different programs were struggling to work collaboratively, or when social workers devised their own procedures, or strenuously advocated in order to facilitate the system to function. When older adults required placement in a facility and were successfully placed, but the unique needs of those individuals were not well met by facility care, this was also viewed somewhat ambivalently.

**Success.**

According to the social workers, success was achieved when the interventions used to resolve the issue were non-intrusive or least intrusive. Non-intrusive was demonstrated in the case of letting an adult, supported by informal care, continue to live and make his/her own choices. Least intrusive interventions were relatively measured, that is interventions that had a degree of intrusiveness that were considered balanced off by other factors such as the client had accepted the services, or a development of a particular service had been accomplished that met the client's need, or a more intrusive intervention had been avoided. In one case thought to be highly successful, where intrusive means were used to extricate an

incapable adult from the control of an abusive individual, one participant remarked that it was interesting that the vulnerable adult who was fearful and initially refused support and assistance consented once he/she was in a safe place.

Another feature of interventions thought to be successful was the idea of setting and achieving smaller goals such as reducing someone's hospital visits to every two weeks or gaining permission to return to someone's home. For example, "they said we can come back again. I say, okay, well then that's a level of success that we can live with. Cause we're going to be going back again at some time." Furthermore, when everything that can be done under the legislation has been tried was mentioned as another criterion of success. Finally, the extreme intrusive actions of use of legislation to obtain authority for the Public Guardian and Trustee to manage finances or to have an adult placed in facility care was also seen to be successful when it was considered necessary to address unacceptable risk for an incapable adult. In the words of one participant:

He was not in his right mind to make the decision. He could have been...hurt by staying there. So, yep I consider that a success. Not the way I would hope it could have gone. I wish he were more agreeable. But...he wasn't. And all the risks were there and his wife wasn't there to support him anymore.

### **The Organizational Structure**

Social workers interviewed for this study recognized many of the positive organizational efforts to date that have been put forward to support adult guardianship practice. Resources have been used to create consultant positions to advise staff, develop manuals and clinical decision-making tools, and provide education which were all strongly commended as being worthwhile and helpful. The Public Guardian and Trustee was also viewed as a source of support with their educational materials and workshops as well as their front line staff.

### **Inadequate resources.**

The list of resources that were described as lacking and necessary for effective practice was extensive and ranged across a spectrum which included the need for more staff who have the capacity to undertake the time consuming work, home support workers to provide support and assistance, additional housing and care options, emergency housing and care options, transportation, accessible and affordable legal planning tools for families, geriatric specialists, specialists to do at home assessments, assessment units, and educational resources for health care staff and members of the larger community.

### **Problematic structures.**

“It’s still too much of a wild west show. And it still feels too hodge podge,” is how one social worker expressed his/her dismay with the current lack of formalized standards and procedures to underpin the practice. While abuse and neglect of older adults may have been addressed at a macro level by the creation of new legislation, a corresponding change in Health Authority policies and procedures that support a functioning response did not necessarily occur. The participants in the study expressed examples of difficulties that could be traced back to a lack of support at an administrative level. Gaps in or absence of a formalized framework of designated responders; no system mechanism for red flagging high risk cases; managers who were unaware of the legislation and standards of practice and unable to adequately support their staff; job descriptions that are silent on the adult protection responsibility were some of the examples mentioned.

Inflexible service mandates that result from eligibility policies limit access to resources for support and assistance, as in the case of an older adult who does not meet the eligibility criteria for a home support worker that would provide support and assistance.

Furthermore, service mandates that require voluntary consent from vulnerable adults who may not have the insight or judgment to perceive their risk was mentioned as a concern; it was suggested that an outreach model of support and assistance to these types of clients may prevent adult guardianship situations from occurring in the first place.

One remarkable instance that demonstrates the lack of procedures underpinning this practice that requires social workers to improvise ad hoc solutions can be found in the following story from one social worker. This participant described having to write a letter to an emergency room physician that directed him/her to admit an older adult in need under the emergency clause in the adult guardianship legislation, in order to assure the physician of the legitimacy of the action. Also mentioned as a structural problem at the provincial level was the essential disconnect in planning that arises from the fact that the Ministry of Health which is responsible for the operations of health services is not responsible for the adult guardianship legislation; in fact it is the Ministry of the Attorney General that is responsible for this law.

### **Dual role.**

Particular mention was made of the fundamental conflict that arises from the structure of the dual health provider and adult protection role that results in disadvantages for the adult protection agenda. For example, adult protection statistics are difficult to collect, because documentation of the work is not centralized but is embedded in the files of the multiple services that exist across the complex structure of health authorities. Adequate training for the adult protection role has not been provided. Participants identified the issue of competing mandates and speculated on the question of how resources can be allocated to an adult protection purpose within a Health Authority structure with so many competing demands and

no accountability to an adult protection lens. One participant pointed out that the enormous cost to the health care system to obtain a support and assistance order through the courts may influence decision making in this area and present a conflict of interest for Health Authorities.

### **Participants' Recommendations**

Simply put, to summarize what the social workers said was lacking in this practice was sufficiently prepared personnel and support from the organizational structure to implement an effective response; their voices were united in an appeal for change. All the participants wanted to see social workers that were better equipped at all levels to respond to the demands of the work through: the provision of resources that have been lacking; more education and training; the development of standards; better support from consultants, supervisors, and managers; policies and procedures that enable, not interfere, with support and assistance; configuring collaborative paths with physicians; and opportunities to forum with provincial counterparts. More than one participant referred to the need for specialized adult protection roles within health care, either to act as designated responders, or as consultants who have the knowledge and skill to walk other staff through the issues. Skilled mentorship, which could be considered a feature of consultation, was described by one participant as being about the ability to critique performance without making an individual feel criticized, a skill of knowing when to push someone forward and when to hold someone back. One social worker pointed out that services with flexible mandates are required in order that a continuum of services can be offered, "to meet the continuum of capability."

The question of separating the adult protection role from health care versus remaining integrated was speculated upon, prompted by the apparent conflict that can occur between the

dual roles and the sense of deep concern with the considerable inadequacies of the practice. Some of the opinion was in favour of exploring the possible benefits of a separate adult protection service; other participants suggested the mandate could successfully remain in health care, but only if it were better resourced.

### **Wisdom Gained**

During the interviews, the social workers in this study made a number of insightful comments about what they had learned and what was helpful for practice. One of the participants stated that “basic social work skills” and “good broad psychosocial assessment skills” made a good foundation for social work practice in this area. Seasoning and experience was also said to be necessary. Reading was mentioned as helpful by someone else. One participant also made the point that social workers should also “take the initiative to educate ourselves.”

All of the participants discussed the usefulness of the manuals that have been developed, focusing on the idea that they provided general guidelines or “signposts” that made the job less overwhelming. However, many of the social workers also pointed out their limitations in that a step-by-step approach didn’t work for the complexities of practice and should not be a “straightjacket” for room was needed to allow for clinical judgment.

Connecting with others, either on your local team or through available sources of consultation was strongly emphasized as helpful. For example, “Don’t make the decision by yourself,” one social worker said. Making a point about the importance of remembering to consider the opinions of other colleagues, one participant made a particular effort to stress a personal lesson learned about how one should not “discount previous assessments,” referring to a case where the identified high risks associated with a case were underestimated when



they were not immediately apparent but then appeared afterwards without the appropriate supports in place.

One social worker remarked that part of doing a good job was to acknowledge the ethics, to realize “that there needs to be a balance between the right to autonomy and the ethic of care.” Another social worker commented about the use of deception.

Every time I’ve seen deception I’ve seen it go bad...I fully get why sometimes we need to deceive people in...the moment to make it safe so that we can intervene. But if you’re going to participate in some sort of deception for the greater good you have to come in really quickly with the truth telling.

The participants in this study also articulated a number of different maxims that spoke to the practice which included: be creative, keep an open mind, don’t panic, take time, don’t be afraid to ask for help, adopting a stance of “inquiry” versus judgment, and to consider how you would want your grandmother to be treated. And finally I would like to conclude this chapter with a particular comment from one of the social workers who said that it was important to remember that “it’s always a bigger story” and that “the truth is somewhere in the middle.”

## Chapter Five

### The Discussion

#### Meanings and Definitions

These stories depicted a diverse array of abuse, neglect, and self neglect circumstances that reflected many of the thoughts and ideas discussed in the literature review. The diversity of the stories reflects the wide variation of causes of elder abuse described in the literature review and provides support for Gordon and Brill's (2001) call for an integrated theoretical model. Moreover, Harbison's (1999) point about the limitations of the positivist approach to researching elder abuse is warranted. Abuse and neglect has many faces; it is not just the case of the unknown stranger that inveigles his/her way into an older adult's private life, or the example of the grandson who is desperate for money to support a drug habit, or the caregiver who has no capacity to discern someone else's need and manages the behaviour with abusive control. Self neglect is not just the older adult woman in a high rise apartment no longer able to remember to take her pills, or the old prospector with diabetes who lives miles away from health care services who is refusing to come into town, or the cat lady surrounding herself with ceiling high stack after stack of magazines, or the unmarried old logger living out his final years by drinking day and night in a cheap downtown hotel. Indeed, abuse, neglect, and self neglect encompass all of these variations and more. The social worker's remarks about working with the so-called abuser, who was also a vulnerable adult, challenges the powerful abuser/weak victim discourse and illustrates Harbison and Morrow's (1998) point about the dominant constructions of elder abuse being based on paternalistic assumptions and offers yet another facet of the elder abuse picture that needs to be accounted for in our explanations and interpretations.

The definitions of abuse and neglect arise out of relationship and are therefore contextual to the unique mutual expectations created by individuals in a relationship. A set of behaviours in a parent-child or spousal relationship may be considered appropriate in one circumstance, but a turn of the kaleidoscope and a shift in the lens can result in a similar set of behaviours being labelled as abusive. The very definition of self neglect points to our societal expectation and assumption that individuals will be responsible for their own care. Why the inherent expectation embedded in the terminology is maintained for individuals with cognitive and/or physical functioning abilities limited by various illnesses and disorders without appropriate supports is a matter for discussion beyond the scope of this thesis. But the point I wish to underline is that the phenomenon of abuse, neglect, and self neglect is contextual and that the struggle to capture it with a label, however broad the definition, risks oversimplification of the rich meaning in a cross cultural society. This also speaks to the hazards of expecting multiple unprepared health care providers armed with legislation to assess abuse, neglect, and self neglect, and interpret the meaning, each with their own unique disciplinary and cultural filters.

### **The Inadequate, Legislative, and Curative Response**

The literature spoke to the inadequate provision of services and the need for a continuum of services in order to satisfy the principle of least intrusiveness which are views that were further supported by these research findings. The arguments about the inadequacy of a curative approach (Harbison, 1999) and the ineffectiveness of a solely legislative response for the complexity of the issues (Harbison & Morrow, 1998) are worthwhile to consider here. Certainly, the participants' comments regarding the lack of support at the administrative level demonstrate the point about the futility of legislation that is not backed

by resources and processes to use the tools. However, it could be argued that the adult guardianship legislation in British Columbia was not reflective of a positivist and curative framework; the guiding principles guard against an oversimplified interpretation of the legal mandate and the legislation was based on the foundational belief that individual competence is not just a function of individual pathology, but also a person's social supports (Gordon, 2001). The constructs of abuse, capacity, and autonomy that underlie the legislation are complex though, and their meanings are not necessarily shared which is illustrated by the participant's comments about how everyone stands on the autonomy side of the room. Despite their lofty goals, these foundational, but abstract and intangible principles do not appear to be sufficient to counteract the prevailing culture of the under resourced health care system which was described by many of the participants to be curative in nature and predisposed to respond in all or nothing fashion. In other words, even if the legislation did extend beyond a simplistic diagnosis and treatment framework, without the appropriate training, resources, and process the end result is the same.

### **Relationship and Autonomy**

The inextricable link between autonomy and relationship discussed in the literature review (Bergeron, 2006; Clement, 1996; Manning & Gaul, 1997) was well portrayed by the ample instances of social workers building relationship and the central role it played in the practice. Clinical savvy, creativity, and acting as a health provider were tactics used to get in the door, engage with the adult, and assess the circumstances. Without a relationship, the social worker cannot even begin to know who the older adult is, what the older adult wants, and the values that must be inserted into the risks and abilities equation. Every relationship that a social worker forms with another individual is an act of creation; an opportunity is born

for a new beginning, a making room for the individual self to conceive a new way of being in the world. The nature of this unique exchange cannot help but affect the self's capacity to express itself when the public domain crosses the threshold into the individual's private world.

Relationship building is the platform for how the social worker begins to get to know the individual they are working with. The theme, *Getting to know the adult*, is a portrayal of social workers acquiring and using what is referred to as narrative knowledge (Clark, 2001; Gass, 2001). Narrative knowledge is defined as knowledge of the particular as contrasted with paradigmatic knowledge where details are collapsed into abstract models (Clark, 2001; Gass, 2001). Narrative knowledge is thought to have the depth of understanding that allows a better understanding of connections, contradictions, and the noncommensurate aspects of life choices (Gass, 2001). This way of knowing is considered a preferred resource for clinical decision making, particularly in the area of complex ethical dilemmas, which ultimately improves health care for older adults (Clark, 2001; Gass, 2001). Appearing to directly echo this argument for the value of narrative knowledge, are the participants' own comments about their belief in the importance of knowing and understanding the world of client in vivid detail; they expressed that this way of knowing assisted with decisions on how to move forward and how to balance the ethical principles of autonomy and care.

Superficial, and possibly inaccurate, impressions of an adult's capacity to choose to live at risk are the potential outcome of inattention to the foundations of engagement and relationship building. In order to form a reasonable opinion about an adult's ability to choose, social workers must have time to build trust and get to know the client and understand the multitude of factors that underlie their choices. Furthermore, Bergeron (2006)

points out that for older adults whose capacity to engage in relationships is impaired, the social worker may withdraw without sufficient time to complete the picture. The remarks from the social worker about the client who was easy to support because he was likeable are particularly striking. It is not farfetched to suggest that the clients who are unable to elicit a connection in the health care provider may be perceived incompletely or differently and receive a different response from the system than one who does; this resonates with the comments in the literature that contend that the client's likeability and ability to form a relationship may influence the degree of service that is provided (Bergeron, 2006; Galambos, 1997).

### **Respect for Autonomy and Care**

The social workers in this study, not surprisingly, expressed high regard for the value of autonomy. Not only would this be expected, because this value is so fundamental to the profession of social work, but the right to self-determination is also a commonly held belief in contemporary western culture. However, the social workers in this study also demonstrated substantial support for an ethic of care. They showed concern for older adults living at risk and who had refused support and assistance and made efforts to stay connected. They were also in support of actions on the upper end of the continuum of intrusiveness when there were justifiable circumstances, which is consistent with the other research on social workers' attitudes about autonomy.

The balanced support for both autonomy and care and avoidance of the either/or scenario that was evident in the results is precisely what Healy (1998) argued is required to resolve ethical dilemmas. The literature points out though, that social workers support for protection and care over autonomy is not widely acknowledged, and that there is a lack of

guidelines to assist social workers with this complex decision making. The question of what these participants thought about the wider social work profession's support for overriding autonomy when necessary was not probed specifically in the interview and may have proved to be a rich area for examination.

### **Avoiding Intrusiveness and Finding the Middle Ground**

The decided preference of social workers for coaxing the client into accepting services in order to avoid intrusiveness deserves significant focus. A comment by a participant in this study was remarkably similar to one from an adult protection service worker quoted by Bergeron (2006). Compare: "you failed at the sales job" and "I work real hard to sell myself [to the client]," (Bergeron, p. 90). These two workers practicing in different times and countries with differing legal and health care contexts expressed a similar approach to the work, which is possibly the result of parallel organizational directives or the natural outcome of the lens that a professional with a particular set of values brings to the work.

The participants in this study were able to express and illustrate how two central ways of avoiding intrusiveness mentioned in the literature, negotiated consent (Bergeron, 2006) and accompaniment as the ideal middle point in a practice continuum model (Beaulieu & Leclerc, 2006), are realised in actual practice. Remarks about their aversion of the "all or nothing" solutions, skills to negotiate degrees of change, and the tactics used to facilitate the system to provide the middle ground, compromise solutions where they are able, demonstrated the effort that is made by social workers to be respectful of individual choices and take the extra steps to avoid seizing full control. However, as Bergeron (2006) pointed out, the challenge of unearthing the middle ground is locating the range of alternatives for

older adults from which to choose. It was clear in the comments of these participants that here in British Columbia there are serious concerns with the adequacy of existing services and definite challenges in satisfying a continuum of need.

### **Is the Least Intrusive Principle Always a Good Thing?**

Woven throughout the data was an abundance of ways that social workers have found to practice least intrusively. Framing the adult protection role as offering support and assistance, searching for ways to provide degrees of assistance to avoid the all-or-nothing scenarios, and mitigating the impact of intrusive interventions appear to be examples of the authentic realization of the least intrusive principle.

Linked to the principle of least intrusiveness is the role of the health care provider. Providing support and assistance is a normalized feature of the health care provider role. So while the legislation imparts the obligation for least intrusiveness, the fact that health care providers are enacting the legislation within the health care context means that there is an additional layer of least intrusiveness that is knotted up with the guiding principle. The participants in this study described how using the role of the health care provider assisted them to practice least intrusively; they also said that this approach was highly successful most of the time.

However, the following question should be asked: if the least intrusive principle is the greatest strength of this legislation, might it also be considered its greatest weakness? The least intrusive principle is a more comfortable stance for most social workers. Is it possible that the stance of least intrusiveness might paradoxically result in more harm?

The land of least intrusiveness encompasses a vast and subjective territory. The practical meaning of the concept can vary tremendously from case to case, from social



worker to social worker. In the everyday business of workloads, least intrusiveness may blur the roles of health care provider and adult protection, may blur the lines of decision making between informal offers of care and formal legal responses with prescribed steps that must be taken to ensure that the correct requirements are followed. Work may begin with a client in an informal manner, but do social workers recognize when their role shifts and remember to operate with a different set of rules? Increasing the potential for confusion is the fact that social workers are using interventions across the continuum of practice from least to most intrusive, a composite of actions that cross the health care provider and adult protection line. For example, do social workers whose practice is to persuade older adults into accepting an involuntary intervention such as the Public Guardian and Trustee taking on management of their financial affairs, ever forget that this intervention is in fact a permanent removal of individual rights? If this happens, are the necessary steps to ensure an adequate process is followed overlooked? These cases necessitate a continual shifting between the two lenses, which increases the risk of confusion and possibility of error.

The guiding principle of presumed capability means that disability is not automatically equated with incompetence and works hand-in-hand with least intrusiveness. It discourages the automatic appointment of permanent decision makers and encourages the finding of middle ground support and assistance solutions for adults who may be incapable. However, the fact that there may not be one permanently appointed decision maker to manage every decision that may arise has increased the complexity of understanding required for knowing who has the authority to make a decision when one is required; the separate and differing processes that come into play for individual circumstances, depending on the decisional domain and factors unique to that situation, adds an additional layer of intricacy.

Without well-defined legal labels for capable and incapable adults, there is a resultant blurring that can cause uncertainty, confusion, and errors.

When health care providers look into reports of vulnerable adults experiencing abuse, neglect, and self neglect, the fact that the legislation sets out the expectation that an adult's capacity is not questioned until the adult refuses support and assistance places the onus squarely on the health care provider to determine whether the support and assistance plan is appropriate and involves an acceptable level of risk. When vulnerable adults agree to the support and assistance being offered they may not be capable of informed consent; they may be assenting to support and assistance and any associated risks that they do not understand or are capable of managing. In other words, if there is not an appointed and appropriate decision maker, it becomes the judgment of the health care provider staff from the health care system to determine the suitable level of support and assistance for an individual and the degree of risk that is appropriate. As one of the participants pointed out, a standard legal process is only used when a designated agency is applying for a support and assistance order for an incapable adult who has refused support and assistance. As this process is for the most part not being used, standards to guide the decision making of health care providers are lacking with regard to defining the threshold of when to suspend the presumption of capacity and assess for incapacity.

Also of concern is the lack of clarity that may arise directly from the dual role between adult protection and health care. Using the health care provider role allows social workers to engage non intrusively and fulfill the adult protection agenda. The adult guardianship legislation gives the health care provider a mandate to engage with the adult and offer health care services, which supports the role as a health care provider. The

question is: do older adults understand the mixed agenda when the social worker knocks at the door? Conversely, do the social workers themselves know from which agenda they are working? Or perhaps the two purposes are so integrated as to be inseparable, and if that is so, does it matter? The social workers' comments about deception, illustrate the potential concerns about what degree of explicitness is necessary when explaining the purpose of their presence in an individual's home. The degree to which a social worker should be explicit, the conditions for which it is critical that their purpose is fully understood, and the circumstances that would increase the risks of fully disclosing an adult protection purpose remain ambiguous, and a thorough discussion of the issues would be helpful. Furthermore, the conflict between the two roles travels more than one way. The adult protection role can also interfere with the health care provider role. The participants referred to the idea that if care was not taken with initial engagement this could impact negatively on the ability of health care providers to offer routine health services.

Complexity and ambiguity is the state of this current ethical and legal climate and the risk for error is high. A case that happened in the province that ended in spectacular failure could be argued as caused, at least in part, by least intrusiveness and the dual role of health care and adult protection<sup>3</sup>. An older woman had been admitted to the hospital under the ruse of medical treatment due to concerns about care from her spousal caregiver. Her spouse removed her from the hospital without anyone's knowledge and took her home where he ended her life and took his own. This tragedy is an example of how least intrusiveness can go awry. The adult was admitted to hospital for a purpose that was not made explicit to the

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<sup>3</sup> The names and identifying details of this case have been protected to respect the privacy and confidentiality of the family. The case was subject to a coroner's report and general facts were discussed at the 2009 BCASW conference for professional development purposes.

caregiver, a decision justified by the principle of least intrusiveness. In most cases this intervention would have addressed the issue and that would have been the end of the story. In this particular case though, it was an action that led to more harm. Precautions such as increased security were not used which are actions not typically used by the hospital as its reason for being is typically health care and not adult protection. Actions such as full disclosure, increased security, and understanding the potential for violent reaction belong to the expertise of an adult protection role. In this case, the professional responders acted in their dual role of health care provider and adult protection, using least intrusiveness and a health care resource not designed for this alternate purpose. The result was a tragedy, traumatizing for all involved. In hindsight, it can be argued that this case is an example where the least intrusive principle was not appropriate and full control should have been used. Perhaps there are other cases where it is justifiable to step forward and unapologetically take control. Questions need to be posed and debated. Do the stance of least intrusiveness and the role of the health care provider interfere with recognition of the circumstances where immediate and full control is necessary?

In summary, although the least intrusive principle and the role of the health care provider can be argued to be advantageous and ethically preferable, the inherent qualities of flexibility and ambiguity may also lead to multiple interpretations and blurred understandings which result in confusion and error. Failure to follow appropriate process if control measures are eventually required may also result. The emphasis on least intrusiveness and the health care provider lens may also contribute to the lack of recognition of circumstances where taking immediate and full control is critical in order to protect.

### **Assessing Incapacity**

The comments of the social workers referenced the many difficulties that hinder smooth practice and prevent the theory of the law from being fully operational. Comments were made about the lack of shared understanding of capacity, difficulties with the role of the assessor, the power and status attached to the physician's role, how the information is constructed for the assessor, and a lack of understanding how the interface of the medical process of assessing incapacity and the legal process may vary with the legislation that is relevant to the case.

The social workers in this study clearly understood and supported the principle of last resort for incapacity assessments with their expressions of reluctance to take this step, preferring to persuade older adults into accepting support and assistance. Furthermore, the social workers also reflected an appreciation for the complexity and risks inherent in the process to make determinations about incapacity. The comments about the older adult whose refusal changed to consent once they were in a safe place is significant, because it demonstrates the point about the complexity of reasoning that underlie refusal (Bergeron, 2006) and the need to consider the influence of disempowerment on individual decision making (O'Connor, Hall, & Donnelly, 2009).

Definite concern was voiced in some cases about the accessibility of incapacity assessments when they were needed. This appeared to be caused partly by the lack of physicians who were prepared and comfortable with the role. Frustration was also experienced when social workers felt that physicians ignored or dismissed their knowledge of when a client was in need of an incapacity assessment. Moreover, regarding the comments about physicians not being specifically named in the Adult Guardianship Act as having the

power to assess incapacity, as long as the hospital continues to be the resource that is used for placing an incapable adult at serious risk of harm in an emergency, the fact that the law did not exclude other disciplines from having a role in assessment is irrelevant, because in the health care system the physician is the only member of the team who has the power to admit an individual to the hospital. This point is significant, because it speaks to the fundamental dissonance between the current written law and how it is operating in actual practice.

While the adult guardianship legislation mandates designated agencies to respond to vulnerable adults experiencing abuse, neglect, and self neglect, the actual support and assistance that is provided to incapable adults may require drawing in other legislation. The assessment path for each of these laws differs in process and standards. The results of this research are consistent with the widely understood perception that instead of the Adult Guardianship Act, designated agencies are using the Mental Health Act for placing older adults in facility care when they are refusing to consent. Only one participant in this study referred to assessing incapacity for the purpose of obtaining a court order and this was referring to the one case that had occurred in that Health Authority a number of years previous. The reasons for the underutilization of court ordered support and assistance are plentiful and are not a primary focus of the research. But in order to understand the lack of coherence in the incapacity process, it is necessary to understand that the practitioners are working with a varied assortment of applicable law, not written with the same cohesive purpose and principles, and not necessarily designed for the purpose that it is being used. For the incapacity assessment process to run effectively it requires the tools of the law to harmonize with the institutions that enact their intention; the role of assessor needs to be aligned with the power structure of the system that is being utilized. The qualifications for

those fulfilling the role of assessors need to be clearly defined, and those who act as assessors must be educated in the process and accorded the power necessary to perform their function. The results in this study would suggest that there are many miles to walk before this will be accomplished.

### **Addictions**

“What are we going to do about booze?” one of the participants asked during the interview with equal mixtures of perplexity and frustration. Indeed, it is an excellent question. At the current time in our society, we appear to believe that overriding autonomy is not justifiable in cases where the incapacity is temporary and due to the use of substances. Part of the hands off policy seems to be a result of the belief that individuals have the right to live without interference from the state, even if their lifestyles and choices include damaging substances. There is a sense that individuals need to be free to make their own choices and experience the consequences of those choices. Aside from this philosophical position, the practicality and ability of the state to effectively control individual substance use is debatable.

This position of non-interference is somewhat problematic when working with individuals who are aging and are dependent on others to assist them with their day-to-day functioning. It is the intersection of the public and private domains; a vivid example of the collision of the individual’s right to choice and society’s obligation to provide care. When older adults or their caregivers experience issues with problematic substance use to the extent that providing care becomes either impossible, unbearable, or hazardous, health care providers are refusing to engage. This does present an ethical conundrum when the older adult also cannot continue to function without assistance. In other words, does the ethical

equation shift when the community is not able to fulfill their obligation to provide care for a vulnerable adult whose use of substances is causing a barrier? Further complicating this picture is the theory that, if an adult is permanently incapable by reason of another mental disorder, separate and apart from the substance use, there is justification to declare the person financially incapable and have a Committee of Estate appointed. However, to assess the incapacity of an adult with a chronic substance use issue when they are not under the influence of the substance is very difficult to accomplish in practice. The concept that society will not interfere with individual choice around substance use does risk reducing the concept of substance use to an unencumbered choice and resists conceptualizing substance use as an illness that requires treatment.

Is it right that society refuses to fulfill its obligation to care for the vulnerable when individual choices create these barriers? Is it right that society doesn't control individual choices, when vulnerable adults place themselves at such risk? Why has society decided that the individual who has decided to end their life with one swift measure will be brought to hospital against their will, but the individual who decides to kill themselves inch by inch with harmful substances will not be accorded that same response?

### **Practice Wisdom**

The wisdom expressed by the social workers about the nature of their practice and the approaches that proved useful were remarkably similar to the literature. They spoke about tolerating risk, avoiding the extremes of all-or-nothing solutions, creativity, the helpfulness of general guidelines, an open mind, taking time, using the team to discuss options, all of which was discussed in the literature review. The coping strategy of recognizing that they do the best they can is comparable to Taylor and Bentley's (2005) comments about the need to



recognize good enough practice. Taylor and Bentley's ideas about accepting complexity and willingness to sit with dilemmas, and Rowe et al.'s (2001) comments about the clinician's need to accept ambiguity also resonated in these results. The social workers' descriptions of the rich varied texture of their work and their observations of practice as being "shades of grey" and "not black and white" are indicators of their appreciation for the complexity and ambiguity of the practice, and perhaps to some degree their acceptance as well. The participants were not asked about whether they felt accepting of the ambiguous nature of the practice, but this would have made for an interesting discussion.

The comments about the inappropriateness of the "cookie cutter" template and the ineffectiveness of step-by-step methods highlight the possibility that rational models built with formulaic type of procedures will not be helpful for practice. Decision making in the context of this practice requires fluidity and flexibility. Not only are no two cases exactly alike, but the principles may apply differently to the same individual over time. It is reasonable to suggest that the social worker with a low tolerance of ambiguity and a desire for clear laid out paths will experience high anxiety in this practice. This discussion speaks to the argument that this practice requires experienced social workers with clinical skills and expertise more than the development of clinical formulas for application. It requires the kind of clinical expertise that Parton (2003) refers to in his article about rethinking professional social work practice with an ethic of care lens. He makes a case for acknowledging that rational approaches that call for the application of correct rules and procedures to resolve problems have limited usefulness in the real world of complexity and uncertainty; he calls for social workers to have comfort with ambiguity, expertise in forms of process and relational knowledge, and willingness to engage in a process with an uncertain outcome.

### **Insider Role**

As mentioned earlier in the methodology chapter, qualitative researchers have argued that a different set of criteria are needed when evaluating the merit of a qualitative research project. Reflexivity and bracketing are two strategies that have been proposed by qualitative researchers as increasing the trustworthiness of a research project (Creswell, 1998; Jacelon & O'Dell, 2005; Patton 2002). Reflexivity is a term that has been used in the literature with a wide range of meanings, but is generally understood as a process where the researcher reflects on their own preconceptions, beliefs, and values and how that may influence the results (Jootun et al., 2009; Patton, 2002). According to Hertz (1997), reflexivity is achieved through detachment and internal dialogue (as cited in Jootun et al., 2009). Bracketing is the process where the researcher puts their beliefs aside and requires the researcher to engage in a reflexive process (Jootun et al., 2009). Bracketing presumes that researchers are able to fully separate themselves from the research, but it has been argued that the reflexive researcher understands that true detachment is somewhat illusory and that their responsibility lies in making every effort to articulate and make the influence of their presence in the data transparent (Jootun et al., 2009). Qualitative researchers have argued that the experience and the insights of the researcher are a legitimate and vital component of research knowledge construction (Jootun et al., 2009; Patton, 2002). Moustakas, a central author in heuristic inquiry, stated that “the self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self discoveries” (as cited in Patton, 2002, p. 107). A reflexive analysis that includes the researcher’s knowledge, particularly when the researcher is an insider, creates

the opportunity for new and deeper integrated understandings of the phenomenon to unfold (Jootun et al., 2009).

Throughout this thesis I have made an effort to identify and articulate my values, assumptions, and beliefs about this subject in order to demonstrate how they may have influenced the research findings. In all likelihood, my position as an insider influenced this research significantly, from the choice of the research question, to the data collection, and the analysis and the conclusions. The choice of the subject matter arose from my own wish to reflect on practice with which I am intimately familiar. When conducting the interviews the participants were able to speak freely and quickly, knowing that I understood the practice dynamics that they were describing. The familiarity of the stories shared resounded fervently in my own breath and bones. The final themes that were derived can be detected in the transcript of the oral interview I conducted on myself prior to interviewing the participants. My intimate knowledge of this practice may have allowed me to ask more informed follow up and clarification questions which resulted in drilling further into the subject matter and arriving at a deeper understanding. While engaged in this research project, I continued to work in this practice environment on a daily basis, providing me with plentiful opportunities to consider the participants thoughts and examine my shifting perspectives within the practice reality.

It is also true that the disadvantage of the insider role lies in an inability to surface the tacit knowledge, which is the understanding that we are unaware of because it is so deeply embedded. However, I will argue that this learning voyage was more than a recreation of my own preconceptions. Throughout the process I took care to reflect on my own thoughts, querying their origin, differentiating between my ideas and those of the participants. A

journal was used during the data collection and analysis stage. The writing of this chapter was the continuation of an internal interrogative process where the question of how I knew what I knew was posed. I do not share all the ideas expressed by the participants, and I did not anticipate some of the findings that were obtained. I also did not suspect that I would begin to question deeply held beliefs about the merit of locating and embedding adult protection within health care.

### **Limitations and Further Research**

A limitation of this study is the choice to focus on social workers. The mandate for adult guardianship practice falls to many disciplines who work within the Health Authority. Physicians, nurses, psychologists, rehabilitation professionals are other professionals who may become involved in an adult protection situation through their work. For the purpose of this study I concentrated on the experiences of social workers, because I wanted the work of my thesis to contribute to the profession of social work, particularly in relation to the application of the key social work principle of self-determination. While some of the participants of this study emphasized the tendency of their medical colleagues to override autonomy, my own experience is not entirely similar. To state that social workers emphasize autonomy in comparison to other health care providers is overly simplistic; however, a more detailed comparison of adult guardianship practice across disciplines would make an interesting subject for future research.

The social workers that volunteered to participate in this study are most probably not representative of all social workers in the province that are involved in adult guardianship practice. While the data is rich in details and illuminates an up-close truth for the practice of some social workers, it does not express the voice of all social workers, particularly those

who are unaware or hostile about the nature of this work. These social workers may not have been made aware of the opportunity to participate, or if aware may not have felt willing or comfortable with reflecting upon their practice. Therefore, the findings of this study cannot claim to represent the full spectrum of opinion or awareness of the subject matter. Research that aims at social workers and other health care providers that are less comfortable with material would illuminate further problem areas that could be addressed.

Although the subject of my thesis is quite specialized, it is clear that within the parameters of a one hour interview the scope of the research question was still quite broad. It was not possible to drill down into detailed decision making for each case. A single case study research design may allow for a more thorough examination and explication of the numerous variables that impact on decision making. Alternatively, a research design that compares decision making across cases with similar fact patterns may yield an in-depth analysis of decisions and interventions that are effective for certain types of cases. Grounded theory methodology allows for returning to the field for further sampling in order to explore and refine theoretical concepts that arise in the data. If such a methodology had been used in this study, the notion of the paradoxical harm that may result from least intrusiveness could have been explored with the participants and developed further.

The value of research is limited if the knowledge is not returned and used in the community. The results of this study have already impacted my own practice; the thematic structure and insights gained have informed and will continue to inform educational efforts in Northern Health. Findings will also be shared in the wider community via oral presentations and articles yet to be written. A presentation about this study was conducted at the 2009 BC Association of Social Workers annual conference; another presentation is planned for the BC

Psychogeriatric conference in April 2010. A summary of this research and the findings will be sent to the participants and key stakeholders in the hopes of initiating further dialogue and promoting positive change.

### **The Future**

The results of this study demonstrate the need for resources and attention to the lack of a supportive organizational foundation for this work. One of the most fundamental questions raised about the organizational structure related to the appropriate location for the adult protection mandate. The findings from this thesis have caused this researcher to examine her assumption that the embedded adult protection role in health care is a feature of the legislation that should be whole-heartedly endorsed. While the least intrusive principle and the use of the health care provider role are clearly successful in many, many cases, it is also evident that the dual role and competing mandates are responsible for less desirable results. The results of this research would suggest that for the agenda of adult protection practice to move forward, it either requires its own separate structure or major attention within the health care system. One does wonder though, that if the work of adult protection were extracted from health care, would the principle of least intrusiveness evaporate without the partnering of the health care role? Wherever adult protection is located though, undoubtedly there will be a role for social work.

## Chapter Six

### The Conclusion

The title of this thesis questions how social workers know the difference between autonomy and abandonment. The findings from this study suggest that social workers do know the difference, at least according to contemporary interpretations of autonomy. Furthermore, the results demonstrated that social workers support both self-determination and an ethic of care and attempt to balance the two principles through building relationship, getting to know the adult, and finding least intrusive solutions by facilitating flexibility of the system and negotiating degrees of change. The participants in this study also expressed support for intrusive action when incapable adults are living in high risk circumstances. Of course whether or not social workers have the means to make a difference in all these cases is a separate question altogether. Barriers to making a difference were concerns related to inadequate resources and problematic structures. Other challenges that were identified included addictions issues and the dual role of adult protection and health care provider. Strengths and weaknesses associated with the principle of least intrusiveness were explored. Social workers expressed an appreciation for the complexity and ambiguity of their practice and highlighted how the usefulness of applying clinical formulas is limited; the qualities of fluid and flexible decision making skills and comfort with ambiguity are critical for practice.

I chose this subject for my thesis, because I wanted to understand this perplexing practice in a deeper way. There may even have been the faint glimmer of hope that if I did enough thinking and enough writing ambiguity would magically transform into crystal clarity. Predictably, perfect enlightenment did not transpire, but my personal perspective did shift and deepen. Prior to my research it was my belief that our social systems are

abandoning individuals who are suffering. It is not so much that I am an advocate for absolute care and control, but I am horrified daily about the lack of basic routine supports for adults with disabilities. I am aware of the existence of attitudes that suggest that if individuals with disabilities are not independently initiating engagement with a health and social service system this is somehow construed as choice. It is my contention that a social service system that expects individuals who have disabilities that interfere with insight and judgment to knowingly take responsibility for seeking out their own services is a case of the community forsaking the obligation to care for its members.

While the participants in this study did refer to concerns similar to what I just expressed, the findings from this research also illustrated the risks on the other side of the care equation and reminded me how narrow the line is between appropriate care and abusive control. From the stories I heard and my own personal experience, I believe that apprehension about the system's tendency to roll over on individual choice is valid and well placed. However, I would argue that caution and suspicion is required not just for the decision to act, but also for the decision not to act. The history of social work's relationship to the principle of self-determination reflects the influence of the surrounding belief systems of the time, an indicator of the principle's susceptibility to political influence and not an underlying morality. Social workers are all too aware how an under resourced system may be eager to use a high sounding principle to rationalize its restriction of resources. The profession of social work is called to uphold both autonomy and care; the Code of Ethics recognizes that the right to self-determination is not unlimited. In order to support social work practice in this area, a space for conversation about the validity of social work support for ethical restrictions on autonomy needs to be opened up. While the results of this study



may suggest that the health care environment is predisposed towards control and benefits from the voice of advocacy for autonomy, I do not believe that all health care providers can be painted with the same broad brush. The participants in this study did refer to colleagues who shared similar attitudes. Social workers will need to develop partnerships with all their colleagues in other disciplines in order to build and broaden harmony and accord. A wider shared understanding across professional disciplines will contribute to the knowledge base, develop a consensus on a definition of intolerable risk, shed light on any practices that are in fact unethical, gather support for ethical intrusion, and assist social workers to understand the difference.

Autonomy versus care is a universal dialectic, a perpetual paradox. How social workers can balance these oppositional principles is an infinite riddle with no one right answer. It is somewhat like the concept of making a type I or II error in quantitative research. No matter what the decision, there lies the risk of committing an error on either side of the equation. If a social worker chooses to stand aside and respect the autonomy of an individual to make his or her own choice, the risk exists that autonomy is actually the abandonment of an individual who may benefit from someone reaching out. Conversely, every time a social worker chooses to decide in favour of insisting on care, there exists the chance that the action was an inappropriate violation of someone's autonomy. Choosing which error is more serious will depend on the context of the circumstances and is ultimately a value judgement. However, this way of framing the riddle is a false dichotomy. Not every adult protection circumstance is an all-or-nothing scenario, as the participants have pointed out so beautifully. Care can be balanced with autonomy, constructed to be respectful of individual choices. Social workers can support both autonomy and care by taking

responsibility for the reaching out, by slowing down and gathering the narrative puzzle pieces to complete a fuller picture, and waiting to discover the solutions that will open up the middle ground. This balancing act depends on versatility and improvisation, a kind of ethical jazz. The performance is a composition of knowledge and decisions, never executed the same way twice. However, social workers aspire to better practice, and they need a better foundation from which to work. In order to carry the practice forward within the health care system, changes are required.

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## **Appendix 1: Interview Information Sheet**

### **ABANDONMENT OR AUTONOMY PARTICIPANT INFORMATION SHEET**

#### **Project Title**

Abandonment or Autonomy: How Do Social Workers Know the Difference?

#### **Purpose**

The purpose of this qualitative research project is to describe how social workers make decisions when looking into reports of older adults in situations of abuse, neglect, or self neglect. Social workers are required to balance important, but oppositional ethical principles in this type of work: the right to autonomy and an ethic of care. The goal is to generate information that describes the experience, effective strategies, and barriers encountered in adult guardianship practice that will contribute to building knowledge in this field. The researcher is a graduate student at UNBC and a social worker who has worked in the field of elder abuse and neglect. This thesis research is being conducted for the partial fulfillment of the requirements for the degree of Master of Social Work.

#### **How Respondents Were Chosen**

You were asked to participate in this study because you are a social worker who is currently or previously has been employed by a Health Authority in British Columbia and have had at least two years of experience in responding to reports of older adults in situations of abuse, neglect, or self neglect.

#### **What Will Respondents Be Asked to Do?**

If you agree to participate in this research, you will be asked to participate in a telephone interview that will take about 1.5 hours to complete. The interview will be an opportunity for you to discuss your experience with making decisions in adult guardianship practice. Prior to the interview, I will send you a copy of the interview questions and some background material, a short summary of academic thought on the topic, in order to promote discussion. Before the interview, it may be helpful for you to reflect on examples of cases where different levels of intervention were employed, i.e. the adult accepted support and assistance, the adult refused support and assistance and no further action was taken, the adult refused support and assistance and further intrusive action was taken, and situations where available support and assistance could not solve the problem. The telephone interviews will be audio-recorded, and I will also make written notes. The audio recordings will be transcribed into text without any identifying information. A paid assistant may be used to help with transcribing the recordings. If you wish, transcripts of your interview will be made available to you for feedback in order to verify the accuracy of the text.

### **Potential Risks and Benefits**

The potential benefit of participating in this study is that you will have the opportunity to critically reflect on your practice with a social work colleague and to contribute to the social work profession by sharing your knowledge and experience. Also, a copy of a summary of the research findings will be provided on request. The primary risk that may be experienced in participating in this research project is the inconvenience associated with donating your time.

### **Voluntary Participation**

Your participation in this interview is voluntary. If there is any question that you do not wish to answer, you have the right to skip the question. You have the right to withdraw from the interview at any time without explanation. If you choose to withdraw, your information will also be withdrawn.

### **Who Will Have Access to Your Responses?**

Only my academic supervisor, Dawn Hemingway, the transcriptionist that may be used, and I will have access to the consent forms, audio recordings, transcripts, and written notes.

### **Storage of the Information**

Information obtained in this research project will be stored in a locked filing cabinet in my home and in password protected files on my computer. Consent forms will be kept in a separate location from the transcripts and notes. Interview transcripts, notes, and audio recordings will be retained for five years after the completion of the study at which time the paper data will be shredded and the audio files will be deleted.

### **Anonymity and Confidentiality**

Your anonymity and confidentiality will be protected. The researchers will not disclose the identity of the research participants. If a transcriptionist is used, he or she will be asked to sign a confidentiality form. Identifying information on the consent forms will remain confidential and be protected by storing the forms separately in a locked cabinet. No identifying information will be used in the transcripts, analysis, or final report. Pseudonyms will be used instead of names. Any quotations used in the final report will not be able to be linked to an individual or a specific location.

### **Concerns or Complaints**

If you have any concerns or complaints about this research project, you may contact the UNBC Office of Research by phone at 250-960-5820 or by e-mail: [reb@unbc.ca](mailto:reb@unbc.ca).

### **Access to Research Results**

At the conclusion of this study, all participants will be provided a summary of the research findings upon request.

### **Contact Information**

If you have any further questions about this study, please e-mail or speak to **Louise Holland** or her thesis supervisor, **Dawn Hemingway**. Our contact information is provided below.

**Louise Holland, MSW Student**

**Address: c/o Dawn Hemingway, UNBC School of Social Work,  
3333 University Way, Prince George, BC V2N 4Z9**

**Phone: 250-960-5824**

**Fax: 250-960-6764**

**E-mail: [holland-l@shaw.ca](mailto:holland-l@shaw.ca)**

**Dawn Hemingway, Associate Professor**

**Address: UNBC School of Social Work,  
3333 University Way, Prince George, BC V2N 4Z9**

**Phone: 250-960-5694**

**E-mail: [hemingwa@unbc.ca](mailto:hemingwa@unbc.ca)**

Thank you for your time and consideration. If after reading this information you wish to participate in this research project, please contact me to arrange an interview. Please read and sign the attached informed consent and fax or mail to myself at the above address.

**Please keep a copy of the information sheet and your signed informed consent for your own use.**

## Appendix 2: Informed Consent

### ABANDONMENT OR AUTONOMY – INFORMED CONSENT

**Please circle Yes or No**

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached information sheet?	Yes	No
Do you understand that the research interviews will be recorded?	Yes	No
Do you understand the benefits and risks involved in participating in this study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or to withdraw from the study at any time? <i>You do not have to give a reason.</i>	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to the information you provide?	Yes	No
Would you like a copy of the summary of findings?	Yes	No

This study was explained to me by: \_\_\_\_\_  
*Print Name*

I agree to take part in this study:

\_\_\_\_\_  
*Signature of Research Participant* Date: \_\_\_\_\_

\_\_\_\_\_  
*Printed Name of Research Participant*

\_\_\_\_\_  
*Signature of Witness* Date: \_\_\_\_\_

\_\_\_\_\_  
*Printed Name of Witness*

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

\_\_\_\_\_  
*Signature of Investigator* Date: \_\_\_\_\_

**Participant's contact information:**

**E-mail address** \_\_\_\_\_ **Telephone number** \_\_\_\_\_

**Please fax completed consent form to: Attn: Dawn Hemingway @ 250-960-6764 or mail to Louise Holland, c/o Dawn Hemingway, UNBC School of Social Work, 3333 University Way, Prince George, BC, V2N 4Z9.**

### **Appendix 3: Interview Protocols**

#### **Interview Guide**

- 1. I want to begin by just getting some information about who you are, the experience you bring to the work, and the nature of the community where your practice.**
  - Gender
  - Level of social work education
  - Years of social work practice
  - Years of experience working with vulnerable adults
  - Years of experience as a designated agency responder for adult abuse and neglect
  - Amount of education received specific to adult guardianship issues
  - Size of community
    - i. Population
    - ii. Described as urban or rural
    - iii. Extent of geriatric services in the community
    - iv. Any special characteristics about the community.
- 2. Can you tell me about how you begin an investigation? What are some of the standard approaches you use? Is this specific to a formal Designated Agency response?**
  - E.g. collecting collateral, getting to see the adult, engagement strategies etc.
- 3. I am going to ask you to tell me about some specific examples of adult guardianship situations for different levels of interventions.**
  - When the older adult accepted non intrusive levels of support & assistance, e.g. home support services, informal banking arrangements, referral to other services, etc.:
    - What kind of support & assistance services?
    - Any examples of improvisation?
    - Were particular approaches necessary from the social worker for the client to accept services?
    - Was that considered successful or not?
  - When the available forms of support & assistance that would have solved the problem did not exist:
    - What support & assistance would have solved the problem?
    - Any examples of improvisation?

- When the older adult refused support & assistance and no further action was taken:
    - How do you respond when a client refuses?
    - Was that considered successful or not?
    - Should further action have been taken?
      - i. Was the capacity of the client in question?
    - Any examples of improvisation?
  - When the older adult refused support & assistance and further intrusive action was taken:
    - What kind of intrusive actions were taken?
    - What led to the decision to take the intrusive action? What was that decision like to make?
    - Should further action have been taken?
    - Was that considered successful or not?
  - When the older adult refused support & assistance, no intrusive action was taken, and if you made the decision today it would be different.
- 4. Can you describe for me the way you have found to balance the right to autonomy with an ethic of care that feels right for you?**
    - How important is autonomy to you in the autonomy/care equation?
    - Are there times when the decision to respect autonomy does not feel right?
    - Are there times when the decision to intervene against an individual's expressed wishes does not feel right?
    - Are there times when the choice between respecting autonomy and intervening to provide care is a real struggle and you are able to succeed at finding the middle ground? How did you get there?
    - Does your practice environment encourage a particular position on the autonomy/care continuum? If so, how?
  - 5. What are your thoughts about the assessment of capacity process and the part it plays in the autonomy/care equation?**
  - 6. What wisdom do you have to offer? What tools, approaches, or resources have you used/developed that you have found helpful when doing this kind of work?**
    - Step-by-step procedures? Did you find them helpful?
    - Pieces of advice for others?
  - 7. What tools/resources/approaches need to be developed for social workers to do this work effectively?**
  - 8. Are there any other thoughts you wish to share?**
  - 9. Do you want to review the transcript of this interview?**

## **Appendix 4: Background Information for Research Participants**

### **Autonomy, abandonment, and the role of relationship**

Self-determination is a moral principle, fundamental to the profession of social work. The Canadian Association of Social Workers Code of Ethics states that social workers are obligated to uphold “each person’s right to self-determination consistent with that person’s capacity and with the rights of others (CASW, 2005, p.4). The choices we make as a society in how we respond to abandonment and abuse have been conceptualized as two opposing moral visions. The moral vision termed an ethic of justice prescribes acting fairly toward others; the moral framework called an ethic of care supports responding to those in need (Gilligan, 1982). Seeking the balance between these two ethical frameworks is what social workers are called to do every day in adult guardianship practice. The decision to intervene against individual choice in order to prevent harm risks violation of an important ethical and legal principle; however, the decision to respect an individual’s right to refuse services risks abandonment of the client. Being simultaneously responsible for both care and autonomy leads to the paradoxical dance between abandonment and autonomy that lies at the heart of social work practice.

Most laws pertaining to adult guardianship maintain that competent adults in situations of abuse, neglect, or self neglect have the right to refuse services if they are considered capable. Bergeron (2006) suggests that it is difficult to separate the concept of individual capacity from the relationship that is created between the individual and the health care provider that is assessing the individual. She believes that the context of the relationship between the health care provider and the older adult will affect the process that leads to the determination of the individual’s capacity; the questions that are asked, the information that

is received, and the choices that are weighed will shape the picture of the older adult's decision making and functioning. Bergeron states, "It is unlikely that anyone, once they have entered into a relationship can autonomously decide anything. Within any relationship, voluntarily or involuntarily, once ceases being totally autonomous and is influenced by the exchange" (p. 90). Bergeron believes that to assess an individual's ability to make decisions requires critical thinking and comprehensive knowledge because superficial assessments may result in inaccurate determinations that may lead to abandonment of the client.

Intervention approaches have been put forward in the literature that extend beyond the binary choices of intervening or walking away. Moody (1998) has proposed the concept of negotiated consent where degrees of assistance are offered that provide relief to the victim or assistance to the perpetrator that reduce the harm of the abuse and neglect. Beaulieu and Leclerc (2006) have introduced a practice continuum model where the interventions range from negative autonomy to accompaniment to extreme measures. Negative autonomy is described as what happens when the client refuses services and the practitioner withdraws from the case. Extreme measures are when the professional is forced by the risk of the circumstances to take actions without the consent of the victim or the collaboration of the perpetrator. Accompaniment, the middle ground between the two extremes, is thought to be the ideal balancing point where practitioners take the time to build relationship and seek negotiated solutions.



**Appendix 5: Transcriber Oath of Confidentiality****TRANSCRIBER OATH OF CONFIDENTIALITY**

As a professional transcriber hired to transcribe interviews for the MSW thesis research project, *Abandonment or Autonomy: How do social workers know the difference*, I understand that I must treat as confidential all information learned through transcribing the interviews of research participants.

I further understand and agree that this Oath of Confidentiality will continue in force indefinitely, even after I cease being an employee on this project.

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(Print Name)

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(Signature)

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(Date)

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(Witness)

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Note: A copy of this Oath of Confidentiality will be given to the transcriber.