# SOCIAL WORKER'S ROLE IN AN ADULT PROTECTION AGENCY

by

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**Abstract**

My graduate practicum was completed at Adult Protection Services, Department of Health and Wellness in the Government of Nova Scotia office located at Yarmouth, Nova Scotia. Adult Protection Services receives referrals for suspected adult concerns related to an individual that may be living at immediate or significant risk. The risk can be due to self-neglect, unsafe living conditions, or the adult may be experiencing abuse by others that may result in serious harm. Mental and physical incapacity often contribute to the referrals made to Adult Protection.

The principal objective of my practicum was to learn about the role of a social worker in delivering Adult Protection Services. In addition, my practicum learning objectives included goals that built my knowledge of community networks and I developed my understanding of how Adult Protection Services worked collaboratively with other organizations from an inter-agency perspective to resolve Adult Protection concerns.

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# Chapter One: Introduction

The Adult Protection Act (2014) is in place to protect vulnerable adults from significant risk of self-neglect, abuse, or neglect by others. Adult Protection Services is an organizational branch of the Nova Scotia Department of Health and Wellness. Adult Protection Workers are appointed as employees under the Civil Service Act (1989). In Nova Scotia, the Adult Protection Act (2014) gives the authority to Adult Protection Workers to intervene on behalf of the Minister of Health and Wellness in order to protect adults who are vulnerable due to physical or mental incapacity. Adult Protection Services has established protocols to ensure timely referrals, interventions, and supports, are conducted in the least intrusive manner with the collaboration of health and social service partners.

Adult Protection Services strikes a delicate balance between protecting adults at risk and ensuring respect for the values of life, liberty, and security of the person. Rights for autonomy are enshrined in the Constitution Act (1982) as part of the Canadian Charter of Rights and Freedoms. Interventions under the Adult Protection Act (2014) are only warranted if there is a reasonable basis demonstrating significant risk to the life of an adult who is unable to protect themselves from harm.

## Personal Positioning

I am a Registered Social Worker (RSW) in Nova Scotia where I have practiced Clinical Social Work for five years in urban hospital settings located in Yarmouth and Sydney. During my clinical practice, I have gained experience in palliative care, continuing care, in the emergency department, and in the acute care wards of the regional hospitals. In addition to my work as a Clinical Social Worker, I have six years of experience working with Veterans Affairs Canada (VAC).

I have a Bachelor of Social Work degree (BSW), a Certificate in Counselling from Dalhousie University, a Bachelor of Arts in Community Studies (BACS), and a Certificate in Public Administration from Cape Breton University (CBU). I am currently enrolled in the Master of Social Work (MSW) program at the University of Northern British Columbia (UNBC).

I chose this practicum because I am interested in helping individuals who are vulnerable, at risk of harm from others, or at risk from self-neglect. I enjoy working as part of an integrated healthcare team with a wide range of health care professionals who deliver client-centered care. My background has afforded me the opportunity to work closely with a number of community agencies and service providers in my practice of Social Work. My professional experience in the area of Adult Protection was limited. My practicum granted me the opportunity to expand my practice knowledge and skills in the clinical setting of Adult Protection Services.

During my practicum, I wanted to develop an understanding of the barriers, the challenges, and the rewards of delivering Adult Protection Services in urban and rural communities. Under the supervision of an Adult Protection Worker (MSW), I aspired to learn new techniques for dealing with difficult situations and to expand my social work skillset by learning new practice tools.

Social work practice in the realm of Adult Protection is specialized in nature and is guided by a specific legislative framework. From a personal perspective, I wanted to build my knowledge regarding the roles and responsibilities of an Adult Protection Worker, how legal professionals interact with Adult Protection Services to protect vulnerable adults, and how various agencies collaborate to mitigate risk for vulnerable adults.

**Practicum Placement**

My practicum was under the supervision of Lisa Bowden, MSW, RSW, within the clinical setting of Adult Protection Services. My supervisor is responsible for service provision in the geographic location known as the tri-county area which encompasses the counties of Digby, Shelburne, and Yarmouth. The three counties cover a significant area with road distances exceeding 200 kilometers between some parts of the territory. The mission of Adult Protection Services is "to protect vulnerable adults in Nova Scotia from significant risk of self-neglect, abuse, and neglect and to ensure timely and appropriate referrals, interventions, and supports in the least intrusive manner possible in collaboration with health and social service partners" (Section 1.3.1).

Part of my learning experience was to understand how Adult Protection Services worked collaboratively with other organizations in the community. The inter-agency network of organizations that works collaboratively with Adult Protection Services includes: Long-Term Care facilities, Continuing Care, Mental Health Departments, the Yarmouth Regional Hospital, Police Departments, the Department of Community Services, other small community hospitals, legal offices, and the Provincial Court. During my practicum, I had the opportunity to work with each of these partner organizations and I learned how they interacted with Adult Protection Services. I now understand the differences in their unique roles, responsibilities, and services compared to an Adult Protection Worker.

**Learning Goals**

In accordance with the University of Northern British Columbia *Handbook for Master of Social Work*, I developed my practicum learning contract (see Appendix A). The learning objectives and strategies to achieve the goals of my practicum were:

1. To engage in supervised learning activities designed to meet goals of increasing knowledge of Social Work and Social Work practice - achieved by:
    - Building knowledge of the legislative and policy framework for the delivery of Adult Protection services;
    - Building knowledge of the supports and services offered by Adult Protection Services; and,
    - Building knowledge of the case management process of Adult Protection Services from the point of intake, inquiry, assessment, and the closing of a case file.
2. To increase knowledge of Social Work networks and other organizations that work closely with my practicum agency to provide resources for the population group at risk – achieved by:
    - Consulting and attending meetings with various community agencies to discuss cases, the roles of the different agencies, and how they interact on Adult Protection cases; and,
    - Building knowledge of the Social Work environment and interaction with other organizations and professionals for the delivery of Adult Protection Services (such as: long-term care facilities, mental health departments, hospitals, RCMP, etc.).
3. To acquire and demonstrate advanced practice knowledge, values and skills in a clinical agency setting - achieved by:
    - Learning therapeutic approaches and assessment techniques for various mental health conditions;

- Participating in group and individual care plan meetings that require the application of a range of theories and modalities to protect adults at risk;
- Learning the roles and responsibilities of an Adult Protection Worker, as part of an integrated healthcare team for trauma-informed practice in Adult Protection;
- Learning to recognize the ethical issues faced by an Adult Protection Worker; and,
- Building knowledge of the issues, barriers and challenges facing an Adult Protection Worker in the delivery of services to individuals at risk and their families.

4. To expand my clinical Social Work skills – achieved by:
    - Building my knowledge of Social Work and intervention methods in practice;
    - Developing Adult Protection case management experience;
    - Building knowledge of the latest developments, research, and thinking in Social Work;
    - Reflecting upon systems theory with emphasis on reciprocal relationships between individuals, groups, and organizations in the Adult Protection environment;
    - Building knowledge of the practical application of the principles of trauma-informed practice for clients with a history of trauma and/or abuse; and,
    - Building knowledge of various practical applications of Social Work practice models that address risk in Adult Protection.
5. To engage in a practicum experience that reflects my individual learning needs, interests, and experiences – as achieved by:

- Engaging in reflexivity through journaling;
- Learning how vulnerable adults are protected from harm by a policy framework that also respects individual autonomy; and,
- Learning techniques to calm or redirect irate and/or challenging behaviour.

6. To preserve a healthy balance in my personal and professional life – as achieved by:
    - Expanding my Social Work practice skills and engaging in self-care strategies to cope with a high-stress work environment.

## Chapter Two: Literature Review

In this chapter, I present a review of the current literature related to Adult Protection Services. The literature review includes an informed discussion of legislation, policies, and processes that inform Adult Protection interventions. Each progressive stage of the Adult Protection case management process is examined in sequence from the referral to the intake stage, inquiry stage, the assessment of risk, the assessment of capacity, and ending with the care plan.

In the literature review, I discuss a variety of issues and challenges associated with Adult Protection which include: the definition of elder abuse, what constitutes an adult at risk, autonomy, consent, capacity, systems theory, trauma-informed practice, inter-agency collaboration, and the implementation of Adult Protection policies.

### The Adult Protection Act and Policy in Nova Scotia

Legislation is introduced to the Nova Scotia Legislature in order to make a new law or to amend an existing law. Upon introduction to the House of Assembly, the statutes of the legislation are publicly debated and voted upon by the elected Members of the Legislative Assembly (MLA) until royal assent is achieved. The Adult Protection Act in Nova Scotia was initially passed in 1989 and subsequently amended in 2014 to protect adults from abuse and neglect. The Bora Laskin Law Library (2017) note, that statutes of legislation outline broad principles that govern our lives in society.

The Adult Protection Act (2014) defines the terms and outlines the sections of the legislation that regulates the practice of Adult Protection. The Minister of Health and Wellness holds the responsibility to delegate this authority to a coordinator by specifying the powers,

privileges, duties, and functions, to be performed in the protection of adults from abuse and neglect.

The duty to make an Adult Protection report is clearly documented in the legislation in the province of Nova Scotia. "Every person who has information, whether or not it is confidential or privileged, that an adult is in need of protection shall report that information to the Minister" (Adult Protection Act, 2014, p. 2). Johnson (2011) notes that a large number of calls received reporting concerns of abuse were not Adult Protection issues, but arose as complaints of poor treatment that affected individuals. Regardless of whether the concerns are substantiated, or not, the duty to report should alleviate any hesitancy or fear of recrimination in bringing forward suspicions of self-neglect, abuse, or neglect, of adults at risk. In the event that the report does not result in an Adult Protection intervention, no legal action would be taken by the government against the reporting individual, provided the report was not made maliciously and the report was based on reasonable and probable grounds that the adult was at risk.

The Adult Protection Act (2014) attempts to balance liberties, freedoms, and autonomy, for individuals while ensuring that vulnerable individuals at risk are protected. The Nova Scotia Department of Health and Wellness Adult Protection Policy Manual (2011) will be referred to as the Adult Protection Policy Manual (2011) for the remainder of this report. Policy 1.4.1, of the Adult Protection Policy Manual (2011), stipulates that an Adult Protection Worker must establish reasonable and probable grounds that there are significant risks that put the life of an adult in jeopardy and the adult is unable to protect themselves from the harm. The values, beliefs, and wishes of any adult are to be respected and considered to the fullest extent during the application of an intervention. Furthermore, Policy 1.4.1 clearly reinforces that all interventions ought to be the least intrusive modality and a court action is only to be used as a last resort.

The welfare of the adult is the paramount consideration in Adult Protection and "the best interest standard is only applied when an adult no longer has the mental capacity to make his or her decisions" (Adult Protection Policy Manual, 2011, Section 3.3). Fullbrook (2007) discusses Kant's Moral Philosophy that humans are autonomous, make choices in life, and expect to be treated with dignity. This philosophy promotes the concept that individuals have self-determination to make the choice to receive, or not to receive, healthcare treatment provided they are capable of making an informed choice.

In Nova Scotia, the Personal Directives Act (2008) provides legislative direction on consent and capacity if an individual becomes unable to make an informed decision. The Personal Directives Act (2008) enables a person to appoint a substitute decision maker, to set out instructions, and to establish general direction for healthcare instructions, should they become incapable of consenting. A hierarchy of substitute decision makers can be established under the authority of the Personal Directives Act (2008) with a Public Trustee as the last resort in the hierarchy.

In addition to the above noted legislation, an Adult Protection Worker is required to be knowledgeable of various legislations related to Adult Protection including:

Protection of Persons in Care Act (2013);

Involuntary Psychiatric Treatment Act (2005);

Incompetent Persons Act (2014);

Homes for Special Care Act (2010);

Powers of Attorney Act (2010);

Freedom of Information and Privacy Act (2015); and,

Public Trustee Act (2015).

Each of these legislations may influence whether an Adult Protection Worker has the authority to initiate measures of Adult Protection or provide guidance for the appropriate action that should be taken. For example, if an adult in a healthcare facility discloses some form of abuse in relation to the professional care within the facility -- the allegation would be managed by the legislated authority of the Protection of Persons in Care Act (2013).

At the macro level, the Adult Protection Policy Manual (2011) outlines the responsibilities of an Adult Protection Worker through case management strategies governed by the Adult Protection Act (2014). An Adult Protection Worker screens and assesses the caller's information and determines the most appropriate protection response regarding an adult that may be in need of protection. The Adult Protection Worker assesses the capacity of the client to consent to services, refers clients to appropriate services, and makes referrals for placement options when warranted. Adult Protection Workers initiate court applications and develop care plans that address the protective needs of the adult. Lastly, the Adult Protection Worker conducts follow-up appointments and assessments to ensure the protective needs have been met.

**Adult Protection Case Management**

Adult Protection case management and decision making begins when a referral is made to the agency. The referral is a report, made by an individual that suspects that an adult is at risk, neglected, or abused. At the intake stage, the Adult Protection Worker receives a referral and follows up with the original source in order to collect further information contained in the report. In order to advance from the intake to inquiry stage, the Adult Protection Worker must have reasonable grounds to believe that the adult is at risk and may be in need of protection (Adult Protection Policy Manual, 2011, Section 4.1.1).

Beadle-Brown, Mansell, Cambridge, Milne, and Whelton (2010) conducted a study of 6,148 referrals for Adult Protection and found that 32 percent were related to individuals with intellectual disabilities. Of the investigated cases, 41 percent resulted in a finding of abuse. In this study, 63 percent of the individuals with intellectual disabilities were living in residential care while 37 percent were living with family or in other living arrangements. From these statistics, not every reported incident of suspected Adult Protection resulted in an intervention and the data showed that the living circumstances surrounding an adult may vary widely.

During the intake process, the referral is categorized using the Adult Protection Risk Continuum (Adult Protection Policy Manual, 2011, Section 8.2). If the adult's situation is assessed as extremely high risk placing the adult in imminent danger, the Adult Protection Worker must contact the source of referral within one hour.

At the inquiry stage, the Adult Protection Worker contacts collateral sources to acquire information in order to determine the level of risk, whether the adult is unable to protect themselves from the risk due to physical or mental incapacity, and whether there is a permanent, irreversible condition affecting the capacity to protect themselves from the risks.

Cambridge and Parkes (2006) note that some of the most challenging Adult Protection cases require an integrated, multi-agency response, as the cases may have included serial abuse, physical, or sexual offenses, committed against vulnerable adults. The actions that are taken by an Adult Protection Worker vary significantly when there is suspicion of a criminal act. In the event that an Adult Protection Worker suspects that a crime has been committed, they must contact the police immediately and make every effort not to contaminate forensic evidence.

The assessment stage begins after reasonable and probable grounds of risk have been established at the intake and inquiry stages of the intervention. During the assessment stage, the

Adult Protection Worker may refer the client to a qualified medical practitioner in order to determine if the individual shows signs of abuse or egregious neglect.

Adult Protection assessments and interventions have the potential to be highly invasive. For example, if cooperation is refused by either the person who has power of attorney, or responsibility of the adult in question, or by the client themselves, the Adult Protection Worker must make every reasonable effort to explain, in plain language, the consequences of refusing to cooperate during the assessment process. Should the Adult Protection Worker be unable to secure cooperation for an assessment, it may lead to an application for a court order, called an Order for Entry, to assess or remove the individual. The Order for Entry may include court sanctioned assistance of the police.

In the context of an Adult Protection investigation, the primary methods for collecting information include a face-to-face interview with the client, contact with various collateral sources, and an interview with the alleged perpetrator, unless it compromises a criminal investigation. The Adult Protection Worker must make every attempt to interview the client before contacting collateral sources. If the Adult Protection Worker determines that contacting a collateral source or the perpetrator may interfere with a criminal investigation or endanger the client, the Adult Protection Worker must document the rationale for not interviewing the collateral sources. Given the complexity of Adult Protection, understanding the legislation, roles, and responsibilities of an Adult Protection Worker, is very important through all the stages of the intervention.

The final assessment stage reaches a conclusion once it is determined that there are no reasonable and probable grounds to meet the criteria for Adult Protection. Hence, the case file is

closed. If there are reasonable and probable grounds to believe the adult is at risk and in need of protection, the Adult Protection Worker develops a care plan that mitigates risk.

Under the Adult Protection Act (2014) there are three options available for an adult in need of protection. Under Section 7 of the Act, if the person in need of protection is willing to accept assistance, the Adult Protection Worker assists the person to obtain the necessary services to enable the person to care and adequately fend for themselves or obtain services that will protect the person from abuse or neglect. Under Section 9 of the Act, the second option available is to obtain a court order that enables the necessary action to be taken to protect the adult dependent upon a number of factors. Under Section 10 of the Act, the third option available is removal to ensure preservation of life for the adult in need of protection.

The care plan must consider the least intrusive option available which honours the client's best interest. The Adult Protection Policy Manual (2011) requires the Adult Protection Worker to involve the client or substitute decision maker in the development of the care plan to the greatest extent possible. The care plan must include a summary of the adult's protective requirements, the services that satisfy the protective needs of the client, and the expected outcomes, from the Adult Protection intervention. The care plan outlines the tasks that must be completed, who is responsible for certain responsibilities, the time-frame for completion of the tasks, and the follow-up plan, to ensure the services met the protective needs of the client. In the development of the care plan, a placement option is only considered if all other intervention measures have been exhausted (Adult Protection Policy Manual, 2011, Section 6.6.1).

When an Adult Protection Worker makes a referral for services for an adult in need of protection, this gives the client priority for services or placement with Continuing Care or the Department of Community Services (Adult Protection Policy Manual, 2011, Section 6.9). When

an Adult Protection Worker makes a referral for services, they are mandated to use the least intrusive intervention and the first level of intervention is to solicit voluntary consent from the client or the substitute decision maker for the required services. In the event that the Adult Protection Worker is unable to obtain voluntary consent, a court intervention is required to ensure the adult at risk is protected. In the absence of cooperation from the client or the delegated decision maker, the Adult Protection Worker can request the court to issue a mandatory order for services or placement to Continuing Care or the Department of Community Services (Adult Protection Policy Manual, 2011, Section 6.9).

The Adult Protection Policy Manual (2011) provides set time standards for intake, inquiry, assessment, the care plan, follow-up, and documentation. At each stage, the time criteria are variable dependent upon the level of risk to the client. For example, the Adult Protection Policy Manual (2011) stipulates that a client at extremely high risk or in imminent danger must have their intake, inquiry, and assessment completed on the same day as the referral to Adult Protection Services. In addition, the policy framework provides a number of prescriptive decision-making and risk assessment tools that assist the Adult Protection Worker in the thorough assessment of an Adult Protection situation.

Gordon (2001) asserts that the Adult Protection legislative philosophical foundation was paternalistic and it contrasted sharply with the progressive approach of Prince Edward Island that sought to balance the rights of self-determination and autonomy. A number of court cases challenged the Nova Scotia Adult Protection Act (1989) and the court found a number of violations of the Charter of Rights and Freedoms specified in the Constitution Act (1982). For example, the court expressed profound apprehension over the use of legislation to force individuals to live in care facilities in direct contradiction to their stated wishes.

The Government of Nova Scotia launched a review of the Adult Protection Act in 2004, including a comprehensive public discussion, and subsequently amended the legislation in 2014. Upon reflection, I found the revised Adult Protection Act (2014) provides the foundation for a balanced policy framework that respects the autonomy of vulnerable adults while ensuring they are protected from abuse and neglect.

Society is not static and I suspect the legislation for adult protection will continue to evolve as it did from 1989 to 2014. For example, the Nova Scotia Adult Protection Act (2014), Statute 9 (5) dictates that a court order for an intervention to protect an individual who is mentally incompetent shall expire in six months. In conducting a critical analysis of the legislation, this section of the statute presents a dilemma. It is possible that this timeframe outlined in the Act is an inherent weakness? Can services only be imposed on an individual at risk for a limited time of six months? In contrast, is it possible to present an equally strong argument that this interval represents a structural strength of the legislation that imposes a review by an Adult Protection Worker in six months to ensure the need to protect the best interest and civil rights of a vulnerable adult? At a minimum, this section of the statute represents an opportunity to conduct research to determine if the lapse in time is appropriate or if this section of the legislation needs to be amended.

Gordon (2001) notes a lack of Canadian research that evaluates or compares adult protection legislation in different jurisdictions and that legislative models in Canada are often driven by fiscal considerations. I am hopeful that the jurisdiction of Nova Scotia will continue to learn from others so that the Adult Protection legislation will evolve over time to encompass the best practices from the rest of Canada and from around the world.

During my practicum, as I reflected on my practice, I have come to realize that the legislative framework should not be overly prescriptive, but offer some latitude to make decisions that enable Adult Protection Workers to deliver services in the best interests of adults at risk dependent upon one's circumstances. For example, the Adult Protection Act (2014) stipulates that the Minister may authorize the immediate removal of a person to protect them if the adult is in need of protection. The broad brushstroke of this legislative authority is not prescriptive but enables the Adult Protection Worker to conduct an assessment and should it be determined that the person is living in accommodations that present a significant risk of fire, dependent upon the circumstances, the Adult Protection Worker has the capacity to apply for a Court Order to remove the individual.

Furthermore, as healthcare professionals, I would argue that Adult Protection Workers can provide valuable input to policy makers in relation to how the existing legislation and policy manifest in practice. Reading the legislative and policy frameworks of the Adult Protection Act (2014) and the Adult Protection Policy Manual (2011) was a valuable learning experience as it caused me to reflect upon the actual legislative authority and I pondered how this would be applied in real-life situations. The legislation forced me to consider the statutes from the public's perspective, a legal perspective, the Adult Protection Worker's practice perspective, and from the very important perspective of the vulnerable adult.

**Defining Elder Abuse and Adults at Risk**

During my practicum, I developed an appreciation for concise definitions in the realm of Adult Protection. Brammer and Biggs (1998) highlight the problems caused for conducting research, developing legislation, or establishing practice guidelines, when definitions for elder abuse were ambiguous. The authors note ambiguity had arisen concerning the nature of the

problems in elder abuse, whether actions were intentional or neglectful, and whether the abuse, was an act of commission or neglect from omission. Brammer and Biggs (1998) highlight that confusion over the definition of elder abuse results in competing interests developing their own self-serving definitions or interpretations that create a lack of clarity for policy, intervention, and legal foundation. Brammer and Biggs (1998) also observe that elder abuse was systematically situated in social policy within a domestic, welfare perspective rather than within a criminal framework so that victims were not afforded recourse in the judicial system.

Brammer and Biggs (1998) examine four prevalent definitions and state that "Abuse has shown itself to be a highly flexible term, both through categorizing the number of behaviours that can be discerned and through increasing generality of the phenomenon as a whole" (p. 291). The four definitions they examine did not comprehensively define a threshold for intervention. Consequently, Brammer and Biggs (1998) assert the need for a precise definition of the term elder abuse to establish the basis for a statutory obligation to investigate an allegation, to initiate community care services, and/or protective action.

A decade later, Dixon et al. (2010) note that an authoritative definition of elder abuse was unlikely to be achieved because of the persistent need to be provisional, flexible, and pragmatic, in reflecting the range of concerns. Dixon et al. (2010) point out the difficulties in classifying abusive behavior, in identifying failures of service, or in attaining agreement, on the criteria that constitutes neglect.

In some cases, Dixon et al. (2010) comment that the definitions were too broad in scope and constitute discriminatory abuse based on race, sex, disability, or slurs. Dixon et al. (2010) view a number of definitions as problematic because the specified range of perpetrators was considered too narrow and exclude a number of relationships that normally engender an

expectation of trust. They found the definitions of elder mistreatment inconsistent because some definitions include financial abuse and sexual abuse, while other definitions exclude these factors altogether. Furthermore, Dixon et al. (2010) argue that mistreatment based on a chronological age is arbitrary, potentially discriminatory, and contributes to definitional disarray.

Hall, Karch, and Crosby (2016), of the Centres of Disease Control and Prevention (CDC), address the longstanding, divergent definitions by establishing concise, clear definitions for the phenomena of elder abuse. The publication by the CDC provides uniform definitions for previously confusing situations or terms including: elder abuse, physical abuse, neglect, sexual abuse, emotional abuse, psychological abuse, financial abuse, and financial exploitation.

In addition, Hall et al. (2016) recommend the use of core data elements to standardize research data collection for elder abuse with the data elements for physical abuse that identify the type of injury, the type of weapon, the medical care required, the medical care received, the physical health outcome, and the psychosocial outcome, to the individual after elder abuse. The data elements include field values for codification in every segment of core data elements. For example, in the core data element of physical abuse, the subset that describe the type of injury uses specific field codes for injuries such as contusion, laceration, poisoning, fracture, burn, or penetrating wounds.

As noted above, I have come to appreciate some of the complexities associated with elder abuse and the importance to standardize definitions for all professionals who provide services to this vulnerable segment of the population. Without clear definitions of what constitutes abuse or an adult at risk, the literature clearly demonstrates confusion and inconsistent responses from agencies in dealing with Adult Protection issues. What one person interprets as abusive behaviour, could be construed by someone else as an oversight, if the thresholds for unacceptable

behaviour are not clearly defined. More importantly, when confusion exists over what constitutes elder abuse, the vulnerable adult may not be protected from risk. The literature reviewed afforded me the opportunity to understand that the Adult Protection Act (2014) and the Adult Protection Policy Manual (2011) are clear in their definition and interpretation of an adult in need of protection.

**Autonomy**

Part I of the Canadian Constitution Act (1982) is the Canadian Charter of Rights and Freedoms. The Adult Protection Policy Manual (2011) of the Nova Scotia Department of Health and Wellness was developed with due consideration of the Canadian Charter of Rights and Freedoms.

Section 7 of the Canadian Charter of Rights and Freedoms delineate legal rights and specify, "Everyone has the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." With respect to liberty, the Supreme Court of Canada (*Blencoe v. British Columbia*, 2000) ruled that Section 7 of the Canadian Charter of Rights and Freedoms protect an individual's personal autonomy to make decisions free from state interference. Furthermore, the Supreme Court of Canada (*R. v. Clay*, 2003) ruled that liberty, as articulated in Section 7 of the Charter, extend the law to include what is to be considered the core of an autonomous human being with the guarantee of dignity and independence in inherently personal matters.

Section 7, of the Canadian Charter of Rights and Freedoms, was interpreted by the Supreme Court of Canada (*Blencoe v. British Columbia*, 2000) to extend security of person beyond freedom from physical restraint. The ruling (*Blencoe v. British Columbia*, 2000) extends

security of person to include the protection of an individual's psychological integrity with the guarantee of freedom for competent individuals to make important and fundamental life choices.

The Supreme Court of Canada found that the prohibition of physician-assisted dying for competent adults deprived some individuals of the right to life (*Carter v. Canada*, 2015) because it had the effect to force individuals to take their own life prematurely as a result of the fear that they might not be able to do so at a later time when the suffering became intolerable. The Justice of the Supreme Court of Canada determined that the rights to liberty and security of person are also triggered when a grievous and irreversible medical condition is a matter critical to quality of life, dignity, and an individual's autonomy. The ban on physician-assisted dying effectively denied people the right to make decisions concerning their personal medical care and encroached on their liberty. The ban effectively forced individuals to endure intolerable suffering, violating their security of person. The Supreme Court of Canada struck down the sections of the Criminal Code that infringed upon the Section 7, Canadian Charter of Rights and Freedoms; consequently, the Supreme Court of Canada ruled to allow medical assistance in dying for competent individuals who clearly consent to the termination of life provided they have a grievous and irreversible medical condition that causes enduring, intolerable suffering.

My final practicum report prompted profound learning of the principles of autonomy and self-determination through the Carter legal case (*Carter v. Canada*, 2015) and the Supreme Court of Canada ruling on medical assistance in dying. Furthermore, as part of my practicum learning, I found the Canadian Charter of Rights and Freedoms to be an imposing and powerful document. I was enlightened to read about my rights as a Canadian citizen and it caused me to recognize how fortunate I am to enjoy the freedoms and democratic rights guaranteed in the Charter. In reading the decisions rendered by the Supreme Court of Canada related to autonomy,

I found it revealing to see how the simple words of Section 7, the Canadian Charter of Rights and Freedoms, are interpreted in ways that I never conceived.

Furthermore, Fyson and Kitson (2007) conclude that the lack of clear standards for people with learning disabilities was indicative of a fundamental policy failure to promote choice and independence while protecting them from abuse. Fyson and Kitson (2007) observe that advocates of the libertarian agenda were successful in stimulating policy that promoted freedom of choice and independence; however, this was accomplished with little regard for vulnerable adults. Furthermore, the authors note that the agenda for independence and choice exacerbated the problem for vulnerable adults because policies and planning for services does not distinguish a learning disability from a sensory or physical impairment.

Self-determination theory, as described by Deci and Ryan (2008), address social conditions that enhance, rather than diminish, autonomous motivation when individuals experience the exercise of free-will. However, Fyson and Kitson (2007) note that persons with learning disabilities need the support of others if they are to maintain an optimal level of independence. Fyson and Kitson (2007) argue that independence is an admirable goal, but interdependence was more realistic because policy and circumstances often ignore the control exerted by others over individuals with learning disabilities.

For individuals with capacity, the Canadian Charter of Rights and Freedoms ensures they have the right to make decisions concerning the care and protection they may or may not want to accept. Once a professional explains in plain language the risks, healthcare treatment, and protection options to an individual with capacity, they have the right to make an informed decision. Sometimes, the patient's decision is not always congruent with the healthcare professional but every professional has an ethical, moral, and legal obligation to respect the

patient's decision and treat the person with dignity. Needless to say, during my practicum, I learned to appreciate the obligation to respect autonomy while considering the need to protect an adult at risk.

**Consent and Capacity**

The Universal Declaration of Human Rights (1948) states, "All human beings are born free and created equal in dignity and rights. They are endowed with reason and conscience and should act toward each other in a spirit of brotherhood." Fyson and Cromby (2013) assert that this declaration infers a presumption that all individuals have reason and conscience. As a consequence, this created problems with respect to the human rights of individuals with intellectual disabilities with an impaired capacity for reasoning as defined by the World Health Organization (1993).

Through doctrines, such as The Universal Declaration of Human Rights (1948), civil society grant meaningful rights to citizens; however, Fyson and Crombie (2013) note the universal rights, as applied to persons with intellectual disabilities, create tensions and dilemmas in law and in the delivery of welfare services. Carulla et al. (2011) observe that the developmental conditions for persons with intellectual disabilities are characterized by significant impairment of cognitive capacity, demonstrated by limitations in learning, skills, and adaptive behaviour. Fyson and Crombie (2013) highlight the disconnect between the conceptual framework of universal human rights, that presumes reason is demonstrated through autonomous decision making, and the reality of persons with intellectual disabilities who are incapable of self-care or self-determination.

Fyson and Crombie (2013) argue that the heterogeneous composition of the intellectually disabled population meant the capacity to make decisions, the capacity for reasoning, and the

abilities for independent living, varied widely within the population and varied widely from the average citizen. Fyson and Crombie (2013) point out that it had become politically correct to ensure that all persons, including those with intellectual disabilities, have the freedom of choice as part of the notion of individual human rights. However, these authors argue that society does not completely understand the consequences of choice and that promoting choice for people with intellectual disabilities may be disconnected from the issues of capacity and protection. It was the view of Fyson and Crombie (2013) that the indiscriminate application of human rights based on reason may have negative impacts for individuals with intellectual disabilities.

When constructing services, Fyson and Crombie (2013) assert that policy-makers and practitioners should consider the full spectrum of social, economic, and political, circumstances that frequently impact persons with intellectual disabilities in an inequitable manner. These authors are clear that they are not calling for a return to a paternalistic model of care for persons with intellectual disabilities. Furthermore, the authors are not promoting that persons with intellectual disabilities should be denied involvement in decisions that have the potential to affect their lives. Instead, Fyson and Crombie (2013) want policy-makers and practitioners to be accountable for the choices they impose upon people with intellectual disabilities.

My practicum prompted me with opportunities to reflect upon the actions of advocates of neoliberalism and free choice. In my experience, offering unconditional free choice to persons challenged with impaired capacity may pose a risk that society may limit their rights or choices in other ways. For example, the reduction of government delivered programs espoused by neoliberalism is problematic and potentially harmful to persons with intellectual disability if the welfare state gives money to individuals to purchase services on the open market. An individual with profound intellectual disability will not understand the full range of options, the

consequences of a specific choice in securing shelter, or that some choices, may cause them harm.

Prior to the Mental Capacity Act (2005), there was no clear authority as to who could act on someone else's behalf and the legal instruments that attempted to provide direction were poorly crafted. Fullbrook (2007) contends that the autonomy of individuals was not respected, advance healthcare directives were disjointed, and existing protections for financial and welfare issues, were deficient in safeguards for incapacitated individuals. Fullbrook (2007) asserts that the Mental Capacity Act (2005) provides clarity in understanding the roles and responsibilities for healthcare professionals when treating individuals that lack mental capacity.

The Mental Capacity Act (2005) serves to make it a criminal offence to willfully neglect or abuse an individual who lack capacity. Should an individual lose mental capacity, Fullbrook and Sanders (2007) explains that the Lasting Power of Attorney, embedded in the Mental Capacity Act (2005), allows an individual to appoint someone to make decisions on their behalf should they lose mental capacity. The Lasting Power of Attorney gives expanded rights to a delegated person to make decisions on financial, welfare, and healthcare issues.

Fullbrook and Sanders (2007) note that a healthcare professional may expose themselves to civil liability or criminal prosecution for not respecting a valid advance decision of a patient that expresses his or her wishes prior to mental incapacity. For example, Fullbrook and Sanders (2007) explain that a person who refuses treatment might claim damages for the tort of battery, or seek criminal prosecution of a healthcare professional, if the professional knowingly applies treatment contrary to a valid advance decision to refuse treatment.

Fullbrook (2007) presents the underlying philosophy that autonomy and the inherent right to make a decision should be respected when an individual has the capacity to make rational

choices. Johnson and Cureton (2017) note that this philosophy promotes the concept that individuals have self-determination to make the choice to receive or not to receive health treatment, provided they are capable of making informed choices. The legal right for a competent adult to withhold consent to treatment applies unequivocally, even when the refusal may result in a person's death.

In Nova Scotia, the Personal Directives Act (2008) enables an individual with capacity to create a legal document called a Personal Directive that outlines their personal care decisions in the event that he or she is no longer capable to make informed decisions on their own. Section 2, the Personal Directives Act (2008), defines capacity as "the ability to understand information that is relevant to the making of a personal-care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision."

The Nova Scotia Health Authority (2016) identifies three types of Personal Directives: Delegate Directives, Instruction Directives, and Combination Delegate/Instruction Directives. Delegate Directives name a person over 19 years of age as a substitute decision-maker who will make decisions for the person when he or she no longer has the mental capacity to do so. Instruction Directives contain instructions or an expression of the maker's values, beliefs, and wishes about future personal care decisions to be made on their behalf when they are no longer able to make certain decisions. A Combination Directive names a delegate and specifies instructions for future personal care decisions. A Personal Directive must be signed by the individual and witnessed by someone other than the delegate.

The Personal Directives Act (2008), Section 3 (5), enables a person to appoint more than one delegate, provided each delegate has different responsibilities. In addition, the Personal Directives Act (2008) allows for the appointment of an alternate delegate in the event that the

primary delegate dies, declines to act, resigns, is unavailable, becomes incapable of acting as a delegate, or has the delegate authority removed by a court.

In Nova Scotia, healthcare providers are bound by the Personal Directives Act (2008) which prompts healthcare professionals to ask if a person has made a Personal Directive before they seek a decision from a statutory decision-maker, such as a Public Trustee. If a Personal Directive exists, the healthcare provider includes a copy with the healthcare records and shall follow the instructions provided by the delegate. In the case of medical emergency, a healthcare professional is not obligated to seek a decision from a delegate or statutory decision-maker if the medical treatment is necessary to preserve the life of the person or if seeking a decision from a delegate would cause a delay that would pose a threat to the person's well-being.

A Personal Directive does not need to be completed or endorsed by an attorney; however, a Personal Directive must comply with the statutes of the Personal Directives Act (2008) and it is preferred practice to provide a copy of any Personal Directive to a lawyer. In situations where an Attorney has filed an Enduring Power of Attorney for an individual, the Personal Directives Act (2008), Section 23, allows the Personal Directive to be incorporated within the Enduring Power of Attorney as part of a single legal instrument compliant with the Powers of Attorney Act (2010). Normally, the Enduring Power of Attorney provides for the management of personal affairs and the Personal Directive is a complimentary document that deals specifically with personal care decisions.

While the Personal Directives Act (2008) spells out the legislative framework, there are a few practical considerations to ensure an individual's personal care decisions are respected should a Personal Directive come into force. Individuals should provide a copy of their Personal Directive to their physician, their delegate, and keep a copy in a safe place with other important

documents. It is a good idea to have a discussion with the delegate to ensure a clear understanding of their responsibilities and that the wishes of the individual are clearly expressed in the Personal Directive.

Provided an individual has capacity, a Personal Directive can be cancelled or changed at any time. It is advisable to review or update a Personal Directive each time an individual experiences one of the five "D-events" of life: entering a new decade of life (40, 50, etc.), death of a loved one, divorce, a decline in health, or a diagnosis of a medical condition that could shorten or affect an individual's quality of life.

The Adult Protection Policy Manual (2011) provides guidelines and tools for an Adult Protection Worker to conduct a mental capacity assessment. The assessment enables the Adult Protection Worker to determine whether or not the client is able to understand the situation of significant risk. In conducting an assessment, the Adult Protection Worker assesses the client's responses to questions and makes a clinical determination of whether or not the client has the capacity to protect themselves from the risk(s) identified in the risk assessment. During the capacity assessment, the Adult Protection Worker determines if there is a need for a second opinion on whether the client has capacity. If required in difficult or unclear situations, the Adult Protection Worker solicits the services of a physician to determine if, in their opinion and based on the evidence provided, the client has the physical and/or mental capacity to protect themselves from the identified risk(s). The information provided by the physician is meant to clarify whether or not the client has capacity.

A capacity assessment may contain clinical evidence that informs the decision of the Adult Protection Worker. Cognitive deficiencies may inform the assessment in relation to capacity; however, the assessment involves a series of questions to determine if the client

understands the circumstances of the risk(s), the available choices, and the consequences of making or not making a decision, with respect to the available choices. The Adult Protection Worker must consider that there may be temporary factors that can affect a determination of incapacity such as delirium (dehydration), depression, or transient capacity. Section 5.14.2 of the Nova Scotia Adult Protection Policy Manual (2011) stipulates, if the Adult Protection Worker suspects a temporary factor is affecting the determination of capacity, arrangements are to be made for the client to go to a hospital for a medical assessment. In addition, Adult Protection Workers must be aware of cultural differences, the influence exerted by a family member who may be present during the assessment, and that poor judgement or eccentric behaviour, does not constitute incapacity.

In Section 15, The Canadian Charter of Rights and Freedoms of the Constitution Act (1982) states that every person in Canada is guaranteed equal protection and benefit of the law regardless of mental or physical disability. This guarantee is balanced by Section 7 that provides for individual autonomy with the right to life, liberty, and security of person. As individuals, we can take some comfort in the knowledge that when we are vulnerable and without the capacity to make decisions, our rights and freedoms remain protected by the Personal Directives Act (2008). As such, the Personal Directives Act (2008) serves to ensure individuals are treated with respect and dignity according to their personal wishes, beliefs, and values.

**Systems Theory and Trauma-Informed Practice**

Social Workers may use systems theory to understand the complexity of relationships between individuals, families, communities, society, and institutions. Systems theory enables Social Workers to develop an understanding of how a specific system functions and with this knowledge, the Social Worker considers challenges, strengths, supports, and barriers, at multiple

levels to effectively deliver services to the client. This unique perspective can support a Social Worker in the management of the obstacles they encounter in obtaining the necessary services to meet the needs of the client. Understanding systems theory and the application of the theory in specific circumstances can assist a Social Worker in establishing a harmonious relationship with the client and other individuals in the system's network.

Wirth (2009) argues that a theoretical approach to systems informs the practice of Social Work so professionals and volunteers can ensure that persons and families get the best assistance that they are legally entitled to receive in order to bring their condition of need to an end as soon as possible. During my practicum, I observed systems that worked harmoniously to provide adults at risk with the services they needed. By understanding systems theory and adopting the functional solution to a specific problem, Wirth (2009) stated, "we can create new possibilities of solutions by shifting our perspective from an ontological to a more constructivist one" (p. 416).

During my practicum, my learning experience was enhanced by observing trauma-informed practice, as some of the clients served by Adult Protection Services had suffered traumatic or abusive events. Goodman et al. (2016) identify six broad principles associated with trauma-informed practice: "establishing emotional safety, restoring choice and control, facilitating connections, supporting coping, responding to identity and context, and building strengths" (p. 749). During my practicum, I observed trauma-informed practice presented in a radically different perspective than my experience in the practice of medical social work in a hospital setting. I observed that the principles eschewed by Goodman et al. (2016) for trauma-informed practice were tempered by circumstances. For example, establishing emotional safety was complimented by creating physical safety for both the client and inter-agency personnel. Restoring choice and control for clients who received services by the way of Adult Protection

was dependent upon the severity of the risk and whether the client was determined to have capacity. Adult Protection Services may have to limit someone's choice and control in the best interest of protecting the vulnerable adult.

Trauma informed practice at Adult Protection Services facilitated connections and fostered inter-agency collaboration at all stages of intervention. I observed situations where the Adult Protection Worker implemented pro-active services and support to mitigate the risk -- which strengthened the adult's coping strategies. Responding to one's identity and context were critical elements that were taken into consideration at all stages of the intervention. During the care plan and follow-up stages, the Adult Protection worker re-assessed whether the client required on-going services by assessing the outcomes of the objectives that were implemented and documented in the care plan.

Adult Protection Workers engaged in trauma-informed practice related to the principle of emotional safety. Adult Protection Services and the inter-agency partners always demonstrated respect towards the client, protected the client's privacy, and the Adult Protection Worker displayed understanding and compassion when the client was having a difficult time.

**Adult Protection Policies**

The work of Cambridge and Parkes (2006) highlights the importance of communication and regular updates to ensure effective, timely interventions in Adult Protection case management. In considering inter-agency cooperation in Adult Protection, Cambridge and Parkes (2006) identify the requirements to be strategic in identifying the desired outcomes, the need to monitor progress from an inter-agency perspective, and the need to follow-up, to ensure the long-term objectives are achieved for the vulnerable adult. Cambridge and Parkes (2006)

report other challenges in inter-agency collaboration with respect to confidentiality, consent, and information management.

Cambridge, Mansell, Beadle-Brown, Milne, and Whelton (2011) highlight the importance of collecting and sharing Adult Protection data because of the insights provided for policy development, understanding the nature of adult abuse, the development of risk management strategies, and the development of adult abuse prevention strategies. Cambridge et al. (2011) caused me to reflect upon the delicate balance that must be struck between information management, information sharing, confidentiality, and privacy. Cambridge and Parkes (2006) identify the importance of understanding the tolerance and threshold for sharing information so criminal investigations are not compromised while ensuring the adult at risk is adequately protected. Cambridge and Parkes (2006) regard police as invaluable, critical resources for the effective management of evidence, witness support, domestic violence, and the security of persons.

Cambridge and Parkes (2006) mention the issue of inter-organizational cultural barriers that restrain effective case management due to differences in professional practices, accountability, the way resources are allocated, financial systems, and organizational structures. Despite these impediments, Lachs and Pillemer (2015) assert that using inter-disciplinary teams is a key intervention strategy to resolve complex, multi-dimensional cases of elder abuse.

In the document titled No Secrets, the Department of Health (2000) provides guidance to Police, Social Service Agencies, Health Authorities, and other non-governmental organizations (NGO's) on developing multi-agency policy and procedures for adult protection. McCreadie, Mathew, Filinson, and Askham (2008) conclude that the staff found the inter-agency policies ambiguous and caused uncertainty for employees in implementation. McCreadie et al. (2008)

consider the data from their studies in the context of the ambiguity-conflict model of policy implementation developed by Matland (1995).

In the development of the ambiguity-conflict model, Matland (1995) contemplates policy implementation from a top-down and a bottom-up perspective to identify four policy implementation paradigms. The four identified policy implementation paradigms are: administrative implementation (low conflict-low ambiguity), political implementation (high conflict-low ambiguity), symbolic implementation (high conflict-high ambiguity), and experimental implementation (low conflict-high ambiguity).

McCreadie et al. (2008) characterizes multi-agency adult protection policy as highly ambiguous because it is not prescriptive and goals are set at the local level with appropriate consideration of local conditions. Furthermore, the authors consider multi-agency adult protection policy low-conflict because it embraces at all levels of the different organizations and does not generate political controversy. Using Matland's ambiguity-conflict model, McCreadie et al. (2008) finds the multi-agency adult protection policy implementation aligns itself to the experimental implementation approach (low conflict-high ambiguity) and that implementation is most influenced by a bottom-up approach by staff in the local authorities.

Despite the latitude of a bottom-up, low conflict-high ambiguity approach for local authorities, McCreadie et al. (2008) find it was not devoid of conflict. Similar to Cambridge and Parkes (2006), McCreadie et al. (2008) states that the multi-agency approach to policy implementation suffers from differences in organizational cultures, a parochial approach to organizational priorities, and divergence of priorities, due to differing norms amongst professionals. McCreadie et al. (2008) concluded that conflict also arose when priorities are not

integrated at the highest organizational levels or because individuals do not clearly understand their role in a multi-agency approach to adult protection.

Matland (1995) argues that ambiguity and difference in approaches to practice should not be considered as a problem with the policy, but it should be viewed as an opportunity to learn. In fact, McCreadie et al. (2008) suggest implementing policy from the bottom-up can be a catalyst for technological advancements that ultimately lead to positive outcomes despite the friction that occurs along the path.

Northway, Davies, Mansell and Jenkins (2007) found adult protection policies on multi-agency intervention to be helpful in promoting collaboration, awareness, and clarity, on adult abuse. Northway et al. (2007) notes that most staff at social service agencies do not read their policy manuals, but know they exist. In contrast, one of my first assignments by my practicum supervisor was to read the Adult Protection Policy Manual (2011).

The Adult Protection Policy Manual (2011) delineates the legislative authority, vision, mission, as well as operational and ethical guidelines, for Adult Protection Workers in Nova Scotia. In addition, the Adult Protection Policy Manual (2011) provides specific guidance on the administration of Adult Protection for documentation, privacy, information sharing, and the requirement to close files.

The final section of the Adult Protection Policy Manual (2011) provides a number of policy tools specific to Adult Protection case management. When assessing the level of risk, the Adult Protection Worker must use the Adult Protection Risk Continuum (Section 8.2.1) at the intake, inquiry, and assessment stages of intervention. The Adult Protection Care Planning Decision Tree (Section 8.3.1) is to be used by the Adult Protection Worker when making care plan decisions. The processes at the various stages of Adult Protection intervention are complex;

therefore, the Adult Protection Policy Manual (2011) provides detailed Process Maps (Section8.4.1) that the Adult Protection Worker must follow for the following:

Intake and inquiry;

Assessment;

Section 7 Process (Referral for Services);

Section 8 Process (Order for Entry);

Section 9 Process (Application to the Court for Protection);

Section 10 Process (Application to the Court for Immediate Removal);

Transporting and removing clients;

Follow-up Process; and,

File Closure Process.

A Section 7 Process (Referral for Services) occurs when a client agrees to a placement and results in a priority referral for services to protect the adult at risk. A Section 8 Process (Order for Entry) requires a Court Order for entry to the Adult Protection client's residence to conduct an assessment. Once the Court Order is granted, the police and any other appropriate service providers are contacted to conduct the entry and enable the assessment to be conducted. A Section 9 Process (Application to the Court for Protection) is a planned removal that is sought when a client is considered mentally incapacitated and unable to protect themselves from risk and is consistently refusing services, or is experiencing serious harm due to abuse or serious neglect at the hands of others. The most intrusive action is a Section 10 Process (Application to the Court for Immediate Removal) and results only when the client is assessed to be in immediate danger.

**Summary of the Literature Review**

The literature reviewed enabled me to better understand the roles, responsibilities, and challenges, of professionals in the field of Adult Protection. The legislative and policy framework brought clarity to the duty to report adult abuse, case management for adults at risk, and how Adult Protection Services intervenes to protect vulnerable adults. The review of research demonstrated the need for clarity in defining terms so professionals involved in Adult Protection decision making have a common understanding of what constitutes abuse or whether an adult is at risk.

On the subject of autonomy, the literature was instructive in understanding the need for respecting individual rights; however, independence and the liberty for individuals to make choices must be informed by the context of unequal power relationships, mental capacity, and risk. Consent and capacity are inextricably linked. With capacity, an individual can give consent to health care treatment or make their wishes known before they lose capacity. Indeed, it is an individual's right to withhold consent for medical intervention, provided they have capacity.

Adult Protection Services is complex and systems theory plays an important role in inter-agency collaboration. Adult Protection Workers must consider trauma-informed practice in the context of each individual case, as restoring choice and control to an adult experiencing abuse which may depend upon capacity and risk. Social service agencies experience challenges when working together as a result of differing inter-agency perspectives. However, improving outcomes for vulnerable adults requires commitment from all levels of the various organizations.

## Chapter Three: Summary of Learning Experiences

### Overview

The overall objective for my practicum was to learn the role of a Social Worker within Adult Protection Services and advance my Social Work knowledge and practice skills. The practice of Social Work occurs in a wide variety of settings requiring a broad base of skills, knowledge, and experience. I have spent the majority of my career practicing in medical Social Work. My practicum in Adult Protection Services has broadened my experience and provided me with a valuable base of new knowledge in Social Work practice.

As a medical Social Worker, I was accustomed to inter-agency collaboration, I worked with various community agencies, and I was a member of a multi-disciplinary team in an urban hospital setting. In that role and environment, I recall when I was contacted regarding an Adult Protection case concerning an adult that had been admitted into the Emergency Department. I worked in collaboration with the Adult Protection Worker with the emphasis placed in the best interest of the patient. However, it was evident to me that the Adult Protection Worker viewed the client from a different perspective than my role as a medical Social Worker. I developed an interest in Adult Protection and I recognized that I did not fully appreciate the reasons why some patients did not meet the criteria to be considered an Adult Protection client.

During my practicum, I developed knowledge of the legislative and policy frameworks for Adult Protection Services by reading the Adult Protection Act (2014) and the Adult Protection Policy Manual (2011). Under the guidance of my practicum supervisor, I learned the practical application of the policies and developed an understanding of the professional guidelines an Adult Protection worker must follow. Consequently, I have developed insight into why some adults require services from Adult Protection while others do not meet the criteria for an adult at risk.

The following sub-sections delineate my specific learning performance by describing the tasks, activities, and strategies that I engaged in to achieve the objectives of my Learning Contract. Each sub-section followed the structure of the Learning Contract to enable the reader to understand how I met all the learning objectives of my practicum.

**Increase Knowledge of Social Work and Social Work Practice**

During the early stage of my practicum, as I became familiar with the policies and guidelines, I maintained a journal while shadowing my practicum supervisor through a number of cases and learned how she handled a variety of Adult Protection referrals. This provided me with a fundamental understanding of Adult Protection Services, the organizational structure, daily operations, processes, and inter-agency networks. As previously stated, one of the first tasks my supervisor assigned was to read the Adult Protection Act (2014) and the Adult Protection Policy Manual (2011). This enabled me to develop knowledge of the legislative and policy framework for the delivery of Adult Protection Services.

I learned from my supervisor how important it was to use the prescriptive policy tools for specific tasks for Adult Protection case management. The experience of shadowing my practicum supervisor through a number of cases enabled me to build knowledge of the supports and services offered by Adult Protection Services. For example, I had an opportunity to view how the Adult Protection Worker assessed mental and physical capacity of an adult at risk.

I met with my practicum supervisor daily and discussed my cases, to ensure compliance with practice standards, and I participated in meetings. In order to exercise my reflexivity skills and keep track of daily events, I maintained a journal. I referred to my Practicum Learning Contract on a regular basis and found the practice of a daily journal helpful as it tracked my progress in the achievement of my learning objectives. As my knowledge of Adult Protection

Services expanded, I managed and documented a case from start to finish demonstrating that I understood the complexities of an Adult Protection case. I maintained professional boundaries, and engaged in effective, ethical practice.

During the case management process, I was required to use the knowledge of the policy framework for Adult Protection Services and demonstrated to my supervisor that I understood the relevance of systems theory and its application in relationships between individuals, groups and organizations. In attending case management meetings, I enhanced my documentation skills and understood Adult Protection terminology as demonstrated by my contribution to an Affidavit. Adult Protection case management documentation is extensive and requires unwavering attention to detail in order to complete the requisite forms for intake, inquiry, risk assessment, and capacity assessment.

**Increase Knowledge of Social Work Networks and Inter-agency Partners**

During my practicum, I met, consulted, and interacted, with various community agencies that had involvement with Adult Protection Services. In meetings, I observed their interaction with Adult Protection Services from an inter-agency perspective. My daily journal provoked reflection upon the diverse roles and responsibilities of the various community partners.

Williams (2011) identifies issues and barriers related to inter-agency collaboration that potentially hinder organizations from working effectively due to different practices, ideologies, and cultures. Often, there is a climate of professional suspicion amongst agencies and Williams (2011) suggests this may be mitigated by establishing policies with clear guidelines for the roles and responsibilities of each organization. Williams (2011) observes that there are systemic issues related to inter-agency cooperation that can be attributed to an absence of policy and direction from government. Williams (2011) further describes inter-agency collaboration that

appears to be narrow in scope and does not retain the best interest of the client as a primary objective.

Adult Protection Workers have a responsibility to work collaboratively with other organizations or individuals, such as police and physicians, to ensure the best interests of adults at risk. During my practicum, I observed an inter-agency working model that promoted collaboration and the sharing of information to serve the best interests of the client at risk. The inter-agency model clearly articulated individual organizational accountability in the context of a client-centered approach to serve the adult at risk and effectively resolve problems. Each organization made various resource contributions reflective of their responsibilities and the specific nature of individual case.

In addition to my observations during inter-agency meetings, I requested a meeting with individuals from each discipline to specifically learn about their roles and responsibilities related to inter-agency Adult Protection cases. Specifically, I met with the following individuals:

Department of Health and Wellness, Intake Agent;

Continuing Care Coordinators;

Department of Health and Wellness, Long-Term Care Placement Officer;

Royal Canadian Mounted Police Officer;

Senior Safety Officer;

Fire Marshal;

Nova Scotia Health Authority, Mental Health Worker;

Nova Scotia Health Authority, Physician, Nurse, and Social Worker; and,

Court Officials.

The Intake Agent discussed how she responded to a call or referral when someone reported an alleged adult abuse or an adult at risk. I learned about the call system and how she gathered information from the caller, recorded information in the system, and transmitted the referral to the Adult Protection Worker.

In my meeting with the Continuing Care Coordinator, I learned that they are healthcare professionals who worked within the community to put services in place for clients. The Continuing Care Coordinator worked for the Department of Health and Wellness either from a hospital or in the community conducting home visits and client assessments. Often, the Continuing Care Coordinator maintained the same clients on a long term basis. It was common that a client's care plan would evolve with increasing needs as their health deteriorated over time. The Continuing Care Coordinator managed services such as Home Care or Nursing Care and facilitated applications for placement in Long-Term Care.

The Department of Health and Wellness, Long-Term Care Placement Officer coordinates placements for individuals in Long-Term Care facilities. The demand for placement exceeds the available capacity so potential clients have the opportunity to put their name on a waitlist to live in one of the Long-Term Care facilities. Under normal circumstances, the Long-Term Care Placement Officer considers placing a client on the waitlist if Home Care Services can no longer meet the needs of the client. For example, if the client requires twenty-four hour supervision, the Long-Term Care Placement Officer places the client on the waitlist and facilitates the placement at the first opportunity. If a client was under Adult Protection and required a bed at a Long-Term Care facility, the Adult Protection Worker would obtain a Court Order and the Long-Term Care Placement Officer is required to give the at-risk Adult Protection client first priority for a bed.

The Royal Canadian Mounted Police (RCMP) responded to calls concerning personal safety. For example, they responded to a report of someone walking down the road on a cold winter night without appropriate clothing. In addition, the RCMP ensured compliance with Court Orders, investigated criminal activities, and acted as expert witnesses. The RCMP explained their role as ensuring safety of the public, protecting individuals at risk, and protecting staff, from harm in high-risk, volatile situations. The RCMP assists an Adult Protection Worker when executing Section 9 or 10 of the legislation. This involves the removal of a client from their home or from circumstances of risk when there is immediate danger or the client resists relocation. My practicum supervisor always tried to limit the involvement of RCMP when removing someone from their home. Clients can become agitated during removal and authoritative figures, such as RCMP, can escalate the situation. My practicum supervisor used the least intrusive intervention possible when she dealt with Adult Protection clients.

I participated in meetings with other community partners to build care plans for clients and families at risk. The Senior Safety Officers are professionals hired under a specific community program operated by the RCMP. These professionals manage at-risk clients within the community to ensure that they have the necessary supports to live safely and successfully within the community. There were times when the Senior Safety Officer consulted with Adult Protection Services as an individual's circumstance had potential to evolve into a protection concern.

The Fire Marshal was called by Adult Protection Services because an adult hoarder had created so much clutter the house was considered unsafe. During my practicum, we met with the Fire Marshal and the Senior Safety Officer to develop a care plan for the client and his wife. The

Fire Marshal identified the fire safety issue as a result of hoarding and created a plan of action. The wife agreed to have the house cleaned to avoid having their home condemned.

During an Adult Protection case, it is essential to determine if the person lacks capacity and if that condition is permanent and irreversible. In some cases, healthcare professionals must conduct a medical assessment to determine mental capacity in order to rule out any underlying temporary condition that may be causing confusion, depression, delirium, or impaired judgement. I met with Nurses, Physicians, Medical Social Workers, and the Mental Health Workers, to understand their roles in assisting with the physical and psychological assessments. To conduct assessments, each of these professionals used the prescriptive forms supplied by the Adult Protection Worker from the Adult Protection Policy Manual (2011).

I met with the Lawyer assigned to the Department of Health and Wellness and acquired knowledge on the legal aspects of Adult Protection cases. I gained experience in the preparation of an Affidavit, reviewed applications for Court Orders, and worked with the Lawyer. I prepared court documents and attended Court. This was a new learning experience as I have never attended Court. It was an impressive process that involved several meetings with the Lawyer in order to properly prepare and attend court on the appointment date. I was pleasantly surprised by the compassion and understanding displayed by the Judge. We provided the Judge with all of the relevant documentation and information required for her to render a decision. The application involved the placement of a client under the care of the Minister.

After each interaction with another professional discipline or community network, I made entries in my journal and reflected upon the roles and responsibilities of inter-agency partners. I also made note of when interactions did not occur, if the other disciplines were not available, if other disciplines did not want to be involved. The majority of our interactions were very

effective and the inter-agency teams worked very well together. I attributed a large measure of this success to my practicum supervisor's ability to maintain strong community networks and good working relationships with the professionals in other disciplines.

A number of the inter-agency partners sought guidance and support from the Adult Protection Worker, Lisa Bowden. In addition to her collaboration and networking skills, I observed that my supervisor used a practical approach to support external agencies while ensuring the wishes of the client were respected. My supervisor was tactful, respectful, professional, and a critical thinker. In her role as an Adult Protection Worker, she used preventative measures to ensure that the clients were safe in the community and she worked to put the appropriate services in place before the situation became a crisis.

**Advanced Practice Knowledge, Values, and Skills**

One of my goals was to advance my practice knowledge, to learn new therapeutic approaches, and to learn new assessment techniques, for various mental health conditions. In retrospect, I came to understand that I was already using the most effective and useful techniques for Adult Protection clients with mental health conditions. I was curious to know if there were specific therapeutic approaches that I was unaware of that could be applied for a person with dementia, schizophrenia, or a person with an intellectual disability.

Upon reflection, I noted the importance of recognizing the condition and understanding that each condition is significantly different. As far as therapeutic approaches, one size does not fit all. However, during my practicum, I observed that Adult Protection Services made a concerted effort to treat all clients with respect, dignity, and compassion. This ethical approach was already engrained in my practice skills due to my previous professional practice experience.

Throughout my practicum, I consulted, observed, and with my supervisor, I discussed a number of tools used to assess one's intellectual disability, physical, and mental capacity. I learned that an Adult Protection Worker observed, assessed, and documented cognitive functioning risks such as, hallucination, delusion, poor concentration, confusion, the inability to retain new information, paranoia, or the inability to plan. In assessing physical capacity, I learned the Adult Protection Worker assessed for hearing and visual impairment, mobility issues, fall history, skin care, foot care, and continence.

In assessing mental capacity, I learned the Adult Protection Worker started by determining if the client clearly understood the reason for the assessment and whether the client had an appreciation of their situation of risk(s). If not, the Adult Protection Worker proceeded with a cognitive assessment using observational tools such as, the Mini-Mental State Exam (MMSE), the Confusion Assessment Method (CAM), the Montreal Cognitive Assessment (MOCA), Clock Drawing, or the Frontal Assessment Battery (FAB). The Adult Protection Worker also assessed the client's mental capacity related to specific areas of risk and insight.

It was interesting to observe and discuss approaches used for each client with my practicum supervisor. My supervisor did not overwhelm the client or family by presenting a large assessment document and check off boxes, but she gathered information through what seemed like a regular conversation. This style provided a relaxed environment for the client and family so the process was not overpowering. After obtaining this information from the client and family, we returned to the office and completed the necessary documentation for the assessment. We discussed various mental conditions, as noted above, and I made reference to the DSM-5 regarding various conditions and how they affected the individual.

When the Adult Protection Worker conducted an assessment with a client who showed no signs of memory loss, diminished capacity, and they understood and appreciated the situational risk(s), it was determined that the client did not meet the criteria for protection under the Adult Protection Act. At this point, the file was closed.

During individual and group care plan meetings, I maintained a journal and observed the application of a range of theories and modalities that served to protect adults at risk. During our interactions, a strength-based, trauma-informed model was used regularly. Levenson (2017) explains the core principles associated with trauma-informed social work which include: safety, trust, collaboration, choice, and empowerment. I frequently observed my practicum supervisor using this model. She provided the family a choice in how they wanted to proceed. In applying this model, she explained the various options in plain language and the family decided the preferred course of action. For example, a family was given the choice to have a client removed immediately or to have a planned removal that reduced the trauma for everyone involved.

During my practicum, I learned the roles and responsibilities of the Adult Protection Worker as a part of an integrated healthcare team. As a result of my practicum experience, I am confident of my understanding of the roles and responsibilities of an Adult Protection Worker.

I learned that the Adult Protection Worker served to coordinate and provided oversight for inter-agency Adult Protection case management. For example, the Adult Protection Worker initiated the request to Emergency Hospital Services (paramedics) to transport a patient from the residence to the hospital for medical assessment. Upon admission to the Emergency Department, the Adult Protection Worker consulted with the Clinical Lead Nurse and initiated the request for a medical and capacity assessment. The attending Physician or Psychiatrist met with the Adult Protection Worker to discuss the case, at which time the Adult Protection Worker

provided collateral information. The Physician or Psychiatrist assessed the client to determine capacity, insight, judgement, temporary conditions, and if the client's condition was permeant or reversible.

The Adult Protection Worker played a fundamental role in assessing a client's capacity and working collaboratively with other members of the inter-disciplinary and inter-agency team on behalf of adults at risk. I have learned that there were ethical considerations that needed to be taken into account when determining a person's mental capacity. The responsibility of an Adult Protection Worker in determining capacity was profound, as the decision affected the individual's entire life. As part of my learning, I recognized that certain cases raised ethical concerns. I engaged in reflective practice and consulted with my practicum supervisor regarding my perceptions of the ethical issues to ensure that my critical analysis was in compliance with Adult Protection policies, guidelines, and the Nova Scotia Social Work Code of Ethics.

During my practicum, I have gained knowledge about the issues, barriers, and challenges, faced by Adult Protection Workers. For example, practice challenges emerged when communicating with clients who did not understand the conversation or if the client was hearing impaired. Part of the roles and responsibilities of an Adult Protection Worker is to be mindful of their approach when dealing with a client with an intellectual disability. When dealing with a client who has a mental health diagnosis, the Adult Protection Worker must adapt his or her behaviour and modality accordingly. It is incumbent upon the Adult Protection Worker to understand how different medical conditions potentially affect the patient and the need to use an appropriate approach. The safety and well-being of the patient is paramount. The level of skill and professionalism of an Adult Protection Worker is dependent upon his or her education and training.

As noted above, I observed my practicum supervisor using a number of different, well-informed approaches to overcome a wide range of issues and challenges associated with clients who exhibited dementia, Alzheimer's disease, Schizophrenia, or Intellectual Disabilities. Both my practicum supervisor and manager encouraged me to attend workshops and conferences to keep current on the most relevant evidence-based practice approaches when serving individuals with mental health conditions.

In terms of barriers to effective Adult Protection intervention, I believe the policy framework has the potential to limit the effectiveness of an Adult Protection Worker's care plan. For example, once an Adult Protection Worker had determined the client does not meet the criteria of an adult at risk, the file is closed and the client is no longer within the sphere of responsibility for Adult Protection Services. I believe there is an expanded role for the Adult Protection Worker to engage in preventive work and provide support to individuals within the community so they do not become Adult Protection clients. Upon reflection, I believe resources are a barrier to effective Adult Protection in large, geographical areas with significantly dispersed rural population. Based on my observations, I perceive that most rural communities in Nova Scotia are resource deficient and that support to clients and families in rural communities comes from the community itself until a situation requires crisis intervention. Resources for preventive measures, such as maintaining clients in their own environment and community for as long as possible with expanded Home Care, could potentially reduce stress and the need for Adult Protection intervention.

As previously mentioned, if a person lacked capacity and did not have a Power of Attorney (POA) or have a shared bank account with another individual, the client was referred to the Public Trustees' Office. Without a POA or shared bank account, a Public Trustee employee

managed a person's finances if they were being placed in care. During my practicum, I noted a number of barriers related to the Public Trustees' Office.

Firstly, a person who wishes to live within their own community but does not have anyone to manage their financial affairs cannot access the services of a Public Trustee. The individual must be in care to access this service. This creates a barrier to the notion of preventive work within the community. Allow me to use the example of a person who did fairly well on their own, had the capacity to make personal care decisions, but found it over-whelming to handle the complex tasks of managing their own finances. The individual missed payments on their living accommodations resulting in an eviction. Without a place to live, they became an adult at risk which justified an Adult Protection referral and placement into a Long-Term Care facility. There is a shortage of Long-Term Care beds throughout the province and an Adult Protection client takes priority to any other persons on the waitlist. In my opinion, this is an avoidable situation that is not fair for those who have been waiting patiently for a Long-Term Care facility.

I discussed a number of the barriers and challenges with my practicum supervisor on a regular basis and noted them in my journal. I believe it would be beneficial if policy makers were informed by front-line workers since most of the issues and barriers I have identified require a policy solution.

The Code of Ethics for the Nova Scotia Association of Social Workers (2008) provided my primary orientation for the practices of Social Work in the delivery of Adult Protection Services. The Adult Protection Policy Manual (2011) articulates guiding principles for ethical practice for Adult Protection Workers and requires that the autonomy and self-determination of

all individuals be preserved. It was a fundamental presumption that individuals are capable of making decisions on their own behalf.

**Clinical Social Work Skills**

I utilized a number of attributes from social work theory to create solid intervention methods in practice. I demonstrated compassion for clients that experienced trauma and implemented the skill of mindfulness into case planning for Adult Protection Services. In addition, several social work models were used to develop solutions to protect adults at risk, such as, strengths-based, solution focused, and problem-solving models. The use of the strengths-based model assisted negotiations with clients by discussing what their strengths were and it provided an opportunity for clients to have a sense control and empowerment.

This approach was applied with a creative problem solving technique that engaged clients to collectively determine their challenges and develop solutions, provided the client had capacity and demonstrated a reasonable level of awareness. As an example of the practical application of this approach, I negotiated with a gentleman who was intellectually disabled and I was able to establish a relationship with him by explaining my perceptions of his strengths as an individual. I had noticed he enjoyed hockey. He acknowledged and agreed that to play hockey you had to be strong and smart. This connection enabled us to have a conversation of the importance of taking the correct medications and he acknowledged that he was worried that he was not taking the right ones. By building trust and mutual understanding, I gained his approval to be transported to the local hospital for a medical assessment and a review of his medication. Furthermore, I discussed his need for personal hygiene and how we could potentially ensure this aspect of his personal care was attended to. In my experience, clients can be resilient and resourceful in the face of adversity.

During my practicum, I implemented a learning strategy that built knowledge of the latest developments, research, and critical thinking, in Social Work. Education and training are essential for developing and maintaining professional practice skills. I demonstrated my commitment to continuous learning by attending several workshops with my practicum supervisor. At Juniper House, I attended a conference on dementia and domestic violence. This conference provided me with new learning and perspectives on domestic violence and the elderly. I also attended the Tri-County Women's Centre Annual General Meeting. At this meeting, I learned more about the network of supports and services offered within the community that ranged from business development for women to therapeutic counselling services for survivors of sexual violence. As part of my learning agenda, I attended a Dementia Workshop held by Teepa Snow who is a knowledgeable professional that specializes in working with dementia clientele. She provided new insights into different approaches for dealing with dementia clients.

During my practice in Adult Protection, I observed, learned, and reflected upon the Adult Protection Risk Continuum Model that was used to assess adults at risk. The Risk Continuum Model is used to determine if the client is at low risk, medium risk, high risk, or extremely high risk. In order for the client to move from the intake to inquiry stage of intervention, the client must be assessed in the moderate to extremely high range of risk. In order for the Adult Protection Worker to progress the client from the inquiry stage of intervention to the assessment stage, the client must be assessed at high risk or extremely high risk. The model includes a number of factors to be considered by the Adult Protection Worker for each level of risk. For example, one of the factors at the extremely high level of risk identifies the client as being in need of immediate medical attention to sustain life. The practical application of this model is

evidence-based and considers risk in light of changing circumstances. Adult Protection Services also requires an assessment of the client's perception and understanding of risk(s) and the Adult Protection Worker must consider that a client may take greater risk(s) as their perception of risk(s) diminishes.

**Individual Learning Needs, Interests, and Experiences**

I expanded my journaling techniques, as I had not previously spent much time keeping a journal. I found it beneficial to keep track of my experiences and thoughts along the practicum journey. I referred to my notes in order to reflect upon my feelings and how I responded to certain situations. Keeping a journal enabled me to critically think of my practice skills and consider areas for improvement. I am of the opinion that journaling is a beneficial tool and I intend to continue keeping a journal during my career.

I engaged with clients and families and I implemented practice skills that required the application of techniques and modalities that managed a crisis or a stressful situation. I was able to ensure that the safety of the client and everyone involved was protected by following protocol and requested the assistance of other professionals, like the RCMP, as required.

During my practicum, I was not exposed to a client who was irate or presented challenging behaviours. In the past, those kinds of situations have created significant learning and caused me to critically reflect upon how the situation was handled in order to improve practice skills. While I identified learning new techniques to deal with clients who were dissatisfied, my practice skills have improved, as I now have the ability to redirect and prevent the escalation of challenging situations.

During my practicum, I met regularly with my practicum supervisor and discussed her perceptions of the challenges and rewards of working in a rural setting. I learned that she

enjoyed the autonomy of being geographically isolated from direct supervision; consequently, she was not overwhelmed by being micromanaged on a daily basis. She enjoyed the flexibility to practice in a competent manner which was reflected in her sound professional decisions. Lisa is a very intelligent, caring, compassionate, ethical and efficient social worker who worked independently. She bridged the challenge of diminished professional networking in a rural setting by using technology and regularly attended professional workshops, conferences, and learning events.

My practicum supervisor maintained regular contact with her supervisor and felt supported when dealing with challenging situations that required reflection, direction, or review. However, the management team resides 400 kilometers away which can present challenges in developing a common understanding of local conditions, supports, and inter-agency collaboration. Rural social work is challenged by lower levels of resources and community support than urban centres. For example, the tri-county area for my practicum does not have the same level of specialist resources available compared to an urban centre such as, Halifax.

**Personal and Professional Life Balance**

During my ten years in Social Work, I have encountered many stressful and demanding experiences. I understand the importance of self-care and have incorporated healthy techniques into my lifestyle. The nature of direct Social Work practice is mentally and physically demanding; therefore, it is essential to develop a healthy balance between one's professional and personal life. During my practicum, I made a conscious effort to go for regular hikes and camping trips with my friends and family. By taking this time to do things that I enjoyed, it enabled me to be rested and focused for the job at hand. Furthermore, regular journaling acted like another self-care technique. Recording my weekly experiences provided an opportunity to

reflect upon how I felt about the situations I had encountered. It provided me with the time to think critically and to ensure that I was being true to myself, especially from an ethical perspective.

Over the years, I have heard colleagues and professors stressing how important it is to be mindful of how you are feeling when faced with difficult situations and the toll it can take on your own well-being. Compassion fatigue is a phenomenon that affects many front-line workers. Gregory (2015) states, "In recent years there has been an increase in evidence that has shown that yoga and mindfulness programs have been used to reduce symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), and other psychological conditions" (p. 373).

**New Learning**

My practicum placement was a valuable new learning experience. In my previous Social Work practice, I did not have to consider the legal aspect of case management to the extent that it is required in Adult Protection. During my practicum, I learned new approaches in social work practice and how theory was applied in practice while respecting legislation and policy guidelines designed to protect adults at risk.

In the field of Adult Protection, I learned that inter-agency and community collaboration is a vital aspect of case management. My past experiences in hospital settings included work with inter-disciplinary teams, but with a different focus. In comparison, the experience in my practicum provided me an opportunity to observe how an Adult Protection Worker reached out to collective partners in order to accomplish the objectives of protecting adults at risk by collaborating with organizations outside the agency's sphere of control. I learned that the success of Adult Protection Services is dependent upon the skill of the Adult Protection Worker to successfully network and collaborate with other agencies.

It had been years since I conducted home visits. I found it refreshing to do this again. It was almost like a new experience and reminded me that people are in all kinds of different situations within the confines of their home environment. In recent years, I have seen clients in an agency setting or in a hospital, but seeing them in their homes and inquiring about how they were managing was eye-opening. I experienced some anxiety and trepidation when I arrived at their home with over-grown grass, garbage in the yard, and broken steps. As an Adult Protection Worker, you have no idea what is behind the door.

It was disquieting to find a man in bed, unclothed, covered in urine, and the entire house smelling like rotten food with flies buzzing around your head. Front-line, community Social Work is an entirely different experience than sitting in an office where clients come to see you. I recognized that not everyone can do community work. However, on a personal level I found it rewarding to know that I made a big difference in someone else's life. I am not certain this was new learning, but it certainly was a re-affirmation, that I find great purpose in life when I help people.

In conducting Adult Protection case management, I learned new modalities to assess individuals at risk, how to apply therapeutic approaches to formulate care plans, and how to use specialized tools, developed for Adult Protection Workers. I found the tools to be comprehensive and I learned how to use them to conduct risk assessment, capacity assessment, and application to the courts.

A number of the Adult Protection cases that I experienced during my practicum caused me to reflect upon my practice and the obligation to respect the autonomy of the individual. My work ethic and performance during my practicum work was guided by the Code of Ethics for

Social Workers in Nova Scotia and my practicum placement has expanded my knowledge of the application of ethical practice in Social Work.

## Chapter Four: Implications of Practice and Recommendations

Brownlee, Graham, Doucette, Hotson, and Halverson (2010) note that communities differ and should not be singularly defined by size. For example, a farming district can be substantially dispersed, while a single industry community may be tightly clustered. Northern communities are often isolated and considered remote as distances are significant. In many cases, remote communities do not have direct road links; however, this is changing, as communities, such as Inuvik and Tuktoyuktuk in the Northwest Territories, are now connected to southern communities by the Dempster Highway, but are still considered remote communities by Natural Resources Canada (2011).

Natural Resources Canada (2011) defines the term remote community to be "any community not currently connected neither to the North American electrical grid nor to the piped natural gas network" (p. 3). In addition, Natural Resources Canada (2011) requires a remote community to be a permanent settlement of at least 10 dwellings that has been in existence for at least five years. Using this definition of remote community, Natural Resources Canada (2011) identifies 292 remote communities in Canada and none of the identified remote communities are in Nova Scotia. Therefore, the issues and challenges of Social Work in remote communities are not within the scope of this practicum report.

Brownlee et al. (2010) defines rural as a large geographic area with low density of population and fewer social services available as compared to densely populated urban communities. For the purposes of this practicum report, I will use the definition of rural as delineated by Brownlee et al. (2010). My practicum in the Yarmouth tri-county area was conducted in a mix of an urban centre and rural communities; consequently, I learned about the

challenges, rewards, and practice implications, associated with the delivery of Adult Protection Services in rural communities.

Cooper, Streeter, and Scales (2013) state, "Many authors have noted the deficits of rural communities, such as high poverty rates, inadequate housing, inadequate healthcare, scarcity of resources and professionals, socioeconomic underdevelopment, and physical distance from service and transportation" (p. 13). In addition, the Canadian Institute for Health Information (2006) notes that rural areas experience poorer socio-economic conditions, lower levels of education, and with reduced levels of population, the rural communities do not meet the conditions for government to justify health care facilities. Each of these deficits was evident during my practicum and influenced in the delivery of Adult Protection Services.

Improvements in highway networks offer better and safer access to urban areas for rural residents that must travel for health services, but travel to the rural areas for the Adult Protection Worker continues to have important implications to practice. The Canadian Institute for Health Information (2006) states the mortality rate from injury in rural areas is four times higher than in urban centres with travel on rural highway networks being a significant contributor to mortality statistics. Accordingly, the need for an Adult Protection Worker to travel in order to assess rural clients has important implications related to workplace injury while delivering services to adults at risk.

Computers, cell phones, satellite and cable access, have improved over the years in rural areas. However, the Canadian Internet Registration Authority (2014) highlights that 100 percent of urban centres in Canada have broadband internet access, while the connection rate for broadband internet access in rural areas is 86 percent. Connectivity in rural areas is increasingly important for adults as they link with each other on social media and access services on-line.

The Canadian Institute for Health Information reports the suicide rate for women in rural areas under the age of 20 is 6.5 times higher than in urban centres; therefore, new approaches to the use of technology have important implications for practice with adults at risk, as they can now access the mental health mobile crisis team and telehealth in rural areas.

Despite the tribulations in rural areas, "adults who were raised in a rural setting were significantly less likely to have any mental disorder, any anxiety disorder, or any substance abuse disorder, during their lifetime compared with those not raised in a rural setting" (Goodwin and Taha, 2014, p. 397). There are many reasons why people live and migrate to rural areas. Cooper et al. (2013) identify a number of strengths inherent in rural areas that include a sense of community, strong relationships amongst community residents, an orientation of self-sufficiency, and an ability to develop natural helping networks. These are all aspects of rural communities that can potentially be accessed by a skillful Social Worker to complement services, strengthen preventative measures, and reduce resource requirements for vulnerable adults.

My practicum experiences demonstrated that rural Social Work occurs in unique practice environments with challenges and opportunities that were not present in urban centres. For example, Humble, Lewis, Scott, and Herzog (2013) note rural Social Workers should be prepared for increased visibility and scrutiny in a small, interconnected rural community compared to the anonymity of an urban practice environment. Rural Social Work professionals may appreciate the close personal ties that serve to strengthen and protect rural populations. However, the Social Worker that embraces the close personal relationships in rural communities may inevitably "be unprepared for how much overlap occurs between their professional and personal roles with community members" (Humble et al., 2013, p. 257).

Gonyea, Wright, and Earl-Kulkosky (2014) assert that rural clinicians are more likely to be professionally isolated than their counterparts in urban centres; consequently, rural clinicians are more likely to find it difficult to obtain supervision and consultation. Gonyea et al. (2014) observe the rural Social Worker may be secluded with limited access to colleagues, fewer opportunities for professional development, and lower levels of access to support services. In addition, Gonyea et al. (2014) note the rural Social Worker invariably experiences challenges as they navigate the complex dual relationships of professional and close neighbor.

Despite these kinds of challenges, Riebschleger, Norris, Pierce, Pond, and Cummings (2015) point out many rural Social Work practitioners prefer the independence, rural surroundings, and collaboration, involving interagency and interdisciplinary teamwork. Riebschleger et al. (2015) report rural professionals experience stronger job satisfaction, higher levels of autonomy, greater decision-making authority, and better opportunities for professional growth, compared to practitioners in urban centres. Consistent with my observations during my practicum, the implication to practice and learning for the rural Social Worker is a requirement to be a generalist rather than a specialist.

"Rather than specializing in one particular method of Social Work practice, or a particular population need, the rural Social Worker needs to be able to intervene in many ways on behalf of members of the community" (Murty, 2001, p. 134). Over the long history of literature on the subject of rural Social Work, Murty (2001) notes a recurrent central theme emerges delineating the importance of local community-based and rural generalist practice. She argues that the rural Social Worker must develop an in-depth knowledge of the rural communities in which they reside and work. Based on this specialized local knowledge, the rural Social Worker, as a generalist, can provide a wide range of services. Contrary to the

development of the generalist skillset required for rural Social Workers, Murty (2001) notes "programs and policies do not encourage Social Workers to specialize in knowledge of particular communities; instead they encourage knowledge of specialized treatment, populations in need, and diagnostic groups" (p. 136).

Technological advancements have helped Social Workers who practice in the absence of direct supervision. For example, the Adult Protection Worker in Yarmouth regularly received supervisory feedback and case management support from Halifax, by way of teleconference and video-conference. In terms of practice implications, I believe keeping the lines of communication open with the supervisor is as a key element to the management of expectations. Regular discussions of caseload management enables the supervisor to understand that an Adult Protection Worker providing service to a large geographic area cannot manage the same number of cases as an Adult Protection Worker delivering services in an urban centre.

Brownlee et al. (2010) discuss that technological advancements will continue to diminish the inequities between rural and urban Social Work, but technology should not be perceived as the solution to all the problems that persist for rural Social Work. For example, Brownlee et al. (2010) highlight that many of the Social Work policies and interventions that get imported from urban centres are incompatible with the ideologies and values of rural communities. In my experience, Social Workers must understand the cultural context of rural communities and that clients in rural communities have developed a different socialization than in urban communities. Pursuant to my practicum experience, I believe there is an opportunity to conduct research in the area of rural Social Work to better understand how Social Work interventions in rural communities are differentiated from urban communities based on cultural sensitivity and values.

Technological advancements in road surfacing for country roads has the potential to reduce travel time and improve safety for Social Workers servicing clients in rural communities, but these kinds of changes will not radically alter Adult Protection Services. The practice implications for Adult Protection Services will continue to require face-to-face interventions and assessments of risk. Travel time will remain as a significant impediment to service delivery efficiency for rural communities compared to urban communities, simply because of the size of the rural geographic area versus the ability of urban communities to concentrate services.

A referral classified as extremely high on the Risk Continuum requires the Adult Protection Worker to respond within one hour because the client's life is considered to be at risk. If the Adult Protection Worker is to conduct a face-to-face assessment, it is not possible to travel in under one hour to all points within the service coverage area. There are a number of alternatives that could potentially address this service deficiency; however, changing the response time is inappropriate. Alternatively, the government could assign more Adult Protection Workers for expanded coverage, but limited resources and unpredictable demand for Adult Protection Services influence management's decisions for resource expenditure. An innovative approach may be to provide cross-training in Adult Protection for Social Workers engaged in other practice around the tri-county area. For example, a Child Protection Social Worker located in a rural area might be cross-trained so they could be called upon to respond quickly in the event of an Adult Protection emergency.

Policy and practice standards that enable a Social Worker to prevent crisis situations are a benefit to everyone. The practice of outreach and community follow-up helps to avoid the crisis of Adult Protection and helps to maintain healthy clients who enjoy autonomous living for as long as possible. There is a need for research to understand the benefits of this preventative

approach to practice and whether it has the potential to reduce the number of individuals who require Adult Protection Services. This research would be instructive in determining the level of resources required for prevention and Adult Protection.

Furthermore, Adult Protection Services would benefit from research on policy instruments or interventions that would reduce the probability that an adult in need becomes a client of Adult Protection. For example, perhaps a shift in social policy to make in-home living with family support the preferential choice would alleviate some of the pressure on Long-term Care. In addition, the social policy framework could potentially benefit from research into changes in fiscal policy. For example, changes in tax policy might lead to reduced cost and demand for Long-term Care or Adult Protection Services, if recognition is given to the economic contribution of care-givers who maintain elders in their own homes.

**Conclusion**

Social work is about real people, with real problems. Social Workers exercise ethical and compassionate practice in the client's best interest by helping them obtain the necessary resources and support. At times, Adult Protection Workers must close a file because the client does not meet the criteria of an adult at risk. Sometimes it is difficult to close a file, but the social services fabric in Nova Scotia is comprehensive. Inter-agency collaboration is not only imperative to resolve Adult Protection cases, but the network helps to ensure that individuals who do not meet the Adult Protection criteria are referred to the appropriate professionals.

During my practicum, I developed an in-depth understanding of the legislation and policy framework that governs Adult Protection Services in Nova Scotia. It is not perfect, but it has proven that to be strong. The literature reviewed for my practicum was instructive in understanding the policy failures of other jurisdictions and in understanding Nova Scotia's

approach to Adult Protection Services. I am confident that Adult Protection practice will continue to evolve with more research and persistence in protecting adults at risk.

During my practicum, I engaged in front-line case management. The experience required me to think critically in order to learn about the complexities associated with Adult Protection Social Work. In Adult Protection the needs, risk, and capacity assessments, provided an exclusive focus on outcomes with an objective that streamlined the assessment to a determination of adult at risk or adult not at risk. There is tacit acceptance that an adult at risk is an adult in need; however, an adult in need does not have to become an adult at risk. It is unacceptable to wait until the damage is done. Consequently, I believe social policy for Adult Protection would benefit from further research to determine whether preventative measures could potentially reduce the number of adults at risk.

My practicum placement has provided substantive learning about the roles and responsibilities of Adult Protection Workers in the management of casework for adults at risk. This learning experience has enabled me to learn new techniques and tools that will be useful in the broader spectrum of Social Work practice. I managed the various stages of an adult concern commencing from the intake, inquiry, identification of risk, capacity assessment processes, to the development and implementation of care plans for adults at risk. The experience enabled me to widen my practice skills and to fully appreciate the complexity of community and rural social work.

As I reflect upon my practicum placement at Adult Protection Services, I am reminded of a quote attributed to the civil rights leader Mahatma Gandhi (1869-1948) who said, "The measure of a country's greatness should be based on how well it cares for its most vulnerable populations".

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## Appendices

### Appendix A: Learning Contract

# MSW Practicum II: Learning Contract

**Student:** Michelle Wheelhouse **Academic Supervisor:** Tammy Pearson

**Agency:** Adult Protection, Nova Scotia Department of Health and Wellness

**Practicum Supervisor:** Lisa Bowden MSW

**Length of Placement:** May 24, 2017 to August 29, 2017

| **Objectives** | **Tasks, Activities and Strategies** To assist in achieving goal | **Performance Indicators** Observable indicators of achievement |
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| 1) To engage in supervised learning activities designed to meet goals of increasing knowledge of social work and social work practice in Adult Protection. | Develop knowledge of the legislative and policy framework for the delivery of Adult Protection services; | Attend practicum during timeframe agreed upon with agency;<br><br>Read legislation and policy manual then consult with supervisor during practicum to ensure compliance in practice;<br><br>Document the application of legislation and policy in case management; |
| | Build knowledge of the supports and services offered by Adult Protection Services; and, | Maintain a journal through a number of cases while shadowing practicum supervisor to learn supports, services, process, inter-agency services, and practical application of policy manual; |
| | Build knowledge of the Adult Protection Services case management process from the point of intake, inquiry, assessment, and the closing of a case file. | Manage and document an Adult Protection case from start to finish; and, |

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| | | Maintain professional boundaries and demonstrate ethical practice. |
| 2) To increase knowledge of social work networks and other organizations that work closely with my practicum agency to provide resources for the population group at risk. | Consult and attend meetings with various community agencies to discuss cases, the roles of the different agencies, and how they interact on Adult Protection cases; and,<br><br>Build knowledge of the social work environment and interaction with other organizations and professionals for the delivery of Adult Protection Services (such as: long-term care facilities, mental health departments, hospitals, RCMP, etc.) | Maintain journal and reflect upon roles, responsibilities, and services described in consultation and observed in meetings with community agencies and professionals involved in Adult Protection cases; and,<br><br>Observe/record in journal when interaction occurs or does not occur and reflect upon the effectiveness of the interaction and/or resource contribution made by other organizations or professionals to resolve specific cases of Adult Protection. |
| 3) To acquire and demonstrate advanced practice knowledge, values and skills in a clinical agency setting. | Learn therapeutic approaches and assessment techniques for various mental health conditions;<br><br>Participate in group and individual Care Plan meetings that require the application of a range of theories and modalities to protect adults at risk;<br><br>Learn the roles and responsibilities of an Adult Protection Worker, as part of an integrated healthcare team for trauma-informed practice in Adult Protection; | Consult, observe and discuss with supervisor the various tools and approaches used with clients to determine intellectual disabilities, physical, and/or mental capacity;<br><br>Maintain journal and engage in reflective practice on observed theories and modalities used in case management;<br><br>Demonstrate understanding of the job description of the Adult Protection Worker through case management, Care Plan and follow-up including completion of all relevant documentation; |

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| | Learn to recognize and deal with the ethical issues faced by an Adult Protection Worker; and,<br><br>Build knowledge of the issues, barriers, and challenges facing an Adult Protection Worker in the delivery of services to individuals at risk and their families. | Consult with supervisor when identifying ethical issues and ensure compliance with policies and guidelines set by the agency. Engage in reflective practice on difficult issues with reference to Code of Ethics; and,<br><br>Consult with supervisor to discuss issues, challenges, and barriers facing the Adult Protection Worker in case management and inter-agency interaction. Maintain journal of solutions observed to overcome identified issues, challenges, and barriers. |
| 4) To expand my clinical social work skills. | Build knowledge of social work theory and intervention methods in practice;<br><br>Develop Adult Protection case management experience;<br><br>Build knowledge of the latest developments, research, and thinking in Social Work; | Observe, use, and reflect upon the practical application of theory in trauma for Adult Protection interventions in case management;<br><br>Manage and document an Adult Protection case from start to finish including intake, inquiry, obtaining collateral information, assessments, implementing a Care Plan, follow-up, and closing a case file;<br><br>Demonstrate proper note taking, reports and case management documentation;<br><br>During my practicum, attend any conferences, workshops, or meetings that will enhance my Social Work and Adult Protection skills and knowledge as recommended by my supervisor; |

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| | Reflect upon systems theory with emphasis on reciprocal relationships between individuals, groups, and organizations in the Adult Protection environment; | Create and maintain strong community networks and relationships with allied community agencies though regular contact;<br><br>With my practicum supervisor, reflect upon and discuss the practical application of systems theories in Adult Protection, inter-agency relationships, and the challenges and rewards of rural social work; |
| | Build knowledge of the practical application of the principles of trauma-informed practice for clients with a history of trauma and/or abuse; and, | Through case management and reflective practice, demonstrate a sense of compassion for clients that experience trauma and implement mindfulness skills into case management practice; and, |
| | Build knowledge of the practical application of social work practice models to solve problems in adult protection. | Observe Adult Protection case management and reflect upon the social work practice models used to develop solutions to protect adults at risk. |
| 5) To engage in a practicum experience that reflects my individual learning needs, interests and experiences. | Engage in reflexivity through journaling; | Keep a journal to reflect my activities, observations, and practicum experience; |
| | Learn how vulnerable adults are protected from harm by a policy framework that also respects individual autonomy; and, | Manage and document an Adult Protection case that demonstrates the client was treated with respect, dignity, and compassion while following the approved policy framework; |
| | Learn techniques to calm or redirect irate and/or challenging behaviour. | Engage with clients, families, and care-givers to implement practice skills that require application of techniques to |

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| | | redirect challenging behavior to ensure client and staff safety; and, |
| 6) To preserve a healthy balance in my personal and professional life. | Expanding my Social Work practice skills and engaging in self-care activities to cope with a high-stress work environment. | Meet regularly with my practicum supervisor to engage in clinical supervision, to debrief, and solicit feedback on how to improve my Social Work practice.<br><br>Engage in self-care activities such as camping, hiking, exercise, meditation, and social events with friends and family.<br><br>Engage in self-reflection to ensure the work gets left behind in the workplace. |