Social Work Role in the Decision-Making Capacity Process With Adults

Guidelines for Social Work Practice in AHS Programs and Facilities

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Social Work Provincial Professional Practice Council (SWPPPC)
Health Professions – Interprofessional Practice

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PURPOSE of the GUIDELINES

Understanding decision-making capacity is an essential component of safe, ethical and competent healthcare practice. The Canadian Association of Social Workers (CASW) Code of Ethics 2005, which is endorsed by the Alberta College of Social Workers (ACSW), states that informed consent of the client is fundamental to social work practice. The CASW Code of Ethics 2005 defines informed consent as a "voluntary agreement reached by a *capable* client based on information about *foreseeable risks and benefits* associated with the agreement" (p. 10). One of the key components in the definition of capacity is the ability to weigh *risk and benefit* and make a choice based on the balance of these factors. Informed consent requires that the adult client has the ability to process abstract information in order to make a reasoned decision. Required practice elements for effective implementation of informed consent practice are: (1) the professional responsibility of being able to recognize when a client may be lacking in capacity and (2) having the knowledge required to ensure that either the client's expression of capacity is supported or the client's wishes are voiced by an advocate. To achieve this, social workers need to be able to:

- form a professional opinion regarding their client's decision-making capacity during the course of the professional relationship
- utilize a biopsychosocial assessment approach to understand challenges to expression of capacity and develop mitigating strategies
- understand the legislative framework within Alberta related to decision-making capacity to facilitate the identification of an alternate decision-maker where appropriate to speak on the client's behalf.

These Guidelines are not intended to be used as rules that prescribe practice. Rather, they are designed to provide leading and evidence-based practice direction and parameters to help social workers reason through their professional interventions when addressing decision-making capacity situations. They may be utilized in conjunction with peer and collegial consultation, and administrative and clinical supervision as required. Finally, these Guidelines are designed to be applicable with a range of vulnerable adult client populations and across services sectors and settings where decision-making capacity resources vary

widely. For the purposes of these guidelines, we will use the term client to refer to patients, residents and other service recipients of social work services.

VALUES AND THEORIES that INFORM SOCIAL WORK PRACTICE related to DECISION-MAKING CAPACITY

As employees of AHS, we strive to enact the five (5) AHS values of Compassion, Accountability, Respect, Excellence and Safety; two of which are strongly aligned with informed consent practices and social work values that inform decision-making capacity practice. These are the values of Respect and Accountability. The value of Respect can be described as: *demonstrating compassion; treating others with respect, fairness and dignity; valuing and honouring diversity.* The value of Accountability can be described as: *displaying integrity and ethical behaviour and acting honestly.*

Three of the six CASW Core Values outlined in the 2005 Code of Ethics strongly align with informed consent practices and inform the decision-making capacity process. These are:

- Value 1 - Respect for Inherent Dignity and Worth of Persons which involves *each person's right to self-determination, consistent with that person's capacity and with the rights of others* (p. 4). Self determination is a *core social work value that refers to the right to self-direction and freedom of choice without interference from others. Self-determination is codified in practice through mechanisms of informed consent.* (p. 11)
- Value 3 - Service to Humanity: protecting personal freedoms, working for the greater good which involves promoting *individual development and pursuit of individual goals, as well as the development of a just society* (p. 6).
- Value 4 - Integrity of Professional Practice: ethics, honesty and truthfulness or accuracy of one's actions. In part, this value involves demonstrating *adherence to the values and ethical principles of the profession and promoting respect for the profession's values and principles in organizations where they work or with which they have a professional affiliation.* (p. 7)

Additionally, there are many social work theories and models that guide our practice and thinking. The *Person-in-Environment* and the *Ecological Perspective* are foundational frameworks for social work practice that provide unique value in informing decision-making capacity practice. Social workers understand that individuals live within systems that shape their choices and beliefs. What an individual believes about themselves is shaped by their social interactions, by their environmental context, and the

meaning the individual gives to their personal or perceived experiences. An appreciation of this "context" in which an individual makes decisions and choices has significant implications on an evaluation of the individual's decision-making capacity. Awareness of how change in one part of the individual's environment has impact on other aspects of their functioning is central to these social work frameworks. Social workers consider the impact of a "health" event on the individual (*microsystem)* which in turn has implications for the family or on the individual's employment (*mesosystem*), the health care system or social agencies (*exosytem),* and services are further impacted by policies and societal values *(macrosystem*) that shape which resources and interventions are offered and to whom. The social worker utilizes these foundational frameworks to understand and consider problem solving, provide psychosocial support, facilitate access to resources and advocate for client goals and needs. These social work interventions are guided by the overarching goal of assisting an individual in making independent choices and decisions, or facilitating the identification of a client advocate with the authority and ability to speak on the client's behalf, if it is determined that the client lacks capacity and requires or would benefit from the appointment of an advocate (i.e. – alternate decision-maker).

LEGISLATIVE FRAMEWORK related to DECISION-MAKING CAPACITY PROCESS

There are a number of acts and regulations that provide the foundational legal framework for healthcare practice related to the decision-making capacity process. Social work as a profession plays a lead role in the implementation of relevant components of this legislation in order to facilitate and help coordinate the decision-making capacity process. These acts, regulations and related information are highlighted in Table 1. Two key acts are the *Alberta Guardianship and Trusteeship Act* (*AGTA)* and the *Personal Directive Act (PDA).* The *AGTA and PDA* are based on four guiding principles. These principles are intended to guide decisions related to decision-making capacity:

- the adult is presumed to have capacity and able to make decisions until the contrary is determined
- the ability to communicate verbally is not a determination of capacity and the adult is entitled to communicate by any means that enables them to be understood (AGTA only)
- focus is on the autonomy of the adult with the least intrusive and least restrictive approach
- decision-making needs to focus on the best interests of the adult and how the adult would have made the decision if capable

These guiding principles align closely with social work values already noted.

For individuals, age 18 or older, seeking treatment for physical and/or mental health issues, the information contained within Table 1 is applicable. However, in some instances, social workers may be working with individuals who have been declared a Formal Patient under the *Mental Health Act (MHA)*. The *MHA* regulates the involuntary detention and treatment of persons with mental health issues. Being declared a Formal Patient under the MHA does not mean that the patient lacks the capacity to consent to treatment. With all adults, capacity is presumed until an assessment has been completed that states otherwise. When a Formal Patient is determined to lack capacity to consent to treatment, specific regulations pursuant to the *MHA* must be followed. Information on the *MHA* can be viewed at: www.albertahealthservices.ca/mha.asp.

TABLE 1

ALBERTA LEGISLATIVE FRAMEWORK related to DECISION-MAKING CAPACITY PROCESS with ADULTS

Type of Decision	Legislation	Alternate Decision-Maker/s & Paperwork	Purpose	Who Appoints Alternate Decision-Maker
Personal Decisions	**Personal Directive Act (PDA)**	Agent/s may be identified Personal directive (PD)– enacted when adult lacks capacity Requires legislated Schedule 2 or 3, pursuant to personal directive regulations	Adult indicates their wishes pertaining to personal matters (excluding financial matters), relating to any or all of the personal domains. The personal domains include: healthcare, accommodation, choice of associates, social activities, education/training, employment, and legal affairs	Adult with capacity (the PD maker) decides by drafting a personal directive stating their wishes relating to personal matters (see domains noted in previous column) and by appointing an Agent**/s**, if they wish
	Alberta Guardianship & Trusteeship Act (AGTA)	Guardian Guardianship order	Appointment of alternate decision-maker for adult who lacks capacity Court decides what personal domains the Guardian has authority to make decisions within. The personal domains are noted above	Court application – court decides
	AGTA	Co-Decision Maker Co-decision-making order	Capacity is impaired, but the adult can make personal decisions with guidance and support The adult is assisted by the Co-Decision-Maker to make decisions collaboratively The adult must agree to this arrangement and may reject it at any time	Court application – court decides
	AGTA	Specific Decision-Maker Legislated Form 6	For specific healthcare or residential placement decisions Only applies when no Agent or Guardian exists and adult lacks capacity Form 6 remains in effect while decision-making authorization is required in relation to the decision specified; with the exception of decisions for residential placement. For residential placement decisions, the decision-making authorization is in place for 6 mos. and cannot be renewed Specific decision-making does not apply to mental health disorders, end of life, sterilization, psychosurgery, transplantation of tissue and experimental activities	A physician, Nurse Practitioner or Dentist (for dental work only) will select a relative, from the rank-ordered list, that meets the criteria indicated If no relative is available or appropriate, the Office of the Public Guardian will be contacted to fulfill the decision-making role
	AGTA	Supported Decision-Maker Supported decision making authorization, Form 1	The adult can name up to 3 supporters, formalized through the use of an AGTA form, who can help with: • decision-making process • accessing relevant personal information (incl. healthcare information) • communicate key decisions	Adult with capacity decides – no court involvement
Emergency Healthcare Decision Making	**AGTA**	No decision-maker Document emergency health care provision AHS form #18629 (on *Insite*) - Emergency Health Care: Documentation of Exception to Consent	Emergency healthcare provision under AGTA is an exception to the informed consent process This provides a legal framework to support Physicians in the delivery of emergency healthcare	1st Physician determines: 1. need for emergency healthcare 2. that patient lacks capacity 3. and that the patient had no known prior expressed wish to the contrary When practicable, the 2nd Physician, Nurse Practitioner or Registered Nurse confirms above
Financial Decisions	**Powers of Attorney Act**	Attorney Enduring Power of Attorney document	Adult outlines their wishes related to financial matters or the management of their estate only	Drafted by the adult when they have capacity and enacted when the adult lacks capacity
	AGTA	Trustee Trusteeship order	Appointed adult has the authority to make or help make decisions about financial matters on behalf of another adult who lacks capacity. Financial matters include: person property, realty, money, investments & income	Court application – court decides

Flowing from this legal framework, as well as other foundational documents, AHS developed the Consent Policy suite (one policy, 5 procedures and related consent forms) to guide the informed consent practices within healthcare. The AHS Consent policy suite upholds the principles and values already discussed and can be found at: http://insite.albertahealthservices.ca/2270.asp.

Capacity is defined as the ability to understand the information that is relevant to the making of a personal or financial decision and the ability to appreciate the reasonable foreseeable consequences of the decision. Capacity is not an 'all or nothing' concept. An individual can have capacity to make some decisions in some domains and lack capacity in others. There are eight domains which are assessed when determining capacity. These domains are the same under both the *Personal Directive Act* and the *Alberta Guardianship and Trusteeship Act:*

Health Care	Accommodation	Social Leisure Activities
Employment	Associates	Education/Training
Legal (non financial)	Financial	

Capacity refers to the ability to make and implement a reasoned choice; rather than referring to the outcome of the choice or the actual decision. A reasoned decision involves a process and includes two key elements of decision-making: (1) understanding the options; and (2) appreciation of the risks/ benefits/ consequences of each option. An important aspect of appreciation is the concept of initiation. Simply stated, initiation refers to the ability of the client to take action to implement the decision or to direct another to take action on their behalf. A risky decision is not necessarily an incompetent decision - stockbrokers, soldiers, medical professionals and clients make them every day. It is the decision-making process – or the lack of process – by which risky decisions are made that calls into question the capacity of a client to make that decision. As a result, assessment of capacity must look at more than the outcome (i.e. - the decision the individual is making) and consider how or why they came to make that decision (i.e. - the process that lead to the decision).

At times capacity and competency are used interchangeably but in fact they are uniquely different.

Competency is a legal determination made by a judge or court regarding decision-making ability of an

individual, while capacity is the clinical opinion of a health professional based on an assessment regarding the process by which an individual utilizes information and resources to make a decision. A capacity assessment is used to guide the legal determination of competency.

GENERAL ROLE OF SOCIAL WORK in DECISION-MAKING CAPACITY PROCESS

Decision-making capacity is a critical component of the individual's ability to function in their environment, and in relation to the systems and structures around them. As a result, the ability to screen for and evaluate the client's decision-making capacity, and to facilitate the decision-making capacity process, is central to front line healthcare social work practice.

Social workers have a responsibility to verify that the client understands the intervention options being recommended; including the risks, benefits and alternatives. Understanding cannot be assumed; but rather, requires clarification by the social worker to ascertain the client's comprehension. Further, the social worker needs to appreciate that understanding is shaped by an individual's culture, beliefs, values, and experiences**.**

The fundamental value of self determination noted earlier underlies the concepts of 'right to choose' and 'right to live at risk'. Social workers actively support clients to make 'informed choices'. To this end, some of the primary social worker functions include: educating and informing, facilitating client participation in decisions that impact their well being, helping clients to find and use their voice, mediation, advocacy, and taking action to protect individual rights and freedoms.

Social workers implement the principle that adults are presumed to be capable unless there is evidence to the contrary. Common situations where questions may be raised about an individual's decision-making capacity include:

- Client unable to identify options for solving problems
- Client appears unable to appreciate the risks and benefits of different choices

- Client makes a choice, but is unable to carry it out or to direct someone else to do so on their behalf
- Client appears to be easily led and at risk of being taken advantage of
- Client choices, values or beliefs are in conflict with healthcare team recommendations and the team is concerned about client risks

When an individual's decision-making capacity is being questioned, the social worker is uniquely positioned to collaborate on the following:

- **Assess the Risk**
  - Investigate and document risk and unsafe situations
  - Explore risk-reduction strategies
  - The higher the risk of harm to the client or others, the stricter the standard applied
- **Problem solve potential for least restrictive solutions**
  - Involve clients and families in problem-solving
  - Seek perspectives from other team members
  - Mobilize informal resources
  - Consider formal resources

Issues may be resolved by problem solving without seeking a formal capacity assessment. If these screening and problem-solving activities do not address the capacity concern, the social worker may recommend the need for a formal assessment of decision-making capacity.

When the client has been deemed unable to make their own decisions, social workers will continue to make efforts to involve the client in discussions to the degree that they are able to in relation to the specific decision required. Social workers should be knowledgeable about alternate decision-maker options and able to assist in the identification of a legally authorized alternate decision-maker to speak on the client's behalf. Social workers may also be involved to promote that the alternate decision-maker considers the client's values, beliefs and preferences, with the intent of making decisions that the client would have likely made for them self.

Alberta Health Services

SWPPPC – DECISION-MAKING ASSESSMENT PROCESS GUIDELINES

The Social Work guidelines, roles and functions related to decision-making capacity issues are summarized in the table below, along with the supporting principles. These guidelines, roles and functions are intended to provide general guidance to social workers across a range of service sectors and programs, including areas within healthcare that have implemented the Decision-Making Capacity Assessment Model (AHS-Seniors Health, 2012) and those that have not.

TABLE 2
SOCIAL WORK CASE COORDINATION & FACILITATION of DECISION-MAKING CAPACITY ISSUES within HEALTHCARE SETTINGS

#	Guidelines for Addressing Decision-making Capacity Issues	Tools in Support of Guideline Implementation	Principles	Social Work Roles and Functions
1	**Determine Triggers for Exploring Client's Decision-making Capacity** • adult makes choices or behaves differently than usual ; creating risk for self or others • change seems to be the result of impaired decision-making • conflict about the decision –e.g. adult does not want to give up an activity with clear risk • 'red flag' information provided by collaterals (family, friends, neighbors)	RCAT Decision-Making Capacity Algorithm, Nov. 2012 (Appendix A) DMCA Model – Capacity Assessment Process Worksheet, page 1 (Appendix B)	• Presume capacity unless evidence to the contrary • Support client self determination • Support right to 'live at risk' when client decision-making process not impaired	• Review 'trigger' information available through health record, healthcare team members, and volunteered by collaterals (family, friends, neighbors, external service providers, etc.). • Determine decisional domain/s involved in the trigger situation: Healthcare, Accommodation, Choice of Associates, Financial Matters, Legal Matters, Social/Leisure Activities, Education/Vocational Training, Employment • Discuss 'trigger' situation with client; seek client perspective and their understanding of others' perspectives • Obtain client permission to contact collaterals and external service providers to expand understanding of issues. Social Worker requires signed consent re: disclosing health information – e.g. contacting an external service provider to obtain information involves disclosing that the client is receiving healthcare service; which is a disclosure of health information. • Clarify risk and safety issues, to client and others, and under what circumstances. Indicate client's ability to understand and appreciate risks/safety issues identified by others and client response to same. Indicate any conflict of interest or values on behalf of those identifying 'triggers' for addressing the client's decision-making capacity. • Collaborate with healthcare team to determine whether valid trigger/s present to begin initial capacity assessment process
2	**Initial Social Work Decision-making**	DMCA Model – Capacity Assessment Process	• Continuing presumption of capacity	• Address any communication barriers that challenge the client's ability to engage as much as possible in the initial screening and assessment process –

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#	Guidelines for Addressing Decision-making Capacity Issues	Tools in Support of Guideline Implementation	Principles	Social Work Roles and Functions

	Capacity Screening/Assessment	Worksheet – pages 2 – 4 (Appendix B)
		
		Regional Competency Assessment Team (RCAT) - Psychosocial Prompt Sheet (Appendix C)
			• Balancing client right to autonomy with duty to care & societal obligation to protect the vulnerable	e.g. utilizing strategies designed to facilitate communication with clients with aphasia; work with other providers such as the Speech Language Pathologist to optimize client's ability to communicate; organize use of interpretation when English is an additional language; address/accommodate for vision and hearing issues, etc.
				• Obtain client consent to proceed with initial assessment re: trigger/s situation related to client's decision-making capacity.
				• Client assent is acceptable where client willing to engage in process, but appears challenged to understand the purpose of the interview and appreciate the potential outcomes and implications of the initial assessment process.
				• Proceed with a Social Work assessment to determine the impact of an adult's psychosocial functioning on their decision-making capacity. Relevant areas include, but are not limited to:
				  • client's current living situation
				  • relevant social and family history
				  • client/family understanding of their medical history and current situation (including physical and mental health)
				  • medico-legal issues and documents (previous opinion on capacity, personal directive exists?, etc.)
				  • coping patterns (current & historical)
				  • social supports (formal and informal)
				  • religious and cultural factors (including racism, marginalization or health equity issues due to these factors)
				  • risk of abuse /neglect (including self neglect)
				See Psychosocial Prompt Tool for prompts under each above category.
				• From the Determination of Triggers information, further define and explore the relevant decisional domains.
				• Obtain any additional consent required for obtaining/disclosing health information.

3	**Provision of Psychosocial Support to Client/Family**	Practical Tools for PFCC (enter above phrase on AHS *Insite* main page search bar)	• Supporting each person' dignity and worth • Working to enhance social functioning and person-environment fit	• Allowing client/family/client 's support persons to express their concerns, challenges , hopes and goals related to the client's current situation and specific to the current decision-making capacity process • Supporting the client and family emotionally through an often challenging, overwhelming and bewildering sets of circumstances r/t to changes in the client's wellbeing and ability to manage • Respond to client/family questions as able and facilitate client-provider discussions promptly

TABLE 2 SOCIAL WORK CASE COORDINATION & FACILITATION of DECISION-MAKING CAPACITY ISSUES within HEALTHCARE SETTINGS				
#	Guidelines for Addressing Decision-making Capacity Issues	Tools in Support of Guideline Implementation	Principles	Social Work Roles and Functions
				• Facilitate problem-solving of any immediate client/family issues through care planning and client conferencing as appropriate • Facilitate client/family – healthcare team collaboration through: provision of information to demystify medical-legal and healthcare processes; highlighting and maintaining focus on client/family concerns and goals; and working to actively engaging the client and family in all care planning, as desired and feasible
4	**Explore Options, Problem Solve& Educate** • **Risk reduction strategies** • **Utilizing client and family strengths & resources** • **Provision of client, family and healthcare provider education; option-dependent**	DMCA Model – Capacity Assessment Process Worksheet – pages 2 – 4 (Appendix B)	• Presumption of capacity until contrary demonstrated • Onus on assessor to demonstrate incapacity; not on client to demonstrate capacity • Entitled to most effective, least restrictive /intrusive form of support • Change of legal status is a last resort ; must be evidence that necessary	• As risk and safety factors are defined, the Social Worker collaborates with the client, family and healthcare team to facilitate the problem-solving process. • Facilitates a problem solving process that is guided by the client's values and beliefs about risk, harm, safety, acceptance/refusal of help, independence/ interdependence/dependence and by the client's healthcare & personal goals • Problem solving focuses on risk reduction through environmental changes, monitoring, changes to the client's daily structure and routine, coordination of care plan and caregivers, use of family and informal supports, etc. • Identifies and utilizes client and family strengths to address areas of limitation/risk/harm/safety –eg- client's ability to recognize when help needed; willingness to accept help when needed; informal, trusted decisional supports already in place or able to be put into place, etc. • Contributes to a collaborative and participatory problem solving process through facilitating input from all involved parties; seeking information and resources as required to sustain a productive outcome; and helping to translate input into available options. • Educates client/family and healthcare team as required regarding alternate decision-making options: Agent under Personal Directive Act; Enduring Power of Attorney (financial matters only); Supported Decision-making, Co-Decision Making, Specific Decision Making, Emergency Healthcare Decision Making, Guardianship and Trusteeship (financial matters only) under the Adult Guardianship and Trusteeship Act. • Identifies any medico-legal documents in existence and educates re: current documents such as Personal Directive, Enduring Power of Attorney; determining which options may be viable in the current circumstances. o If the above options do not exist, does the client have the decision-making capacity to initiate a personal directive and/or Enduring Power of Attorney and are they interested in doing so?

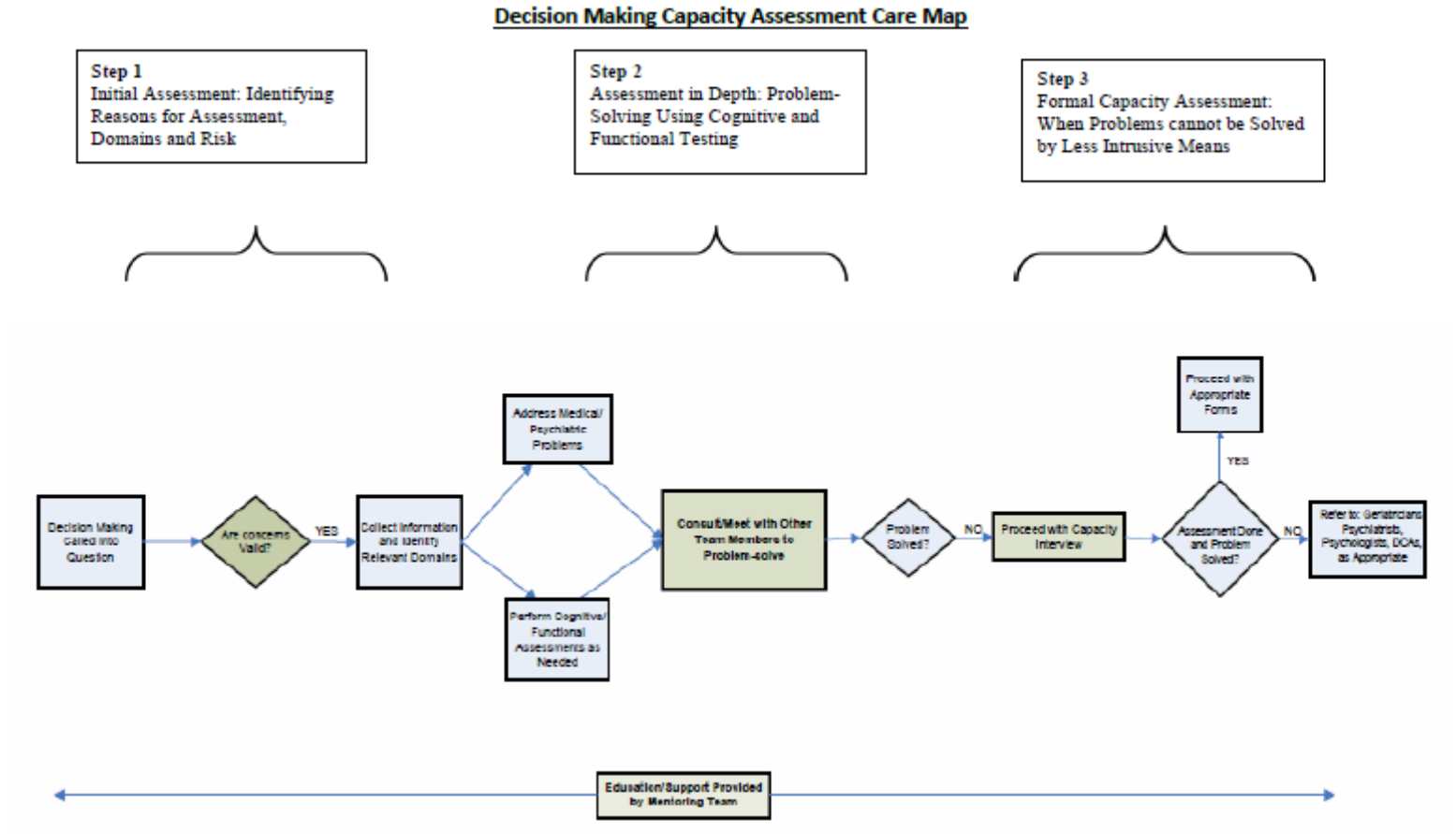
TABLE 2 SOCIAL WORK CASE COORDINATION & FACILITATION of DECISION-MAKING CAPACITY ISSUES within HEALTHCARE SETTINGS				
#	Guidelines for Addressing Decision-making Capacity Issues	Tools in Support of Guideline Implementation	Principles	Social Work Roles and Functions
				o Would there be benefit in establishing a Supported Decision Maker or a Co-Decision Maker? o Is there direct and significant benefit to the client in considering more intrusive limited options such as a Specific Decision Maker or a more intrusive and permanent option such as Guardianship
5	**Collaboratively Determine Least Intrusive Option**	CASW Code of Ethics (2005) ACSW Standards of Practice 2013	• See above	• Collaborates with client/family and healthcare team to develop an option/s for the client to be appropriately supported by informal and formal, family and community supports (including a structured living environment); without requiring formal removal of the client's decisional autonomy. • Collaboration for Social Work involves, but is not limited to: initiating/facilitating client/family care conferences and discussions; following up with relevant parties to understand their perspective; delineating available options and benefits & drawbacks; using the client's values/beliefs/goals as the guide to problem-solving and resulting care planning; and identifying and researching solutions to any specific barriers re: productive problem-solving. • Utilizes communication/negotiation/mediation,/participatory decision-making and conflict resolution approaches as appropriate to the circumstances and provider skill set; in order to achieve an outcome that provides the greatest benefit to the client with the least restriction on their autonomy. • Strives to develop consensus on most effective and least intrusive /restrictive option by inviting and exploring alternate & divergent views; distilling commonalities and distinctions; and reevaluating alternatives for greatest client benefit. • Assist in communicating this option to the client and involved parties; understanding the psychosocial implications of the identified option.
6	**Facilitate Development & Implementation of Action Plan**	CASW Code of Ethics (2005) ACSW Standards of Practice 2013 Health Professions Act & Social Work Regulations AGTA principles: • Presumption of capacity until contrary determined • Ability to communicate	• Commitment to competent, evidence-informed, professional care • Care informed by AHS Mission & Values • Client values/ beliefs/goals inform the care plan • Person – environment fit	• Assists client/family and care team in determining and implementing an appropriate action plan based on the determined option. • Facilitates implementation of risk reduction strategies and strategies to optimize use of client/family and healthcare & community strengths and resources (eg – placement in a supportive living environment for clients with brain injury). • Implements interventions to enhance or restore the social functioning of individuals/families/groups by addressing person-environment fit through ameliorative strategies noted above. • When it is determined that a more restrictive option will be required to provide safe and ethical care to the client, Social Work will strive to facilitate

TABLE 2 SOCIAL WORK CASE COORDINATION & FACILITATION of DECISION-MAKING CAPACITY ISSUES within HEALTHCARE SETTINGS				
#	Guidelines for Addressing Decision-making Capacity Issues	Tools in Support of Guideline Implementation	Principles	Social Work Roles and Functions
		verbally is not a determination of capacity • Focus on autonomy; least intrusive & restrictive approach • Decision-making focused on best interests of adult & how adult would make decision if capable		client and family understanding and involvement to the fullest extent possible . • When appropriate, facilitates referral for a formal capacity assessment to be completed by a Physician, Psychologist, DCA (Designated Capacity Assessor under the authority of the Office of the Public Guardian) or specialized service such as the Regional Capacity Assessment Team (RCAT, Calgary). • Case coordinates and facilitates alternate decision-making processes as required.
7	**Facilitate Medico-Legal Paperwork Process if required**	See above Identifying an Alternate Decision Maker Tip Sheet (Appendix D)	See above	• Educates and facilitates re: the necessary paper work processes • Involves client and family in a respectful and transparent process to the fullest extent possible • Utilize known client values/beliefs/goals to guide and influence the alternate decision-making process and resulting healthcare decisions
8	**Provision of Counseling (e.g. - Adjustment, Grief/Loss)**		• Commitment to competent, evidence-informed, professional care	• Provides counseling to client and family members/support persons to assist with adjustment issues related to change in client status and independence/dependence/interdependence issues. • Assists with processing of numerous loss issues related to a major life transition of this nature: loss of function, loss of identity, loss of body image, loss of role (family, employment, volunteer, and community), loss of financial resources, etc. • Addresses issues related to changes in family roles and relationships • Identifies and utilizes client and family strengths and resources to enhance coping and social functioning
9	**Address Resource Needs to Support Action Plan**		• Person-environment fit • Enhancing social functioning & • optimizing people-system linkages	• Researches and identifies resources to support the action plan • Collaborates with the client/family and healthcare team re: determination and coordination of referrals • Initiates and follows up on resource referrals as required • Facilitates linkages between the client, family and community providers as required
10	**Determine and Facilitate Follow-Up re: Ongoing Risk Mgmt.**	CASW Code of Ethics (2005) ACSW Standards of Practice 2013 Health Professions Act & Social Work Regulations	• Commitment to competent, evidence-informed, professional care • Client values/ beliefs/goals inform care	• Case management and case coordination as defined by program/service mandate and parameters of role

SOCIAL WORK ROLE within the DECISION-MAKING CAPACITY ASSESSMENT (DMCA) MODEL

The DMCA model has been endorsed and implemented in Calgary and Edmonton Zones with gradual uptake occurring in other zones. It is a systematic, team-based problem-solving approach which emphasizes the least intrusive measures in addressing personal and financial decision-making needs of the individual while respecting the person's dignity. The DMCA model is a standardized process that relies on the collaboration of interprofessional team members to identify valid reasons for conducting a formal assessment of decision-making capacity with an individual; isolate domains needing to be assessed; perform appropriate cognitive and functional assessments; and problem-solve to determine the least intrusive and restrictive measures possible in support of a person's decision-making. Interprofessional team members include various health professionals such as physicians, nurses, social workers, psychologists, occupational therapists, physical therapists, speech-language pathologists, chaplains, recreation therapist and therapy and nursing assistants. Although the team may or may not have specialized skills in the area of capacity assessment, they are often involved with dealing with the challenges associated with addressing the lack of capacity.

To assist the interprofessional team members, the DMCA model supports the development of mentoring teams. Mentoring teams consist of seasoned healthcare providers who are available to support and educate frontline staff around the capacity assessment process, and respond to more complex cases. Specifically trained Designated Capacity Assessors (DCAs), who are often part of the mentoring teams, may additionally conduct formal Capacity Assessment Interviews if all other avenues are exhausted and no less intrusive or restrictive alternative can be found (AHS - Seniors Health (2012) p. 10). Interprofessional teams who have adopted the DMCA Model follow a three phase assessment process, as described below and illustrated in the Care Map:



(AHS – Seniors Health (2012) p. 10)

Social workers may have roles in all three steps of the assessment process. In the initial step, as a member of the interprofessional team, social workers can play a key role in gathering information from multiple sources (family, agency staff, significant others) to provide a holistic history of previous functioning, determining current state (what has changed, what has been attempted to resolve the situation) and identifying the client's values and belief system. Social workers may also advocate on behalf of the client regarding the right to self-determination and the right to 'live at risk' when conflict arises either with the team or other family members. The areas or domains of decision-making capacity are identified by the team during this initial period as well as the risks to either the individual or to others.

In the second step of the assessment process, social workers collaborate with other team members to further problem-solve and explore alternative or least intrusive measures including community supports to manage or reduce the risks associated with the capacity concerns. Often at this stage, social workers provide education and support to individuals/families around legal matters (Personal Directives, Enduring Power of Attorney, Guardianship and Trusteeship) and gather copies of legal documents. If none exist, then the social worker contacts family members to determine their ability/willingness to take on the role of alternate decision maker such as guardian, trustee, co-decision maker or specific decision maker if the situation dictates.

Although the mentoring team can be accessed at any point in the capacity assessment process, it most often occurs after the second step of the capacity assessment. The mentoring team exists to support, educate and assist front line staff and is comprised of various health care providers including social workers. Upon request, specific clinical situations are reviewed by the mentoring team who may either recommend further problem-solving approaches or a formal capacity

interview to be completed by a physician, psychologist or a Designated Capacity Assessor (DCA) authorized by the Office of the Public Guardian.

Documentation of the capacity pre-assessment process is to be completed on a standardized *Capacity Assessment Process Worksheet* (Appendix B) by the most responsible health care professional. Input from all the team members involved in the assessment process is to be captured in this single compilation document, as well as the outcome of the assessment. Outcomes may include:

- Client has sufficient capacity with current supports and resources
- Client may have capacity to complete a personal directive (PD) and/or Enduring Power of Attorney (EPOA) documents
- The PD and/or EPOA may need to be enacted
- An application for guardianship and/or trusteeship needs to be initiated.

Social workers may be involved at any point in the standardized process of the DMCA model, either as an interprofessional team member who requests input from the mentoring team, as part of the mentoring team reviewing the case, or in implementing the mentoring team's recommendations.

ROLE OF SOCIAL WORK as a DESIGNATED CAPACITY ASSESSOR (DCA)

Designated Capacity Assessors are required to complete specialized training and have evidence of their capacity assessment work reviewed regularly to ensure they have the requisite skill sets and competencies as outlined by the Office of the Public Guardian and Trustee. While all social workers need to have an understanding of the decision-making capacity process, not all social workers will have the competencies and training to perform formal capacity assessments as expected within the DCA role. Social work's commitment to protecting the vulnerable and respecting the autonomy of individuals places social workers in the position of ensuring that formal capacity assessments are undertaken in

the most respectful and supportive manner possible. A comprehensive social work assessment with an understanding of the components of a reasoned decision (i.e. understanding and appreciation including initiation), provides a solid platform that can be used to form a professional opinion regarding the individual's decision-making capacity.

The role of a DCA is to conduct a formal assessment in order to formulate a professional opinion regarding an individual's decision-making capacity at a particular point in time. The DCA completes the Capacity Assessment Report (CAR) as required by the *AGTA,* relying on physician assessment and medical tests to rule out reversible causes for the impaired capacity, considering other health professionals' assessments of functioning, and conducting a formal interview to form an opinion regarding the individual's capacity. Collateral information gathering is a key role and becomes part of the overall assessment and can be gathered from: the client's family members/friends/neighbours with the client's permission, physicians, nurses, occupational and physical therapists, speech language therapists, Home Care, and other professionals involved in the client's care.

The expressed opinion regarding capacity does not preclude that the individual's functional ability may change at a later date and require an assessment for regained capacity. The formal assessment of capacity may lead to the individual retaining their decisional rights in some or all domains to the extent that they are able to participate. In other cases, the individual's rights may be protected by an alternate decision-maker being appointed where the individual demonstrates a lack of capacity. In both outcomes, the best interests of the adult are considered.

There is no test, or specific set of questions, that will definitively determine when an individual is lacking capacity. The healthcare professional's training and experience will guide and direct their practice in this area. A social work perspective on assessing capacity is influenced by systems thinking, Person-in-

Environment and Ecological frameworks and adopting the lens of a biopsychosocial perspective for viewing social challenges.

A social worker with DCA designation always maintains the option of declining if the case is beyond their expertise or comfort level. It is critical that the DCA be able to separate their role as a social worker from their duty as a DCA in order to be free from bias, and any real, perceived or potential conflict of interest. If this is not possible, the social worker should remove her or himself from the role of DCA, as the first priority of most social workers with DCA designation lies with their primary role as AHS social workers.

In addition, if an AHS social worker with DCA designation elects to use their DCA status in private practice, they need to reflect, identify and address any conflict of interest (real, perceived or potential) with their primary AHS-Social Work role. Information obtained about the client in their role as an AHS employee is not to be used in private practice without an appropriate consent for disclosure of information process and form. In addition, social workers in DCA private practice must consider if their private practice work creates a conflict of interest for their role as an AHS social worker – e.g. referring AHS clients to their private practice for private DCA assessments. In addition, AHS staff in private practice are required to address real, perceived or potential conflict of interest issues with their manager and follow the AHS Conflict of Interest Bylaw –

http://www.albertahealthservices.ca/Bylaws/ahs-byl-conflict-of-interest.pdf.

The Alberta College of Social Work Standards of Practice further states that:

> *B.3 (a) A social worker will be aware of the circumstances that may lead to or be perceived as a conflict of interest and will make reasonable effort to avoid such conflict. If conflict of interest cannot be avoided the social worker will disclose the conflict to relevant parties as appropriate and take measures to minimize the impact of the conflict on clients, coworkers, and employers.*
>
> *B.3 (c) A social worker who intends to provide or provides professional social work services through more than one organization will advise each organization of any potential conflict of interest.*

Finally, the DCA social worker needs to ensure compliance with the continuing competency requirements of their role, while adhering to information disclosure practices stipulated within the *Health Information Act* and outlined in the relevant AHS information management policies. See links to two relevant AHS policies below –

Collection, Access, Use and Disclosure of Information Policy
Transmission of Information by Facsimile or Electronic Mail Policy

SOCIAL WORK ROLE as a 2ND SERVICE PROVIDER in the ENACTMENT of a PERSONAL DIRECTIVE

Another specialized role related to the decision-making capacity process that a social worker may encounter is in regard to acting as a '2nd service provider' on a Schedule 3. Schedule 3 is used to enact a personal directive (PD). The legislation stipulates that two opinions are required to enact a PD**.** The first opinion must come from a physician or psychologist. If the PD does not identify a specific person to determine the maker's capacity or the specific person identified is unable or unwilling to take on this role, then the second opinion may come from a physician or a 2nd service provider. The 2nd service provider completes Part 2 of a Schedule 3. Though a social worker does not need to be a DCA in order to act as a '2nd service provider', it is important that the social worker have the necessary training, expertise and competencies in order to formulate and document a professional opinion about the client's decision-making capacity on a Schedule 3.

VULNERABLE POPULATIONS - ISSUES IMPACTING EXPRESSION OF CAPACITY

A core underpinning to the legislations related to decision-making capacity is that all individuals are presumed to have capacity. It is important to recognize that some client populations have challenges in demonstrating that capacity; with the result of increased vulnerability. **Table 3** addresses several vulnerable populations and identifies considerations for practice.

TABLE 3

VULNERABLE POPULATIONS - ISSUES IMPACTING EXPRESSION OF CAPACITY

Social workers strive to facilitate opportunities for self-determination, reduce barriers, and recognize personal biases or assumptions that may impede understanding or attempts to facilitate the fullest expression of capacity.

Vulnerable Populations	Perceived Evidence of Deficit in Capacity	Implications for Practice
Self Neglect Individual putting themselves or others at risk by seriously neglecting their own care and welfare. Self-neglect presents along a continuum of severity ranging from: • Failure to attend to self-care • Leaving bills unattended • Noncompliance with treatment regimes or service refusal • Not eating or drinking • Inappropriate dress or home temperature • Dilapidated homes & environments • Faulty electrics • Hoarding • Squalor Reference: Day 2010; Black & Osman 2005	• Neglect of medical and basic needs • Refusal of helping interventions may be viewed as denial or lack of insight • Individual's mistrust of helpers or those wanting to intervene may be viewed as paranoia • Pattern of isolation from family and community	• Building relationship and trust are key components with working with clients who self-neglect • Identify real and specific concerns regarding safety and well being • Work to determine the underlying causes – chronic illness, mental health or addiction issues or cognitive impairment • Assess whether the self neglect is unintentional or deliberate (i.e.- a lifestyle choice) • Identify and address ethical challenges re: balancing the individual's right to self determination and autonomy with need for protection: ➢ Which option poses least harm? ➢ What is 'acceptable risk'?
Neurological Barriers (Brain Injury/Stroke) Impairments may include changes in executive functioning abilities including organization, planning, judgment, inhibition, metacognition (thinking about thinking), initiation and the ability to engage in goal-directed behaviour. It may also include dysfunction in linguistic skills known as aphasia.	• Cognitive abilities may be complicated by the fluctuating physical condition (fatigue, illness) • The inability to express thoughts verbally, word finding issues, or challenges with executive functioning abilities – all of which can be mistaken for a lack of capacity • Capacity must be assessed on an individual basis; resulting in challenges for the clinician in adapting their assessment process to accommodate the	Strategies • Shift thinking from "is this person capable?" to "How can this person's capacity for this particular task be revealed?" • Allow adequate time for assessment, over several sessions • Involve Speech Language Pathologist (SLP) if possible to assist with communication strategies • Incorporate yes/no questions and assess for consistency in response • Use nonverbal communication (thumb up or down), pictures

TABLE 3

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Social workers strive to facilitate opportunities for self-determination, reduce barriers, and recognize personal biases or assumptions that may impede understanding or attempts to facilitate the fullest expression of capacity.

Vulnerable Populations	Perceived Evidence of Deficit in Capacity	Implications for Practice
Reference: Pachet, Allan & Erskine 2012	individual's medical condition	• Write key words for emphasis • Observe in-environment and ask others (staff, family) for their observations – can the client follow instructions, attend therapy session or other activities on own initiative? • Consider and reduce other barriers including hearing and visual field neglect
Mentally Challenged/Developmental Delayed Impairments range from mild to severe Reference: Pollack 2005	• Each diagnosis does not present with same degree of impact; incapacity cannot be presumed • Capacity is dependent on the degree of severity of the disability	• When assessing re: decision-making on specific issues (e.g.-abortion), ensure that the elements of reasoned decision-making are examined (ie-understanding, appreciation and initiation) by individual's ability to make an informed decision • Advocate for the rights of individuals with developmental disability ➢ Consent must be given without coercion ➢ Assist Guardian in examining what decision the individual might make for themselves if they were capable; and if not possible, identify best interests of the client • Individual should be encouraged to participate in decision-making process to fullest extent possible.
Mental Health (severe mental illness – not episodic) Includes diagnoses such as depression, anxiety, psychotic disorder, etc.	• Mental health diagnoses may impact the individual's ability or willingness to engage with helpers and others • Some mental health diagnoses and/or treatments for some individuals may slow cognitive processing, impact memory and	• A mental health diagnosis is not a statement about or determination of the individual's decision-making capacity. • A formal certification of an individual under the Mental Health Act (Form 1) is for safety reasons (or the prevention of mental or

TABLE 3

VULNERABLE POPULATIONS - ISSUES IMPACTING EXPRESSION OF CAPACITY

Social workers strive to facilitate opportunities for self-determination, reduce barriers, and recognize personal biases or assumptions that may impede understanding or attempts to facilitate the fullest expression of capacity.

Vulnerable Populations	Perceived Evidence of Deficit in Capacity	Implications for Practice
Reference: Scheyett, Swanson, Elbogen, Ferron 2009	verbal expression, etc. • A formal certification of an individual under the Mental Health Act (Form 1) may also be mistakenly viewed as a formal determination that the client lacks the decision-making capacity to make treatment decisions.	physical deterioration or serious physical impairment) and to facilitate mental health treatment. With Formal Patient status, the client is presumed competent and retains the right to an informed consent process related to all treatment decisions unless a capacity assessment has determined a lack of capacity (Form 11).. • Explore ethical considerations: balancing autonomy with need to protect when risk is identified
Literacy/English as Second Language (ESL) Health literacy definition: ability of individuals to access and use health information to make appropriate health decisions and maintain basic health. This definition also includes whether individuals: (1) can read and act upon written health information; (2) possess the speaking skills to communicate their health needs to physicians; and (3) display the listening skills to understand and act on the instructions they receive. (WHO 2012) Prevalence - *Health Literacy in Canada: A Healthy Understanding 2008* report that 60% of adult Canadians do not have the necessary skills to manage their health adequately. In addition, only 12% of seniors have the ability to manage health care needs independently.	• Social Determinants of Health: income, education level, employment, safety/ quality of housing, community and environmental factors directly impact health outcomes and well-being; which in turn can create challenges re: the expression of their capacity. The most vulnerable populations are the sick, low-income, Aboriginal Canadians and immigrants to Canada whose ancestry is not European (Raphael 2009). • Informed decision-making is founded on an individual's ability to understand information, to ask questions, implement recommendations, access and navigate health care system. Non-compliance or non-adherence to medical regimes may be attributed to cognitive issues (or	• Clinician's responsibility to reduce the barrier of language and literacy to ensure client has information they need to make informed decisions. • Awareness of prevalence of the lack of health literacy in the general population (not just immigrants) is first step in addressing the issue. Strategies: • use of plain language, both written (use of graphics helpful) and oral • Teach/Feedback – review information and confirm understanding • Create a safe environment – shame-free • Use *Language Line* interpreter for English-as-an-Additional – Language clients to ensure understanding

TABLE 3
VULNERABLE POPULATIONS - ISSUES IMPACTING EXPRESSION OF CAPACITY

Social workers strive to facilitate opportunities for self-determination, reduce barriers, and recognize personal biases or assumptions that may impede understanding or attempts to facilitate the fullest expression of capacity.

Vulnerable Populations	Perceived Evidence of Deficit in Capacity	Implications for Practice
References: WHO 2012, Raphael 2009, Canadian Council of Learning 2008	behavioural).	
Frail Elderly Inability to cope in their current environment with available supports often triggers concern re: decision-making capacity. Reference (Newberry & Pachet 2008)	• Physical variables such as vision, hearing, fatigue, nutrition, medication or acute illness can create barriers to the expression of capacity and may impact assessment of decision-making capacity. • Psychosocial factors such as grief and loss, isolation, abuse or neglect may inhibit the demonstration of capacity**.** • Scarcity of financial resources and lack of caregiver support may impact the frail elder's ability to cope in-environment; rather than being a sign of diminished capacity.	• Psychosocial geriatric assessment to include ➢ Medico-legal factors ➢ Current living environment ➢ Social and family history ➢ Social supports ➢ Coping skills ➢ Religious and cultural factors ➢ Risk of abuse • Address variables that address barriers to expression of capacity

CONCLUSION/SUMMARY

Social Work has a unique contribution to make when the client's decision-making capacity is called into question. Case coordination and facilitation of decision-making capacity issues is a value added social work role that benefits client, family and the healthcare team by balancing client self-determination and autonomy with the need to establish a client representative for support and advocacy when assessed as required. Social workers consider the decision-making capacity of the person in relation to their environment as well as the multiple systems impacted in order to determine the least intrusive measures and resources required to support the client. In front line social work practice, as well as in specialized or designated roles, the social work role in the decision-making capacity process is a key social work function.

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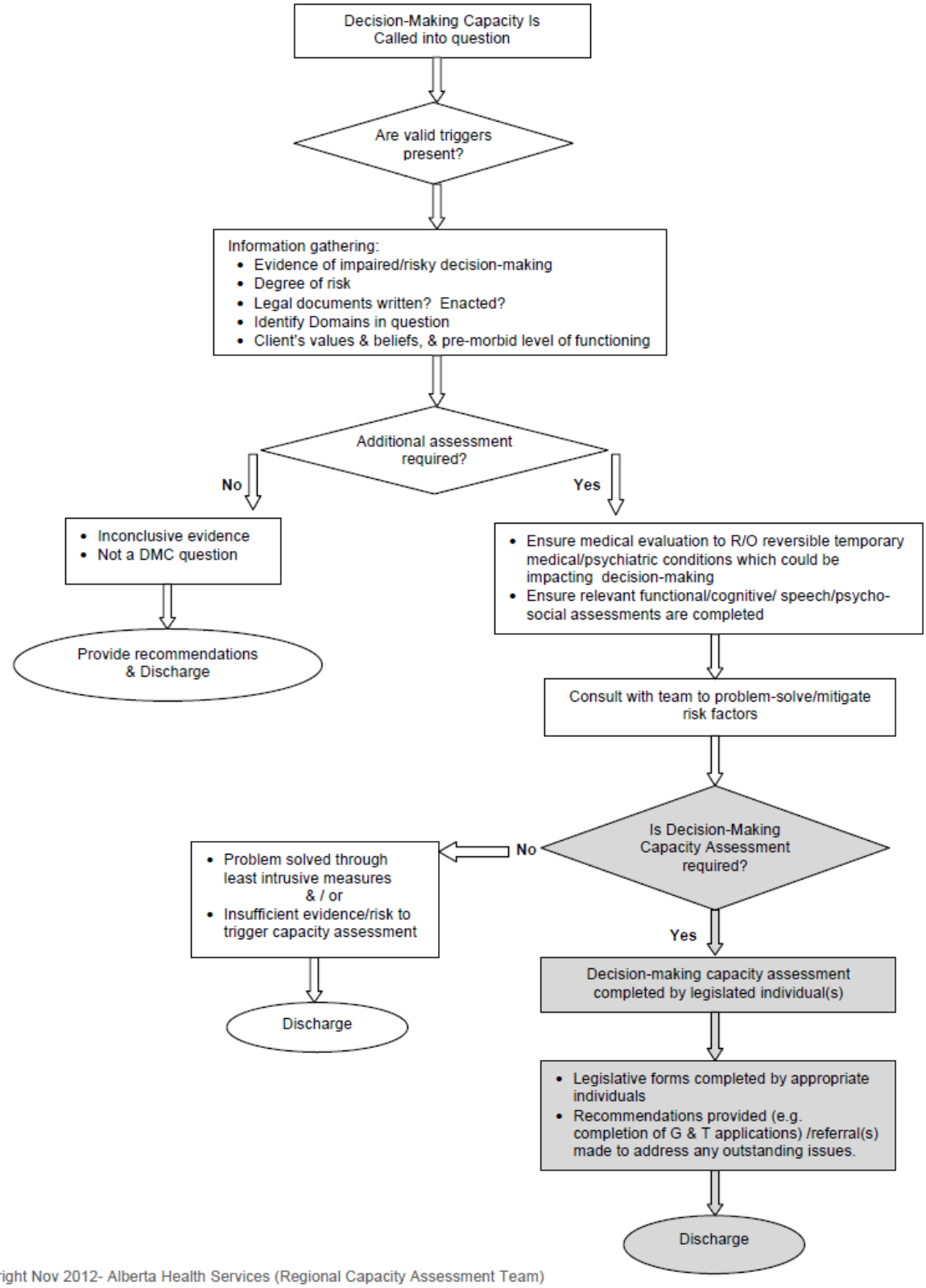
APPENDIX A

RCAT Decision-Making Capacity Algorithm



Alberta Health Services

Affix patient label within this box

Capacity Assessment Process Worksheet

Do not complete this worksheet if the only concern of capacity is to drive. Consider a referral for a driving assessment.

Date worksheet Initiated *(yyyy-Mon-dd)*	Primary Contact

Is the adult making decisions *(or unable to make decisions)* which puts him/herself or other at risk of significant harm? Describe the reasons including risks, severity, conflicts, consequences of behaviours, etc.

In what domains have concerns been identified.

- ☐ Healthcare
- ☐ Accommodation
- ☐ Choice of associates
- ☐ Social/leisure activities
- ☐ Education/vocational training
- ☐ Employment
- ☐ Legal matters *(non-financial)*
- ☐ Financial matters
- ☐ Other *(specify)*_____

Describe relevant collateral information, and evidence of risk for each domain of concern.

What are the adult's values and goals, cultural/religious beliefs, with regards to decision-making in relation to the domain(s) in question? Has there been any recent significant change?

APPENDIX B

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Capacity Assessment Process Worksheet

Describe the person's living situation, including formal and informal supports.
Has there been any recent change?

Has the adult's capacity been assessed on a previous occasion?
☐ No
☐ Yes, describe date of assessment, domain in question, assessment results etc.

Have any and all reversible medical and mental health conditions that are likely to impact capacity been ruled out?
☐ No
☐ Yes

Comments

The date of Medical Assessment *(yyyy-Mon-dd)*	Assessment completed by

Please list the medical diagnoses relevant to this capacity assessment:

Define the cognitive changes which may affect capacity, including standardized and non-standardized assessment

Test name	**Administered by**	**Score**	**Date** *(yyyy-Mon-dd)*

Comments

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Capacity Assessment Process Worksheet

Does the adult have functional limitations in relation to the domain(s) in question?

☐ No
☐ Yes

Comments

Have barriers to a valid assessment, such as language, literacy, vision and hearing, been addressed?

☐ No
☐ Yes

Comments

Can the problem be solved and the risks be managed by a less intrusive and restrictive form of support?

☐ No
☐ Yes, describe the solution *(consider meeting/consulting with other team members to problem-solve)*

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Capacity Assessment Process Worksheet

Affix patient label within this box

Please indicate if the following documents exist:

☐ Personal Directive
Enacted ☐ Yes ☐ No Domains: _____

☐ EPOA
Enacted ☐ Yes ☐ No

☐ Guardianship order Domains: _____

☐ Trusteeship order

Is a formal capacity interview required? *(Is the potential risk of harm to self, or others, high enough to justify the removal of the adult's rights i.e. appointment of an agent/ power of attorney, co-decision maker, guardian or trustee?)*

☐ No
☐ Yes

Comments _____

Referred for capacity interview ☐ No ☐ Yes If yes referred to:	Date of Referral *(yyyy-Mon-dd)*

Name *(print)*	**Signature**	**Initials**	**Designation**	**Date** *(yyyy-Mon-dd)*

APPENDIX C – AHS Calgary Zone - Regional Competency Assessment Team (RCAT)
Psychosocial Prompt Sheet

RCAT Psychosocial Prompt Sheet

Introduction to the assessment

(a) Mother tongue and languages spoken – *If the client and family's first language is not English, is an interpreter needed? Is a cultural support person (such as an Elder) needed to help support the client/family during the assessment?*

(b) Discuss the rationale and process for RCAT assessment and for psychosocial assessment

(c) Consent/assent to assessment and to collateral interviews, release of information

1. Medico-legal Issues

(a) Does the client have a Personal Directive or Enduring Power of Attorney? Have these documents been enacted?

(b) Has there been a previous medical opinion that the client lacks capacity?

(c) Is there a guardian or trustee in place?

2. Current Living Situation

(a) Presenting issues/concerns – Are there alternative, less intrusive ways to manage the risks?

(b) Client's perspective on the questions raised about their capacity

(c) Medical and post-injury history; ADL and IADL; recent hospitalizations

(d) Housing and co-residents

3. Social and Family History

(a) Family of origin

(b) Education (formal, informal, meaning to client)

(c) Occupation

(d) Work skills (i.e. that may not have translated into paid employment) hobbies/interests

(e) Genogram, significant relationships (marriage, children, family of origin, friendships)

(f) Family conflicts (e.g. Value conflicts such as safety versus freedom; decisional conflicts such as how to manage client's care or financial affairs)

(g) Generally, who makes decisions (e.g. the client, the family, eldest son, etc.) and in what areas (e.g. finances, health care, social situations)

(h) Ask the client: Who has been involved in making this decision (family, friends, doctors, etc)? Who do you want to be involved in making this decision? (Moye, 1999)

(i) Family approval (of client's decision): What does your family want you to do? How do you know when your family approves of your decisions (Moye, 1999, Margles 1995)

(j) Significant losses (e.g. death of family members and/or friends; worries such as health problems of family members; disruption caused by divorce, separation, estrangement; *cultural losses associated with migration)*

(k) Social groups (e.g. church/faith community, seniors groups, etc)

APPENDIX C – AHS Calgary Zone - Regional Competency Assessment Team (RCAT)
Psychosocial Prompt Sheet cont'd

4. Coping

(a) Wellness and disease management (e.g. diet, exercise, management of chronic condition)
(b) Coping style and techniques – Ask the client: What lessons have you learned about how to cope with life from day to day? Are there ways you wish you coped better? (Kivnick and Murray 2001)
(c) Use of psychotropic medications, history of psychiatric care/hospitalizations
(d) History of non-functional coping approaches/behaviours (e.g. self-harm, hoarding, rituals, ruminating)
(e) Use of alcohol/drugs (frequency, amount, any problems associated with use)
(f) Sleeping patterns
(g) Alternative/traditional health practices

5. Social Supports

(a) Supports received (e.g. formal, informal; material, emotional/social, instrumental, decisional)
(b) Caregiver issues
(c) Family life cycle (e.g. single adult, newly married, young children, adolescent/teenage children, children leaving home, sandwich generation, grand parenting)
(d) Client's perceptions of dependence – Ask the client: what thoughts do you have about how your illness or care might affect others in your life? (Moye, 1999)
(e) Ask the client: Have other people's emotional or financial interests influenced your wishes (Moye 1999)
(f) Support offered by the client to others – Ask the client: What kind of help, service or assistance do you give? To whom? (Kivnick and Murray 2001)
(g) Adequacy of economic resources
(h) Entitlements accessed (e.g. pensions, drug costs, etc)
(i) Relationships with formal systems and provider (e.g. receptive, high needs, combative)
(j) *Systemic issues such as racism, discrimination, etc.*

6. Religious and Cultural factors

(a) Immigration Status
(b) History (personal and familial experiences) – Ask the client: Describe the cultural/religious/ spiritual traditions you grew up in (Hodge 2001)
(c) Ask the client: Do you have any particular religious, spiritual or moral beliefs that influence your decision (in the area of concern)? What are they? How do they guide what you want? (Moye 1999)
(d) Ask the client: Do you have any cultural beliefs that influence your decision? What are they?

APPENDIX C – AHS Calgary Zone - Regional Competency Assessment Team (RCAT)
Psychosocial Prompt Sheet cont'd

How do they guide what you want (Moye 1999)

(e) Current orientation and practices (e.g. attend places of worship, sweat lodges, etc)

(f) Acculturation/integration

(g) Pre-migration and migration experiences as related to decision in question

(h) Cultural/intergenerational conflicts

(i) Is the client's behaviour considered unusual or worrisome in their cultural context?

7. Risk of abuse

(a) Risk factors/indicators

(b) Nature of concerns

(c) Client insight into any issues

(d) Client's ability to protect self from any mistreatment (i.e. degree of vulnerability)

(e) Client report of safety and necessary care

(f) Ask directly about abuse – "we ask all of our clients about abuse in their lives because it is a concern for many people. Is there any person, or place in your life that makes you feel unsafe?"

(g) Ask: "Does anyone take your money or your belongings without your permission?"

Note: Prompts in italics to be used at the clinician's discretion with clients from cultural minority groups

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APPENDIX D

IDENTIFYING an ALTERNATE DECISION MAKER (ADM)

- **If Adult Patients lack capacity**, check to see if there is a Co-Decision-Maker, Guardian or Agent under an enacted personal directive. If there is no Co- Decision-Maker or Guardian, but there is a personal directive, enact the personal directive to establish the Agent's legal decision-making authority. If there is no Co-Decision-Maker, Guardian or Agent and consent for a specific health care decision is required, proceed with the specific decision-making process outlined in the *Adult Guardianship and Trusteeship Act* (consult clinical legal as required).

- **If the Patient who lacks capacity is, under the *Mental Health Act*, a Formal Patient or a person subject to a Community Treatment Order**, then determine whether the purpose of the treatment/procedure is for the patient's physical or mental health. If the treatment/procedure is in its purpose relating to the patient's physical health, follow the steps of identifying a Co-Decision-Maker, Guardian or Agent. If none of the aforementioned exist, select a Specific Decision Maker. Alternatively, if the treatment/procedure is in its purpose relating to the patient's mental health, then follow the steps of identifying the patient's Guardian or Agent; if none exist, then select the patient's Nearest Relative under the *Mental Health Act* to make the decision on the patient's behalf. If the patient has no Nearest Relative, then select the Public Guardian to make the decision.

- **If the Patient is a Minor**, contact the parent/s or Legal Representative (e.g. – guardian) with decision making authority. Confirm decision making authority as appropriate (e.g. - request copy of the court order if the minor's parents are separated or divorced). If the Minor Patient is assessed and deemed to be a Mature Minor, the Minor may make the specific healthcare decision on their behalf.

January 11, 2013

Retrieved from http://insite.albertahealthservices.ca/Files/clp-identifying-an-alternate-decision-maker.pdf