

"TICKY BOX" PRACTICE: CLIENT CENTRED VERSUS DOCUMENT CENTRED  
SOCIAL WORK

By

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## Abstract

Social work like many other healthcare professions seems to be moving away from client focused care to document centred care in an attempt to meet increasing assessment and accountability requirements. It may be argued that as healthcare has come to be viewed more and more as a business in the current neo-liberal climate, managerialist concepts have become entrenched in healthcare. In October 2005 the Ministry of Health and Long Term Care mandated the implementation of the Resident Assessment Instrument-Mental Health (RAI-MH) for all inpatient mental health beds in Ontario. The tool was hailed as a comprehensive assessment tool that would decrease documentation requirements for the healthcare team, as well as provide the Ministry with a means to develop a case-mix based payment system for inpatient mental health services.

This qualitative research explored the origins of Minimum Data Set tools such as the RAI-MH, as well as the opinions and experiences of mental health social workers two years after the RAI-MH was implemented. Six social workers were interviewed and their practice experience ranged from new graduate to seasoned social worker. All the social workers reported increasing documentation requirements has led to less time being spent on patient care. All of them indicated that the RAI-MH has not decreased documentation but rather was added to existing documentation requirements. The newly graduated social workers had a more positive response to the RAI-MH than the seasoned social workers who appeared more skeptical. They were also more likely to report that the style of their initial interview was driven by the questions asked on the RAI-MH whereas the seasoned social workers attempted to limit its impact. The study concludes with a discussion of the implications of these findings on patient care, critical analysis as well as social work education. Possible research directions for the future are also highlighted.

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## Introduction

Over the past several years within social work practice, documents are becoming an increasingly dominant focus. At times, it appears that we are moving from a practice that is client-centred to one that is more documents centred. Traditionally, social workers in hospital mental health settings were responsible for completing narrative style in-depth assessments, care plans, transfer or discharge notes as well as chart notes reporting on client contact. However, as well as the traditional social work documentation mentioned above, there has also been the addition of other types of documents. Hospital based mental healthcare has experienced the mandated use of computerized reporting tools for both assessment and accountability over the past couple of years. This may lead to added tension within frontline social work practice as we attempt to fulfill the dual role of social service/social justice agent and social control agent i.e. the tension between being the helper and the master (Segal 1999). This juxtaposition is further intensified in today’s performance driven and cost efficacy focused political and economic climate.

These changes are not only effecting social work but also our colleagues in the other helping professions such as nursing, occupational therapy, psychology and, to some extent, psychiatry. For example, STAR Navigator which measures face to face contacts with patients (if a patient is seen three times in one day it is still recorded as one contact) and GRASP MISTro which measures workload (time spent on work activities), are to be completed daily on the computer. More recently the Resident Assessment Instrument - Mental Health (RAI-MH) was mandated by the Ministry of Health and Long Term Care in October of 2005 for all mental health inpatient beds and thus my concern about the shift towards the increasing use of computerized documents in the helping professions greatly intensified. The same information is often recorded in a different style of document based on which source requires it. For example, the

source may be the Ministry, the hospital, the ward, or the social work professional organization. Thus, the time spent on documents is time diverted from direct patient care. It is ironic that in a climate that emphasizes efficiency and accountability an increasing amount of time is being spent on completing documents that are often repetitive and time consuming.

Generally, the people attracted to the helping professions and more specifically those working within the mental health field are those individuals who wish to work closely with, build relationships with and facilitate the recovery of those marginalized by mental illness and often by poverty as well. Ironically, the RAI-MH was introduced to hospitals at a time when Anthony’s Recovery Model (2000) was being hailed as the way to move towards a recovery orientated service system that was to include mental health consumers in their treatment and plan of care. However, as we move towards document-centred care, many may question how they can continue to work within such a business/managerial orientated system that at times seems to contradict the recovery model. Hopefully this brief overview of the tensions, puzzles or “problematic” within my current practice with regards to increasing auditing, documentation and workload will highlight the need to examine more deeply the role played by documents in this setting. This issue is important to the critical study of social work practice as it has implications not only for mental health social workers and for social work practice in general but also for the other helping professions.

As a social worker the concept of social justice is fundamental and thus I began asking questions about the origins of the RAI- MH, its stated purpose, its unstated purpose, its potential impact on patient care, and whether it is beneficial or oppressive to an already marginalized section of society. I also began questioning the use of other computerized documents already in use in hospital based healthcare that purportedly measure workload and the connection of these computerized documents to funding in a political climate that demands cost efficiency and accountability. Further, “ticky box” practice may be defined as

documentation that is really a form of reducing clients to statistics or objective measures that are increasingly linked to funding formulas (O’Neill 2005).

Gustafson (2000, p.89) suggests, “Healthcare as a business has become a widely accepted fact” and thus as a social worker how do I practice within such a context in a profession that values or emphasizes social justice? This research hopes to explore the origins of Minimum Data Set (MDS) tools such as the RAI-MH, as well as the use of documents and specifically the introduction of computerized documents in mental healthcare. It will also explore how social workers have responded to and are adapting to their mandated use. Finally, it will explore whether social workers believe there is an impact on the therapeutic relationship and ultimately how patient care is provided.



## **Research Questions**

The literature suggests that there is a discourse within social work that challenges the move from a more client-centred practice to one that emphasizes efficiency and cost effectiveness. A move towards an emphasis on managerialist concepts will require monitoring both at the local site and from a distant or remote site. Social work has long struggled with the dilemma of serving her two masters: social justice and social control (Segal 1999, Beresford & Croft 2004) and the current political and economic climate is one that is emphasizing cost efficiency, outcome measures and comparisons with other similar institutions. More recently, concepts such as benchmarking which is defined as the continuous, systematic process of measuring and assessing services so they can be adapted to achieve superior performance (Treasury Board of Canada 2007) have been introduced into the social service sectors. These are concepts that have been adopted from private sector business. This trend has resulted in a move towards computerized assessments and computerized workload measures within inpatient mental health services. These are mandatory requirements from the Ministry of Health and Long Term Care which is attempting to develop funding formulas and efficient business practices that will probably impact job security and, ultimately, patient care. This research will attempt to locate the RAI-MH by exploring its origins as well as its stated objectives. The research will also examine the impact of the RAI-MH on social workers’ daily practice and how they are navigating the recent trend towards computerized assessment and reporting systems. How are they managing the tension or dilemma of serving two masters?

In response to the current trend towards what I refer to as “ticky box” practice, this research will therefore explore more specific questions about social work practice in a mental health setting: What is the impact of using these tools on daily practice? Do social workers view this as a tension in their practice? How have social workers responded to this trend? Is it with, compliance, subtle

resistance, organized resistance and so forth? Will it eventually impact a social worker’s ability to continue to use critical thinking skills in their work settings? Finally, what are the implications for social work practice and education as the helping professions move towards practice in workplaces that are driven by concepts of managerialism and a move away from the traditional concepts of the welfare state?

## **Methodology**

As I embarked on this journey to complete a research project, I began to examine my location as well as the theories or ideologies that have influenced my perspective or knowledge base with regards to this topic. I have come to realize the importance of acknowledging my assumptions as a social worker and as a researcher. This journey has at times been difficult as I began to challenge many of the assumptions I held about what is considered good research and especially the consideration of self in research. As someone with a background in a positivist approach to research this has been challenging at times. This one approach to knowledge building suggests science and therefore social science is value free and consists of precise, measurable observations that discover and confirm causal laws which can predict human behaviour. Also, these observations can be repeated by other researchers (Neuman 1997). Thus, during this research journey, this unfamiliar way of thinking made sense to me and yet when I actually began gathering data and analyzing the findings of my qualitative research project I felt like I was charting unknown territory. The readings over the past couple of years may have provided a compass, but I still felt like I was leaping into the unknown with regards to qualitative methods. No t-tests or measures of significance to rely on when analyzing data and the constant struggle to question my assumptions and motives each step of the way realizing that what is asked in research is important but also what is not asked or acknowledged is also important. Mauthner & Doucet (1998) state that all research contains bias and values that are embedded in a historical and linguistic context and, thus, during data analysis we must confront ourselves as researchers and ultimately our own central role in influencing outcome. The authors’ further state that data analysis is the most vulnerable place for a researcher as they are especially open to criticism at this stage of the research and so my yearning for a t-test makes sense as I had been taught by positivist

researchers that such objective measures reduce the likelihood of being criticized during data analysis. However, a positivist approach to research is just one approach to knowledge building and one that is not without criticism (Neuman 1997). This is my first attempt at qualitative research. It is important to acknowledge that I practice social work in a medical program that adheres to a positivist approach to research projects and thus conducting this research felt like a risky business in many ways. It is important that issues around my location are acknowledged so that assumptions or biases are acknowledged which in turn facilitates a more critical stance towards the research. The concept of reflexivity emerged from feminist research and suggests the importance of,

“...reflecting upon and understanding our own personal, political and intellectual autobiographies as researchers and making explicit where we are located in relation to our research respondents. Reflexivity also means acknowledging the critical role we play in creating, interpreting and theorizing research data.” (Mauthner & Doucet 1998, p.86).

As a researcher I also faced the dilemma of being an insider and an outsider and the advantages and disadvantages of this should be explored. As an insider, I am well placed to reflect on how the RAI-MH may influence social work practice and institutional ethnographers would view this as a valuable location (Campbell & Gregor 2002). Being an insider may have made it easier to navigate and obtain approval from the hospital’s research ethics board as well as to gain access to potential participants with the assistance of the Social Work Specialist for the hospital. The participants may have felt a sense of trust and camaraderie as a result of living a shared workplace experience. This may have resulted in a sharing of more in-depth information as the researcher and participant were “in this together”. Participants may have felt that it was safer sharing information with an insider rather than an outsider. However, it may also have resulted in participants withholding information as the insider would be aware of the unit they worked on, the staff they worked with and the managers of their respective units and therefore it may have resulted in a reluctance to divulge information that may

be seen as a critique of the unit or colleague’s practice.

Another potential dilemma is that while the insider has first hand experience of the subject matter this may result in being so involved in the situation that they are unable to appreciate what is unique about the group of participants, may take for granted a shared understanding and not push for further exploration and edit their true opinion for fear of gossip within their setting (LaSala 2003). Potts & Brown (2005) suggest there are insider/outsider tensions in all research relationships and this was indeed my experience. For example, as an insider I am a social worker who was mandated to use the computerized auditing tools and was also given a section of the RAI-MH to complete and yet my response was different than that of the participants which would perhaps delegate me as an outsider.

As a researcher I was in a position of power as I had studied this particular area in detail, developed the interview guide and ultimately decided during the analysis phase which quotations to use and so forth. I wished to conduct a research project where the voices of the participants would be heard and thus social worker’s experiences of practice acknowledged. When selecting quotations I did try to give a good representation of the opinions voiced by the participants. However, I am also acutely aware that I decided which voices are included or excluded and this power differential between the researcher and the participants also needs to be acknowledged. It is hoped that acknowledging these concerns will encourage an analysis and reporting of findings that are truly grounded in the data generated from the participant interviews. Thus, this research project may be viewed through different lenses; the researcher lens, the participant lens and the readers lens (Mauthner & Doucet 1998 p.96).

It is argued that research cannot be neutral but rather it is value-laden. The researcher cannot stand outside of the research as they bring a particular lens or view of the world to the research (Mauthner & Doucet 1998, Absolon & Willett (2005). Absolon & Willett (2005, p.97) who discuss in detail the location of

the researcher in research state,

“We are of the opinion that neutrality and objectivity do not exist in research.”

It may also be argued that the questions asked or the even the decision to conduct research in a particular area is guided by the researcher’s location in the world. Cam Willett (Absolon & Willett 2005 p.104) goes on to state in the article,

“I believe that it is unethical to do research in which you have no stake whatsoever – no interest, no personal connection with, no reason other than your training as a scientist. You need to have some reason for doing it. When you explain your methodology, you need to be able to answer the question “Why are you doing the research?”.....”.

As research is not neutral and cannot be objective as the researcher has a significant role in what is extracted from a research study, it is my hope to be as visible as possible throughout this project beginning with my location and the methodological or epistemological lens through which I came to this project and have traveled on during this research journey.

The main methodology or approach to the research will be from a critical social science perspective. Neuman (1997 p.74) states that this methodological approach,

“is a critical process of inquiry that goes beyond surface illusions to uncover the real structures in the material world in order to help people change conditions and build a better world for themselves.”

As social workers, we frequently advocate on behalf of our clients but I wonder if we prioritize and effectively advocate when our own working conditions are under fire from outside forces. Neuman further suggests that this approach to research aims to “uncover myths and reveal hidden truths” with the goal of transformation and empowerment. As I currently work within the environment or system under study another epistemological influence is the work of institutional ethnographers such as Smith (1987) and Campbell & Gregor (2002) who explore the relationship between everyday activities and power both locally and beyond the

organization. Smith (1987 p.92) states,

“Institutional ethnography examines the ways that everyday activities and social relations are coordinated and linked to the exercise of power both at and beyond the local setting in which they occur. The relations of ruling or the extra local forms of control that regulate local activities are what we might refer to as bureaucracy or management or administration.”

They also emphasize the role of what they refer to as ruling texts and I refer to as documents or “ticky box” practice which ultimately influences the relationship between the worker and their clients. These authors and others explore resistance and transformative practice despite working for a bureaucracy that is increasingly influenced by managerialism. Also, as this study is exploring the opinions of frontline social workers in mental health, it will also include concepts such as social justice as well as the consumer/empowerment/recovery literature (Walton 2005, Beresford & Croft 2004) that continues to influence the lens through which I view my practice.

This study had two objectives. Firstly, to thoroughly examine the literature regarding the RAI-MH and the way it was introduced to service providers and secondly, to explore social worker’s responses to the RAI-MH. A qualitative approach to the research was adopted for the second objective, as this was an exploratory study that hoped to generate rich or in-depth data that would shed light on this particular area of study which would then give some direction to future research endeavors. A qualitative approach also allowed for the reporting of the voices of the participants in a significant way.

## **Methods**

There was a thorough examination of the literature regarding the RAI-MH and its implementation that also required a review of the U.S. Minimum Data Set literature to help locate the origins of the tool. This study also gathered qualitative data through interviews. Ethics approval was sought and received through the hospital’s research ethics board (See Appendix 1 Participant Information Sheet with Consent Statement approved by research ethics board). Participants were recruited by contacting the Social Work Specialist of a Southern Ontario Hospital who agreed to send out an email to all the social workers who practiced in the area of mental health inviting them to participate in this research (See Appendix 2 for Letter of Information and Appendix 3 for Interview Guide). Potential participants were asked to contact the Social Work Specialist if interested who then forwarded their names and I then contacted them by email to set up interviews. Five interviews were conducted with six social workers. Two social workers requested if they could be interviewed together. I conducted all the interviews and the interviews were audio taped and transcribed with the permission of participants.

The approach to sampling used was purposive or judgmental. Purposive or judgmental sampling is a type of nonprobability sampling where the sample or participants are selected on the basis of the researcher’s judgment about which ones will be most helpful for a particular subject under study (Babbie 2004). I wished to interview social workers who worked specifically in inpatient mental health on units where the RAI-MH was used and I wanted to have a selection of both seasoned and recently graduated social workers. The participants included five women and one man. Three of the participants were seasoned mental health social workers who had worked at the hospital for between ten and thirty years. The other three participants had recently graduated from university and had worked at the hospital for 6 to 18 months. The selection of seasoned and newer



social workers was intentional as I wondered whether there would be a difference in experience or response/reaction to computerized assessment and monitoring tools between the two groups. The seasoned social workers practiced before the introduction of the tools while the newer staff came after the mandatory introduction of the tools. Assigned numbers were used to identify the participants to protect their anonymity.

In-depth, active, conversational interviews were conducted with participants that were approximately 45 minutes in length. This was an interactive process where I asked open ended questions using an interview guide (See Appendix 3). The interview guide was composed of 8 open-ended questions that were designed to explore the participants experiences and opinions of using computerized assessment and reporting tools, with a focus on the RAI-MH. I attempted to show flexibility in my responses so that the interviews were conversational rather than rigid or forced. Data gathering followed an iterative process whereby themes and or issues identified in earlier interviews were incorporated into interview guides and explored in later interviews (Glaser & Strauss 1967).

The data was analyzed using a grounded theory approach using the constant comparative method (Glaser & Strauss 1967: Strauss & Corbin 1990: Strauss & Corbin 1998). The transcripts were read through once without coding the data to become familiar with the ideas or views suggested by the participants. The transcripts were then read a second time and a line by line analysis followed with open coding and then the transcripts were reread to allow new concepts to emerge from the data. Handwritten notes were made in the margins and eventually a table was constructed. Categories began to emerge from the data and thus theory grounded in the data began to be extracted.

Connolly (2003) describes a process of generation, reduction and reconfiguration which is based on the grounded theory approach. Firstly, the generative phase where themes are generated from the data. Secondly the

interpretative phase where the themes are translated into categories. Thirdly, the theorizing phase where theoretical propositions are extracted and these may include understanding meaning, identifying implications, refining ideas and linking to research. Connolly emphasizes the importance of the interpretative phase and the development of categories and thus encourages a returning to the data in the generative phase to reexamine categories. Thus the confirmation of categories is an attempt to increase the grounded validity of the findings. Thus, as the research progressed the transcripts were frequently reread to ensure the categories were grounded in the data. The results of this analysis are presented in the “Findings and Analysis” section.

## **Literature Review**

### **Current documentation in hospital based mental healthcare**

Traditionally, social workers in hospital based mental health settings were responsible for writing narrative style in-depth psychosocial assessments, transfer or discharges notes as well as chart notes reporting on client contacts. However, as well as the traditional social work documentation mentioned above there has also been an increase in what I refer to as “ticky box” practice over the past few years.

In October 2005 the RAI-MH (Resident Assessment Instrument- Mental Health) became mandatory and was to be completed for each patient upon admission and discharge. There is some discussion that it may be implemented in outpatient mental health services in the near future. Currently, the following documentation is completed by social workers in mental healthcare. Firstly, traditional narrative documents such as social work psychosocial assessments, discharge or transfer notes and chart notes which meet the requirements of the hospital and the social work college. Secondly, the interdisciplinary care plan which meets the requirements of the hospital and the accreditation process. Thirdly, the RAI-MH computerized patient assessment tool, STAR Navigator and GRASP MISTro which meet the requirements of the Ministry of Health and Long Term Care. Also, social workers complete referrals to community agencies which require their particular style of document be completed. Therefore, the same information is often recorded in a different style of document based on which source requires it and time spent on completing documentation is time diverted from direct patient care.

Perhaps this is merely the beginning of a rigid audit system that will eventually be implemented in all areas of health care including cardiology, family medicine and so forth. A similar tool has been implemented over the past couple of years in the Community Care Access Centres (CCAC) as an assessment for

eligibility for long term care placement. Our colleagues in child welfare have been using the Ontario Risk Assessment Model (ORAM) for a number of years. It has been reported that child protection workers are spending 70% of their time on documentation and only 30% on client contact (OPSEU 2001). It appears the use of “ticky box” documentation is spreading throughout the helping professions at an alarming rate.

Aronson and Sammon (2000) state that within social service settings funding cuts, organizational change, time pressures, ill fitting managerial forms and the fragmenting effects of divided labour has many workers reporting that what they deem as good practice is being squeezed out of their jobs. As social workers spend more and more time on documentation they must then be spending less and less time directly relating to the client. It is argued that completing “ticky box” documentation not only objectifies clients, as it becomes the main source of data about our client and their needs, but also regulates the type of data the worker gathers, dictates the questions asked and thus influences the relationship between worker and client (Gustafson 2000, Campbell & Gregor 2002).

### **Resident Assessment Instrument- Mental Health (RAI-MH) – origins and implementation**

A brief outline of why and how the RAI-MH originated will be given. However, it is important to note that tools such as the RAI, or Minimum Data Sets (MDS) as they are also known, emerged from the United States which has a dramatically different healthcare system than the system here in Canada. Therefore, its development and associated use in research originated in a totally different context than the one in Canada that it has now been adapted to. The history of the RAI-MH can be dated back to the U.S. Omnibus Budget Reconciliation Act of 1987 which mandated the U.S. federal government to develop a comprehensive system to assess and evaluate all nursing home

residents (Lum et al 2005). Further, in 1991 when the Minimum Data Set (MDS) was introduced in the U.S. it was welcomed as a tool that would improve the quality of nursing homes. Subsequently all nursing homes certified by Medicare or Medicaid were required by law to complete a standardized MDS on each of their residents in an attempt to assess care outcomes and also compare care outcomes across facilities over time (Lum et al 2005). The RAI-MH is a MDS tool that has been developed for use in mental health. There are other similar tools that have been developed that are used in other specialties such as palliative care, intellectual development, forensics and so forth.

The RAI-MH is an approximately twenty page electronic document that is to be completed by the various health professionals involved in a patient’s care during an admission to hospital. Incidentally, nursing has to complete the majority of the text (See Appendix 4 for a sample of the RAI-MH). It is to be completed at various stages of care; within 72 hours, at discharge, reassessment at 92 days and when there is a major change in health status. Staff was informed that the RAI-MH was an assessment tool that was being mandated in Ontario by the Ministry of Health and Long Term Care for all mental health beds. There are currently 75 facilities completing and then submitting this data to the Canadian Institute for Health Information (CIHI).

Staff was informed this assessment tool is research friendly and has the potential to access data from large data sets to further research. This was highlighted as an exciting opportunity that could potentially assist us in our efforts to provide evidenced based practice. Staff was also informed this new tool will decrease paper work and so workload as it is a complete assessment tool and care plan and thus other documents currently completed would become redundant. Initially, on a quieter note staff were also informed it is linked to funding and so it is extremely important that it is completed. RAI-MH training documentation (2005) states the following objectives; collect standardized information, prepare for the calculation of weights to be used by the Ministry for

funding and management commencing in 2007, to provide comparative facility level outcome reporting to frontline service providers and management, support privacy sensitive data sharing and research opportunities. There appears to be some discrepancy between the verbal promise to staff and the written purpose or intention of the RAI-MH researchers and the Ministry.

### **The RAI-MH Tool**

The RAI-MH is owned jointly by the Ontario Ministry of Health, the Ontario Hospital Association and interRAI (the researchers). Incidentally, the interRAI or the researchers describe themselves as an international research consortium from 21 countries. The researchers have published a journal article that presents the results of the first reliability and validity study of the RAI-MH (Hirdes et al 2002). Hirdes et al argue there is a lack of good quality, clinically relevant data at the individual level for the behavioral health services. Further, this type of evidenced-based data is important in answering key policy questions. Hirdes et al also suggest the RAI-MH is a comprehensive, standardized assessment tool. They discuss the development of the RAI-MH, their multinational research efforts, current use, and future implementations. The authors argue that the data from the RAI-MH will support care planning, quality improvement, outcome measurement as well as case-mix based payment. The paper provides evidence that the tool is reliable and valid.

However, according to Lum et al (2005), researchers have debated the quality of measurements in MDS tools since implementation. They argue that the studies that have evaluated the reliability and validity of the MDS measurements have mainly been conducted by the researchers who developed the MDS. Other researchers have questioned the accuracy of the data being collected by MDS tools (Teresi & Holmes 1992, Ouslander 1997, Crooks et al 1994, Casten et al 1998). Also in 2001 the Office of the Inspector General at the Department of Health and Human Services in the U.S. found a difference in the basic

information taken from MDS data and from reviewing comparable medical records of residents, reports Lum et al (2005).

Interestingly, the staff trained to complete the RAI-MH for the research study was trained over a two day period whereas at my study site the staff received approximately 45 minutes of training in the team office with frequent interruptions by patients and telephone calls. Thus I would question the reliability and validity of the RAI-MH’s being completed at worksites. Mor et al (2003) when discussing using MDS tools as quality indicators and thus tools to compare facilities argues that as most inter-rater reliability tests are made under optimal conditions they may not reflect real life conditions and thus more attention should be given to training staff in completing MDS assessment tools otherwise inter-facility variation in reliability will undermine the validity of the aggregated quality measures. Published lists comparing different facilities/services or league tables as they are referred to by Munro (2004) will be discussed in more detail later.

Hirdes et al (2002) state that in 1996 the Ontario Joint Policy Committee (JPPC, Ontario MOHLTC & the Ontario Hospital Association) and an international research consortium (interRAI, 40 researchers and clinicians from 21 countries) met and began to collaborate and develop the tool. They state that the initial goal was to support the creation of a case-mix based funding system for inpatient psychiatry. According to Bjorkgren et al (2004, p. 464) case-mix may be defined as,

“a system that classifies patients into groups that are homogeneous in their consumption of resources and cost”.

Further, research has shown that resource use varies depending on how physically dependent residents of nursing homes are. Thus, case-mix classification systems are important tools for managers and policy makers in healthcare to ascertain resources required and therefore cost. (Bjorkgren et al 2004). However, these researchers also note that while case-mix systems should account for physical and nonphysical functions (social interaction and life

management) the MDS tool used in Finland has not been found to be a good predictor of cost when nonphysical functions are used. Thus, one wonders how this will translate into the area of mental health where there are fewer patients who require assistance with their Activities of Daily Living or physical functioning and more with the nonphysical or social functioning problems.

The developers of the RAI-MH expanded their mandate to not only include case-mix funding but also an assessment tool that included care planning, quality improvement, and outcome measurement. Hirdes et al (2002 p.421) clearly state that the mandate was expanded to increase the tool’s appeal to multiple audiences and to be seen to reduce the sense of administrative burden on clinical staff (one assessment tool to be used by all team members) and “to increase staff buy-in through the inclusion of clinically relevant applications”. Therefore, it appears that the initial goal was to develop case-mix funding and so a focus on efficiency will inevitably result. This focus may result in budget cuts and reduced staffing and thus one would assume ultimately negatively impact patient care. As this might be unpalatable to clinicians who care about job security, workload and patient care, it appears that the researchers decided to include clinical assessment and care planning as a strategy that would make the tool more palatable to frontline staff. However, it appears the RAI-MH is yet to decrease the administrative burden of frontline staff as they continue to complete the RAI-MH as well as other assessment and documentation tools.

I will now list the benefits of the RAI-MH, as suggested by Hirdes et al (2002), and my response to these benefits. Firstly, the researchers have an opportunity to be involved in international research. They hope to conduct cross national and cross cultural evaluations of the RAI-MH. However, on a cautionary note, this research investment via time, effort and professional credibility may result in the interRAI researchers finding it difficult to accept its potential limitations or failure in the future should the evidence start to lean that



way. I also wonder whether the researchers have a financial incentive. The tool is jointly owned by the Ontario Ministry of Health, the Ontario Hospital Association and the interRAI (researchers). For example, by promoting its worldwide application I wonder if they will receive monies for the right to use the tool/software. Research tools are a business. Iskowitz (2006) explores how market research has entered a new era which he refers to as the research revolution. He reports that approaches from the consumer world have been brought into healthcare and market researchers have become quite unorthodox in their pursuit of a deeper insight into consumers. They reportedly value longitudinal patient level data. Iskowitz also reported that this methodology primarily uses secondary data sources to put together a complete picture of the patient and their medication use and I wonder whether market researchers for pharmaceutical companies will be able to access or purchase the RAI-MH data in the future.

Related to this is the benefit of using a tool that can be used to promote evidenced-based practice and policy developments that demand valid and reliable data, argue Hirdes et al (2002). Since the introduction of this type of assessment tool in U.S. nursing homes, the data obtained have been used in numerous research studies looking at various topics such as the use of antipsychotic medications (Alanen et al 2006), palliative care (Brandt et al 2006), multiple sclerosis (Newland et al 2005), bed mobility ratings (Bates-Jenson et al 2005), pain management (Won et al 2006) and depression (Simmons et al 2004). Other studies include a comparison of mentally ill patients from the forensic and civil systems (Seto et al 2004) and also an evaluation of the interRAI-ID which is used with people with intellectual disabilities (Martin 2005). Thus the use of MDS or the RAI as a source for data to be used in research studies is an ever expanding area. Some of this research includes data from thousands of patients. For example Martin (2005) used data from over 85,000 patients in Canada. There is also an interest in including questions in a MDS that would assess quality of life

indicators in an attempt to replace the traditional method of direct in person interviews with patients (Degenholtz et al 2005). Thus, it appears there is the potential for the MDS or RAI to gradually become longer and longer computer assessment tools as we try to include more and more questions in an attempt to become more and more cost efficient. Where will this leave the client and the relationship developed through direct communication? Again as already highlighted, the value of this data is dependent on the accuracy of the data inputted into the assessment compared with traditional interviews (Lum et al 2005).

This type of research data may be useful when the goal is to extract demographic types of information, however, such a positivist approach is not the only way to get good data. Geanellos (2004) argues against the move to evidenced-based practice (EBP) in the area of mental health nursing. She states that psychiatry’s main interest is the human experience of illness and human relationships and these are concepts that are difficult to research quantitatively. Further, while qualitative research is not yet fully accepted within mental health it should be included as multiple approaches to knowledge building are essential in mental health research. Mental health research currently aligns itself primarily with positivist approaches that use methods such as the randomized control trial. Unfortunately, while important, such research often does not capture the depth and richness of human relationships. There is room for both quantitative and qualitative research and knowledge building within mental health. Also, it would perhaps become too convenient for researchers to rely on RAI data for research needs rather than gather their own original data.

Secondly, the authors suggest that the RAI-MH will facilitate a more equitable funding system based on patient needs rather than facility characteristics. The current funding for psychiatric services is on a per patient basis. Therefore, a facility that provides services to more resource intensive patients may be under funded while a facility that provides lighter care may be

over funded. Thus, from the Ministry's perspective a case-mix approach or funding algorithm is likely the real agenda behind the implementation of the tool. However, will a funding formula based on severity of illness and need result in staff being tempted to exaggerate symptoms to ensure adequate funding and ultimately employment security? For example, will a diagnosis of schizoaffective disorder receive more funding than a diagnosis of depression or psychotic symptoms receive more funding than other symptoms? Or will patients be discharged when their symptoms are not severe enough to obtain optimal funding? This may lead to an increase in the revolving door syndrome in tertiary care with patients being discharged early and readmitted shortly thereafter with new funding (O'Neill 2005). Segal (1999) when discussing managed care in the U.S. reports that shortened psychiatric stays deny clinicians the time to help resolve patient situations and this leads to the increased probability they will be readmitted.

Thirdly, Hirdes et al (2002) suggest that quality, accountability, efficiency and resource allocation are key items on the policy agenda and thus a tool that measures outcomes would be useful to government, managers and the public. The authors also report that cost effectiveness within psychiatry is an ongoing concern as it is difficult to measure non-pharmaceutical interventions. It seems they are suggesting it is difficult to measure the impact of therapy or the therapeutic relationship. Tilbury (2004) argues that counting something can make it important and thus not being able to count an activity makes it invisible or not important. The importance of the therapeutic relationship will be discussed later in more detail.

Piven (2006) explored the mandated use of the RAI in nursing homes in the U.S. where implementation of the tool was to determine funding and improve the quality of care. She argues that the RAI does not guarantee good decision making, conscientious care or even high quality care. Simmons et al (2004) reported the prevalence of depression in nursing homes using independent

assessments was significantly higher than the prevalence based on MDS data. Further the MDS data underestimated the prevalence of depression symptoms particularly in homes that reported low or nonexistent rates. A low rate of depression amongst residents supposedly suggested better care was provided at these homes. However, one might wonder why some nursing home data was inaccurate and suggested low or nonexistent rates of depression when the reality is they had higher rates. Is it possible that the data inputted was influenced by a desire to appear a better home as we know the results are publicized? Also recognizing the symptoms of depression in residents did not result in better treatment or management of depression, argues Simmons et al (2004). Therefore one might ask what the purpose of MDS data is. Is it to create comparisons and ultimately competition between nursing homes and hopefully a byproduct of this would be improving the quality of care in nursing homes. Mor (2005, p.334) states that,

“..providers will be stimulated to invest in internal quality improvement efforts *if* they believe that consumers will choose providers based on public reports of provider quality or if they will be otherwise rewarded or penalized because of these comparisons”.

However, if the data entered is inaccurate perhaps purposely to show a nursing home in a better light, this all becomes a moot point and it appears that nursing home providers have greater incentive to skew MDS data.

Perhaps what the RAI does accomplish is that it is yet another way to monitor the healthcare team or hospital that will lead to outcome comparisons between hospitals. Something similar has recently occurred in the U.K. where league tables of social services are published in the media and on line outlining costs and outcomes so that comparisons can be made with other social services (Munro 2004). In Ontario similar league tables have recently been introduced into education where the results of mandatory testing of students (EQU) are published in the media and online on a school by school basis. Just as high scoring schools may see increased enrolment, will high scoring hospitals be seen

as better able to provide care and thus see an increased demand for their services? Will those citizens who are in the privileged position of being able to navigate and advocate in such a system be able to access these hospitals more than less privileged citizens?

Fifthly, Hirdes et al (2002) report that while mental health professionals routinely conduct assessments there is little standardization of assessments across settings, the assessments used have never been evaluated for reliability and validity and therefore there is a lack of comparable data. Once again the authors are emphasizing the importance of standardizing patients for research purposes and comparison with other facilities. Psychologists Saakvitne and Gamble (2002) argue that their work must also include political advocacy as currently quantitative research is being used as the evidence to promote time limited treatment approaches dictated by experts in fiscal management. They argue that the results are over generalized so that statistics about groups of clients are used to justify policies that are then applied to individuals and the individuals they see are dealing with childhood trauma that requires longer term psychotherapy. Further, research tends to measure for symptom reduction over the short term rather than clinically significant change which usually happens over the long term.

Sixthly, Hirdes et al (2002) suggest that the RAI-MH is a tool that can readily facilitate the integration of health information across settings such as psychiatric hospitals, community mental health programmes, group homes, family doctors, nursing homes, and home care programmes (CCAC). They argue such integration will benefit patient care as it will provide continuity of the care plan after discharge. Further, this integration of information will reduce the assessment burden on patients and it will aid the government in determining the allocation of health resources (funding) in our communities. Once again it seems that the allocation of resources is the primary goal.

Seventhly, Hirdes et al (2002) states that the concepts of recovery,

rehabilitation, and empowerment underlie the guidelines for responses to triggered MHAP’s (mental health assessment protocols). There appears to be a discrepancy between what the authors’ state and true recovery and empowerment concepts which would encourage patient involvement. Generally, patients are not aware the tool is even used and it has the potential to develop a treatment plan without their collaboration.

Ohayon (2006) argues that a good clinical instrument could be a deficient tool in the epidemiological field and conversely a good epidemiological tool could be a poor clinical instrument. He further states, there is a fundamental distinction between patients and subjects of studies that is often neglected: patients are individuals who are seeking help of a healthcare specialist while subjects are people who are solicited to participate in studies.

### **Assessment tools and the impact on the therapeutic relationship**

A colleague stated that since the implementation of the RAI-MH her initial interview with patients is now shaped by this assessment tool. Previously, during initial interviews she did not write during the interaction and let the client guide the interview with their presentation of their current problems. However, she now completes two documents simultaneously during the interview and the questions asked are related to completing the RAI-MH. This worker is well aware that this changes the nature of the interaction as the interview is now guided by the RAI-MH questions. (O’Neill 2006). Gustafson (2000) when discussing the implementation of the CCAC-RAI states, that the text or document regulates the actual conversation between client and worker and thus the data the worker gathers to construct and standardize the client’s situation. Further, this way of gathering information disconnects the client’s story from the caring conversation that once guided client-worker relations.

There is a body of research literature that explores the working alliance or the therapeutic relationship between clients and the helping professions. This

literature argues the relationship or alliance appears to have a powerful effect on treatment outcomes (Hostick & McClelland 2002; Dozier et al, 1999; Neale & Rosenheck, 1994; Peplau, 1994). Howgego et al (2003) conducted a literature search from 1986 to 2001 on MedLine, PsychINFO and the Social Sciences Index and found 84 articles exploring this topic. They only included research that used validated measures and was related to psychiatry and community case management. They suggest there is a definite correlation between the therapeutic relationship and improved outcomes and they also acknowledge its potential as a prognostic indicator. One of the perspectives they describe is Bordin’s integrated or Pan-theoretical perspective that suggests the three key influences on the alliance are, tasks, goals and bonds. Bordin (1979) argues that collaboration is central to the alliance and it is the key or vehicle for therapeutic change with the patient who is a partner in therapy.

Some other researchers have attempted to explore in detail the nature of this relationship to discover the crucial elements in a good therapeutic alliance. Reynolds & Scott (1999) state that the literature substantiates the widely held view that empathy is the crucial component in the helping relationship. Further, they argue that while most of the literature cited is a decade old, the importance of empathy in a helping relationship remains unchallenged. Reynolds & Scott state the literature suggests the following key components: initiating supportive interpersonal communication in order to understand the perceptions and needs of the other person, empowering the other person to learn or cope more effectively, and the reduction or resolution of the other’s problems. Interestingly, the first component listed highlights the importance of the initial contact. Reynolds & Scott (1999) after surveying the literature also argue that empathy is more important in the helping relationship than the therapist’s ideological orientation.

Nolan & Badger (2005) stress the importance of the therapeutic relationship in treating patients for depression in primary care. They argue that the interpersonal space between the patient and clinician is not neutral space.

Patients have preconceived notions and prejudices about treatment and the first contact is extremely important when hypothesis about the patient's illness and possible paths to recovery are being considered by both. In such an interaction each has the potential to influence the other and ultimately affect recovery.

Others also argue that the initial consultation or interaction is crucial in terms of gaining the patient's trust and commitment to recovery (Broody 2003, Geddes et al 2003). Thus if clients feel they are being processed through an exceedingly efficient healthcare system they may begin to question such assembly-line care and it could potentially have an effect on client recovery or outcome.

A recovery approach would also suggest the clinician and client collaborate in prioritizing needs and treatment goals. In fact it may be argued that patients have different expectations and needs than what professionals may assume they have. Thus a failure to truly understand the client's perspective may be exacerbated by the current emphasis on moving patient's through the healthcare system at an increasingly faster pace (Reynolds & Scott 1999). The authors also suggest that empathy may not be possible if the following conditions exist, high workload, lack of time, poor skills mix, and rapid discharges as they all reduce the opportunity for one to one relationships. I would add to this list increased documentation that results in a move from client centred care to documented centred care which includes the addition of computer based assessments such as the RAI-MH.

An interesting study conducted by Rhodes et al (2006) explored the use of computerized checklists and their impact on patient centred care in the treatment of Diabetes Mellitus. Using a conversational analysis of patient-nurse interviews they discovered that an emphasis on biomedical audit compromised patient centred practice. Mead & Bower (2000) suggest five key dimensions that distinguish patient centered care from the biomedical model: the patient as person, sharing power and responsibility, the therapeutic alliance and the doctor as person. Rhodes et al (2006) suggest that nurses' attempts to maximize



efficiency, due to work load and time constraints, may lead to routinization of tasks and computer tools aid this routinization. Patients may become items or commodities to be processed rather than individuals with different personalities and needs. This routinization and standardization then restricts patient opportunities to present themselves as individuals and thus does not allow a space for the patient’s agenda. Such interactions obviously lack empathy and not only impede the development of a longer term relationship but also may affect treatment outcomes including medication/diet compliance (Rhodes et al 2006).

This example is useful as diabetes is a chronic illness much like mental illness is a chronic illness and both require a therapeutic relationship that emphasizes collaboration with the healthcare team in order to stabilize the illness through addressing treatment compliance. It appears that some staff at this site in an attempt to improve efficiency and thus lessen workload are completing the RAI-MH on the computer while they conduct their initial interview with a newly admitted patient. This attempt to have control over an ever increasing workload does raise many questions. Does the patient or staff believe this impacts the therapeutic relationship or do one, or the other, or both view it as a demographic exercise that needs to be completed prior to them receiving treatment? Will the therapeutic relationship truly begin after the completion of formal documentation? Will the next step be computerized assessments upon admission that will determine diagnosis and so a decreasing need for the in-depth interviews currently conducted by psychiatrists?

Ohayon (2006) states that while computer-based interviews and assessments tools are becoming popular in psychiatry, their large scale use is still the exception. Further, psychiatry is based on human interactions and thus implementing machine-human interactions may dehumanize the diagnostic and treatment process. Ohayon acknowledges that computer based tools offer a low cost, reliable and quick way to collect information on large samples. Will a culture of efficiency and cost reduction push for widespread implementation? Ohayon

reports that some research in this area has suggested that many patients feared this type of assessment would interfere with the patient-physician relationship. Therefore, it is important to continue to research and examine the evidence regarding the therapeutic alliance and treatment outcomes and whether completing a computerized tool such as the RAI-MH affects the therapeutic relationship.

### **Linking local practice changes to wider social forces**

I will now attempt to link what is going on locally to wider societal forces that are more or less invisible to the professional who will ultimately and perhaps unwittingly be caught up as they perform the role of “an agent of ruling relations” (Campbell & Gregor 2002). Munro (2004) discusses the impact of audit on social work in the UK and states that the current political, economic and social climate are linked to the public’s demand for greater accountability and transparency in public services.

#### **Political Climate**

Brodie (2002) argues that there has been a paradigmatic shift in governance ideology within Canada with regards to the relationship between state, civil society and the market. During the post war years (WWII) the governance ideology of “embedded liberalism” emphasized the importance of the welfare state and this influenced the political climate for over 30 years. However, during the Mulroney, Thatcher and Reagan years in the 1980’s, a new political ideology or governance emerged that is referred to as neoliberalism. Neoliberalism emphasizes decentralization, privatization, individualization and the importance of market forces at the expense of the public sector. According to Brodie (2002, p.95), since the Mulroney years various political parties have been involved in further dismantling the welfare state which has been replaced with a “leaner and meaner neoliberal alternative”. Interestingly, the proportion of federal spending currently allocated to social programmes is less than it was in 1949

before the implementation of the welfare state, reports Brodie. She further argues that neoliberal ideologies and policies have resulted in a growing income gap between the rich and poor, the feminization of poverty and marginalization of the already marginalized in our society.

This ideology directly affects my current practice at the local level as I witness firsthand the effects of neoliberalist ideologies on the everyday lives of clients, especially those who rely on Ontario Works or the Ontario Disability Support Program to survive. These clients have been marginalized due to mental illness and also by poverty. I also witness marginalization by gender and the feminization of poverty as some of these same clients are single women raising children on inadequate incomes. Also, in my field a white euro-centric ideology dominates the diagnosing and treatment of clients as the professionals who determine which conditions are in or out of the Diagnostic and Statistical Manual (DSM) are predominantly white males of European descent. It might be argued that the dominant group’s ideologies continue to influence and discriminate by race, gender and class. Potts & Brown (2005) remind us that as white middle class heterosexual workers it is essential we recognize our own place of privilege and work towards dismantling the unjust systems that keep us in this privileged space.

### Economic Climate

The current economic climate is described as being one of economic rationalization with historically disadvantaged groups becoming increasingly more vulnerable with a rationalizing of services (Whiteside 2004). Related to this concept is the promotion and adoption of managerialism within social services and healthcare. Managerialism in social services and healthcare occurs when private business or market technologies and their language are incorporated into the welfare state. For example, the use of computers or documents to audit workers as well as the language of efficiency which includes terms such as, goals, targets, outcomes, effectiveness, cost containment, accountability, audit,

and transparency (Gustafson 2000, Stein 2001, Brodie 2002, Beckett, 2003, Tilbury 2004). It is currently contested whether healthcare has become a business, to the extent that efficiency is often a more important factor than quality. Thus, an organization may be successful in meeting its goals but unsuccessful in meeting the needs of the clients it serves (Gustafson 2000, Globerman et al 2002, and Tilbury 2004).

In the UK, the New Labour government (Tony Blair) is emphasizing the modernizing of social services through scientific management, best value concepts (such as accountability, continuous improvement, ownership) and clarity for the public. This modernizing via scientific management has been presented as empowering with an emphasis on partnership with the general public or service users. Therefore, any resistance to managerialism by social workers is perceived as elitism on their part as this new managerialism claims to include and speak for service users, argues Parton (2004). Laine et al (2005) conducted a study with the aim of exploring the determinants of wage-adjusted nursing time in long term care wards for the elderly and their goal was to improve efficiency in the use of labour resources. They used the data from the MDS/RAI for nursing homes. Not surprisingly, their results showed significant unmeasured patient and ward level effects, inefficiency and randomness in the allocation of nursing time. While I may agree that more staff does not necessarily mean better care they fail to recognize the difficulty in trying to measure factors other than physical aid in the helping relationship. Such factors as caring, comforting and building therapeutic relationships may appear as inefficiencies in a time management study such as theirs.

Managerialism directly affects social work practice in several ways. Aronson & Sammon (2000 p.168) report that managerialism impacts social work as it,

“...effectively reduces important political questions about how need and entitlement are to be defined to seemingly neutral administrative technicalities about targeting, efficiency, and financial accountability.”

Computerized workload/audit measures as well as computerized assessments effects frontline practice as it increases awareness that practice is being monitored by managers, employers and ultimately the Ministry. Aronson (1997) refers to managerial surveillance and this is indicative of a culture that prizes Bentham’s concept of the panopticon where prisoners are under constant surveillance/supervision from the tower (Moffat 1999). Foucault (1979) argues that the panopticon is a mechanism that ensures the efficient expression of power as the prisoners are always aware that they are being monitored and ultimately this results in them then monitoring themselves.

With the RAI-MH, each discipline has a section to complete and the program has the ability to generate lists of what is incomplete and by whom and this information may be sent to managers. Again, computerized documentation may be used as a way to monitor and audit employees and perhaps eventually the vast majority of us will monitor ourselves to ensure we are completing the work that guarantees we will be viewed as good employees and thus feel some sense of job security. Monitoring systems such as STAR, GRASP and RAI-MH have consequences if they are not completed. Emails may be sent, reports sent to managers regarding STAR (number of patient contacts) or comparisons of social work and other disciplines’ statistics made. This may be a deliberate strategy to encourage competitiveness and ultimately increase client contact and workload statistics within different programs. It is also likely that at management meetings the statistics from various programmes are compared and therefore managers are also under pressure to provide good statistics. Interestingly, shortly after the RAI-MH was mandated a colleague informed me that hospitals will be fined for any RAI-MH’s not completed. Further, the colleague reported a southern Ontario hospital was fined for not completing RAI-MH’s.

As employees, are we reflecting on how these documents may be used against us in the future when funding formulas indicate a programme can function

efficiently with one less social worker or two less nurses? Fraser (1989) describes “thin” needs as basic needs such as food and shelter whereas “thicker” needs may be sufficient, healthy food or permanent, affordable housing. If social workers move towards dealing with “thin” needs only in a routinized, deskilled workplace, perhaps it will be argued that this function can be more efficiently and economically met by less qualified workers at a greatly reduced cost to public expenditure. Social workers should not assume they are indispensable. Few disciplines are indispensable as was displayed recently when a southern Ontario hospital recently closed its entire psychology department. As social work is an occupation based on relationships, these documents cannot measure many of its functions. How do we measure the impact of human relationships and relationship building and what is referred to as messy social work? (de Montigny 1995). Further, it is difficult to measure the unpredictability of clients’ everyday lives (Aronson and Sammon 2000, Fabricant and Burghardt 1992, DeMontigny 2003, Parada 2004).

### Social Climate

Our current social climate appears to indicate public trust in social services or the welfare state is diminishing and I would argue that this has been one of the results of a neoliberalist agenda that has demonized many clients marginalized by poverty. For example, during the 1990’s when the conservative party led by Mike Harris was in power there was an agenda that served to judge single mothers and the unemployed with the introduction of Workfare and Ontario Works and its accompanying stringent regulations. It might also be argued that this negative perception is also apparent with regards to social service and public service workers (Munro 2004). Risk management is of paramount importance within business organizations and has infiltrated organizations that employ the helping professions. Managerialism demands accountability and documents are an important way to measure and monitor workers with regards to this. Hood et al (2001) refers to this as “blame prevention engineering”.

Within child welfare, the ORAM was developed as a way to assess risk of harm to children but it also performs the function of monitoring workers and auditing their work performance and ultimately it will still be the worker who is scrutinized and held accountable in child deaths. DeMontigny (2003) argues that standardized documents are a strategy for managing and controlling risks and child welfare has moved towards a model where ORAM’s, supervision, monitoring, control and compliance are paramount and worker autonomy is greatly reduced. Further, risk management is a boom industry whose goal is to reduce legal and civil liability. Aronson & Sammon (2000) also comment on the increased demands for what they refer to as defensive paperwork.

In the mental health system documents such as the RAI-MH may also be used to generate data in the future that will increase transparency to keep the public informed of outcomes and costs. This was mentioned earlier when I referred to the league tables published in the UK that Munro (2004) refers to as the “name and shame “ tables and the published lists of nursing homes derived from MDS’s in the U.S. (Simmons et al 2004 and Mor 2005). Mor (2003) suggested this type of information or “web based report cards” would create greater transparency to guide consumer choice of nursing homes. However, he now acknowledges that although the number of “hits” on such internet sites is high, there is no knowledge of who actually explores these sites (consumers, nursing home staff, potential employees etc) and if it is consumers or their families then whether it informs or influences their decision making. It appears the public want to know that their tax dollars are being spent efficiently, unfortunately this may end up resulting in the status quo or a decrease in the quality of services offered to them as it is contested whether the data from RAI’s/MDS’s are indeed accurate and if they improve the quality of a service.

### **Autonomy and critical analysis**

I also wish to highlight other areas that may be impacted by “ticky box”

practice and an increasing culture of audit within social work practice. “Ticky box” practice and especially the RAI-MH attempts to break down into small pieces the work social workers do with clients. Unfortunately, at times social work practice seems reduced to an assembly-line where clients and their problems are widgets to be quickly attended to or processed and then the social worker quickly and efficiently moves on to the next widget. This assembly-line practice has been discussed by Baines (2004), Fabricant and Burghardt (1992), Aronson and Sammon (2000) and others who argue that the heightened regulation of social service work and the proletarianization of social work may result in reducing the worker’s skill level and autonomy as managerialist control intensifies. Further, clients are standardized and social work practice is fragmented which may result in a deskilled workforce.

A colleague who recently returned to my practice site after a twenty year absence reflected on the skillful work she was previously a part of at the hospital. She reported that back then social workers conducted family therapy, sexual assault therapy and so forth and her clients were not routinely referred to specialized services as is now the case. She lamented the loss of the opportunity to work with clients in a more holistic way and the potential deskilling of workers that may have resulted. This way of practicing may be disadvantageous to patients with complex and varied issues who could potentially be referred to a number of specialty services and therefore repeatedly go through assessments and therapeutic relationship building. For example, a patient may receive treatment for their depressive episode on an inpatient unit, but if they also have substance abuse issues and past sexual abuse issues, or require relationship counseling they may be referred to other therapists. This inevitably results in a fragmented service for patients rather than a holistic approach.

It is also argued by Aronson & Sammon (2000) that there is a reduction in the use of analytical skills and critical reflection as workloads and documentation demands increase. Braverman (1974) and others discuss the move from



Taylorism to Fordism in the workplace. This way of controlling the workplace and the worker came to the fore during the industrial revolution when there was a move away from using skilled craftsmen to produce consumer goods to factory workers producing consumer goods in a more large scale cost efficient way. Thus managers became responsible for gathering all the traditional knowledge possessed by skilled workers and then classified, tabulated and reduced this knowledge to rules, laws and formulas. When Ford developed the assembly-line, workers also lost control over the pace of their work (Yates 1999, Greenbaum 1999, Young 2005). Braverman argues that through capitalism occupations continue to be deskilled, routinized and reified via the use of science and technology with the goal of totally controlling the labour process and therefore controlling the worker. The adoption of new technologies and managerialism has seeped into the helping professions as ways to audit and monitor work have increased. Further, control over skill is one of the main ways to decrease wages and increase control over the worker (Greenbaum 1999). Thus, the deskilling of professions may result in lower wages perhaps through hiring less skilled workers to complete routinized tasks for reduced wages.

There appear to be similarities between the implementation of the RAI-MH and the ORAM in child welfare as mental health also becomes more document-focused. It is argued that child protection workers have become deskilled as their work has become fragmented into intake, risk assessment, investigating, foster care and adoptions. With the ORAM, their interviews with clients are dictated by the document to be completed as is also the case with CCAC workers (DeMontigny 2003, Campbell & Gregor 2002, Aronson & Sammon 2000, Parada 2004). DeMontigny (2003) reports there is a greater risk of pathologizing clients through using these standardized documents.

Child protection is thought to have one of the highest staff turnover rates within social work with two year turnover rates cited of 46% to 90% (Drake and Yadama 1996). This may be attributed to a slump in morale due to time spent on

documentation, the lack of autonomy, and the lack of trust by the public and government (Parada 2004). Most social workers do not enter social work with a desire to complete documents. Rather, they are drawn by a desire to work in close contact with people, building therapeutic relationships and advocating for them to access to scarce resources. Munro (2004) states that in London, England there is a 40% vacancy rate for social work jobs and from 1996 to 2001 there was a 59% drop in the rate of applications for university social work places. Ironically, Munro reports so many people were leaving social work practice in England that in 2002 there was an Audit Commission study to discover why this was happening! The Audit Commission reported the reasons stated by social workers included: a sense of being overwhelmed by plutocracy, paper work, targets, insufficient resources leading to unmanageable workloads, lack of autonomy, feeling undervalued by managers, government and the public, unfair pay and a change in agenda that they felt was imposed and irrelevant. While we may agree that public service organizations should be accountable and transparent we should ensure our quest for this does not alienate and drive out experienced workers (Regehr et al 2002).

### **Transformative social work practice: How to better serve clients within a culture of “ticky box” practice**

Aronson & Sammon (2000) suggest managerialism in social services has resulted in an intensification of and acceleration in work that leaves little time for reflection, discussion with colleagues, critiquing the system and resistance or transformative practice. I have attempted to highlight the puzzles and tensions currently within mental health social work and how “ticky box” practice is encroaching on what is considered good practice. As an insider, I can offer a particular perspective or standpoint but it is also important to hear the views of other social workers on the increasing demands for assessment and accountability documentation. While it is important to not only be aware of how

documentation affects social workers but also acknowledge that in the everyday world clients’ lives are subordinated by ruling practices (Campbell and Gregor 2002). Smith (1987) argues this awareness or knowledge alone is not transformative in and of itself. Social work education and the literature highlights the role social workers can play in addressing social justice issues through resistance, subversion of institutionalization or pushing against the system and attaining small victories (Smith 1987, Aronson & Sammon 2000).

Parada (2004) suggests that creating a culture of critical practices is a way to engage in critical social work and the micro-resistance of everyday life. Does the ability to resist depend on working in an environment that supports a culture of critical practice where the social workers feel connected and supported when they challenge the system? Is there safety in numbers or is it more beneficial in the long run to quietly practice resistance alone or with the support of only a few allies?

As social workers, our role is to advocate and push the system in an attempt to facilitate our clients in accessing much needed services. Healy (2000) states, just as there is no one way of being a good social worker there cannot be only one way to be an activist. Therefore, we must deal with the tensions inside our practice settings while at the same time trying to subvert them. Healy (2000 p. 137) states,

“..activists are recognized as being embedded in the systems which both constrain and enable them to achieve progressive change”.

Beresford (2000) often suggests the importance of social workers and service users working together to make change. He argues that the service user movements have a greater influence on politicians and policy makers than social work practitioners and academics. Also Beresford and Croft (2004) suggest that for social work to develop a more emancipatory role it needs to form much closer links and alliances with service users and their organizations. Beresford and Croft (2004) state transformation is possible if practitioners can gain collective strength

and support from each other and social work should also give priority to forming alliances with service users as this may be the vehicle to influence political agendas and policy in the future. Interestingly, a discussion with some patient advocates revealed that just because the RAI-MH is a Ministry initiative does not mean that it cannot be challenged and potentially changed as the Privacy Commission is in a position to challenge the Ministry if it has concerns (O’Neill 2005).

## **Findings and Analysis**

Key findings or themes emerging from the analysis of interviews are highlighted below and participant experiences as well as direct quotations are also included. Whilst agreement between social workers on the specifics of the RAI-MH tool itself was apparent there were also some notable differences especially with regards to responses to the introduction of the tool, critical thinking and its impact on patient care or the therapeutic relationship. Workers who have more experience appeared more skeptical and questioned the usefulness and the motivation behind the RAI-MH. While newer workers, likely trying to learn the job and who would be in a more vulnerable position, appeared to be more accepting of the RAI-MH. The key themes that emerged included the following.

### **Current documentation and workload**

All of the participants expressed their concerns about increased documentation leading to an increased workload. While it was initially suggested to staff that the introduction of a computerized assessment tool would decrease documentation, it appears this is not the case. All the participants complained about the duplication of information and thus increased workload that ultimately results in less time spent in interaction with patients. They described the different documentation requirements they complete as repetitive, a duplication of information and so therefore inefficient. A participant expressed her frustration with this when she stated,

“...just how many places can I write the same thing or check the same thing.”

Another participant detailed her concern with the impact on workload,

“It is difficult because the information I would be putting in there (*RAI-MH*) I already include that in my assessment - in everyday work. So it’s not as

though I am losing workload to do the RAI. I am doing the RAI in addition to the other assessments and the other information gathering I already do. It takes time away from my day. It adds to my workload.”

The participants all appeared very conscientious with regards to their work and especially the various types of documentation to be completed. They voiced the pressure they experienced when workload led them to feel rushed when documenting.

In mental health there is a revolving door syndrome with regards to some chronically ill patients and a participant noted that on one of her clients, who has approximately ten brief admissions per month and as the RAI-MH is to be completed upon admission and discharge, she will complete the RAI-MH twenty times per month for that individual. She also reported that very little information changes in that short period of time for the patient and her frustration with this repetitive process was apparent. Another participant summed up the current climate within her workplace,

“Do more, do it better and do it with less. You just do it. I just do with the patients what needs to be done”

As workloads increase within a climate that values cost efficiency and increased productivity it is easy to see how care within mental health may result in assembly-line care that could result in workers having to address the “thin” needs of clients rather than “thicker” needs (Frasier 1989).

A disturbing by-product of increased workload was noted by one of the participants who suggested that the RAI-MH requirements and thus an increased workload resulted in less time for her and her peers to engage in peer support after crisis situations. She described crisis situations that resulted in patient seclusions and where unfortunately there are times when due to time constraints a peer may have to complete the RAI-MH before their shift ended rather than spending “time out” from patient activities to obtain much needed peer support. It seems that completing the RAI-MH documentation is a priority and scenarios

such as the one noted above may eventually lead to workers feeling more isolated, experiencing job dissatisfaction and “burn out” and eventually leaving this specialty or even their profession for one that is less crisis orientated or that has more peer support. More recently, the turnover rates within the social work profession have been noted both here and in the U.K. with some specialties such as child protection having 2 year turnover rates of 46%-90%. Research suggests that job dissatisfaction due to stress, increased paper work, increased workload, a lack of autonomy and feeling undervalued as a profession contribute to the high turnover rates (Munro 2004, Drake & Yadama 1996).

### **The rationale given or understood by participants**

When the RAI-MH was introduced, management attempted to positively present the rationale for completing the document and some workers questioned the administrative representation of the RAI-MH. There was a difference in the responses by the more seasoned social workers compared to the newly graduated social workers. The newly graduated social workers reported that the RAI-MH was a standardized assessment tool, it measures the services we provide, it would help staff provide better services to clients, it will help staff assess whether what they do is effective and effectiveness would be measured by fewer admissions to hospital and somehow it was tied into funding. These participants appeared to more readily accept the rationale presented by management. The seasoned workers also detailed the rationale cited by management, but did so with sarcasm, skepticism and criticism in their responses. This participant appeared dismissive when they stated,

“Something to do with funding? Something to do with these care paths.”

While another responded with sarcasm,

“Administration tells me the benefits are measurements .... It is some type of scorer or something..... It was supposed to be a snapshot ... We treat all these things with the same divine care.”

The following participant’s response is a good reflection of the typical responses of the seasoned social workers regarding the tool. She stated with some skepticism,

“I saw it as a demographic gathering tool and it was presented as an evaluation tool, which I don’t think it is. It can’t take the place of a good intake assessment or a social work assessment. It can’t take the place of a person’s story and narrative. It is not particularly recovery based, it is not hope based. So if it is presented to us as “here is a demographic tool that you need to use” that’s great we’d do it. It was actually presented to us as “here is a tool that will cut back on paper work because it will take over from some of your other tools and eventually it will help you do care paths.” I don’t see that happening.”

One of the newly graduated participants could not remember if a rationale was presented for using the tool and appeared to readily accept without question including this documentation in her practice. She stated,

“It was part of what you have to do when you interview clients. Nurses do a portion, doctors do a portion and same thing with myself, social worker fills out a portion.”

Most of the participants showed surprise when the interviewer reported that the RAI-MH researchers (Hirdes et al 2002) stated in their article the tool is primarily to be used for case-mix funding, a funding formula, and the assessment piece was added to try and obtain “buy in” from clinicians who they believed would be reluctant to complete a tool that was for funding purposes only. One seasoned worker appeared to feel relief when she realized her initial critique of the RAI-MH was substantiated when she stated,

“But we didn’t buy into that. It was presented as an assessment tool that is thorough ..... No there was a general feeling that this was a government inflicted demographic gathering exercise. ....It makes me feel vindicated actually. I knew it. We knew it and we did it anyway.”

A newly graduated social worker exhibited strong feelings upon hearing the intent of the RAI-MH researchers for the tool. She stated,

“For me having to do things to ensure funding is a little patronizing, it



makes my job difficult because I feel I have to prove myself in order to serve my clients appropriately and effectively. I think an assessment tool sounds great because I am for technology and if there is something they can organize like the content of assessing somebody but if it is just a funding tool then I am reluctant to buy into it also. I feel that we shouldn’t have to do that.”

This participant further added that she would rather complete a short form that gives the government the statistics needed to determine funding than to complete a computerized assessment tool that duplicates other documentation and that she does not believe contributes to her practice with patients.

### **The RAI-MH tool - advantages and disadvantages**

While the RAI-MH was viewed by all the participants as being time-consuming and repetitive, as the same information was recorded elsewhere, they also clearly expressed their concerns with completing “ticky box” documentation as it was often difficult to complete such a tool accurately for varying reasons. There was concern that the options/categories were limited and at times the option they wished to include was missing and unfortunately if the box was left blank it may be interpreted as the patient being deceased. For example, under the employment section no disabled option is listed, only employed or unemployed. This was frustrating for the participants as many of their patients are not able to work due to a disability. A participant noted that some of the questions are intrusive to clients and their families, especially questions regarding the sexual abuse of family members other than the patient. The tool was criticized for depersonalizing patients and standardizing patients’ experiences. Campbell & Gregor (2002) and others voice concerns regarding the power of documents to standardize the patient’s story or experiences and also the ability to dictate what is heard and noted during a staff and client interaction.

Some of the participants expressed concerns about completing RAI-MH’s on patients they have not met. For example, a patient may be admitted and

discharged over a weekend and therefore the social worker will not have had the opportunity to interact with the patient and yet she will be expected to complete the social work portion of the RAI-MH.

“The expectation is that it needs to be done.”

If the RAI-MH is only considered a demographic tool this may not be an issue but if it is truly considered an assessment tool then this is problematic for the social worker as a valid assessment one would assume would mean some contact with the patient!

Another concern participants raised was the requirement for the tool to be completed during the first few days of admission as at times patients may be so ill they cannot answer questions accurately. Due to the 72 hour deadline, previous chart information is used rather than waiting until a client is well enough to be interviewed in-depth as would be the case with a traditional social work psychosocial assessment.

“So, I’m doing it sometimes without the real information.... There is no “I don’t know yet. There is only “yes” or “no”.”

The literature on the accuracy of MDS tools is currently contested especially when it is compared to data from reviewing comparable medical records (Lum et al 2005).

Some of the participants listed advantages to the RAI-MH which included that it was very organized, in-depth and the use of technology or computers was viewed positively. It was acknowledged that it would be very useful for the government to obtain statistics and thus gaps in service may be addressed. Interestingly, the RAI-MH was also seen as advantageous as it could ensure continuity and consistency across services, it ensured no important information was overlooked and it would guarantee a baseline work performance by various professions. A seasoned social worker commented,

“ The benefit was at least you knew you bring people down to the lowest

common denominator ... we knew the clinician had asked all these questions or hopefully had asked all these questions ... it was a kind of a safety. ... I could see it would be useful to be sure we had all that information ... that all information was gathered ..... every intake person does their intake in a different way and some are more in-depth than others. So this is giving a baseline of what is expected. So that would be a good thing.”

The comment above suggests that as not all employees have the ideal work performance or skills when completing assessments then perhaps by decreasing autonomy or self efficacy all employees would meet a relatively low baseline when completing assessments. It appears for this participant the tool may be used as a means to control and monitor work performance but unfortunately this may result in a deskilling of employees rather than enhancing practice or assessment skills and ultimately clinical judgment.

While it appeared that the newly graduated social workers saw the benefits of a computer generated treatment plan, the seasoned workers were more skeptical. The newer employees did not mention that the computer generated treatment plan was based on inputted data, data they would be inputting and so it appeared they were discounting their own clinical judgment. Thus, they deferred to a computer program that ultimately depended on the data they inputted in the first place. Further, a treatment plan will only state very general maps, for example the patient has housing issues or financial issues and the specific goals need to be entered by the staff. For example, Apply for ODSP or OW. Therefore, one questions the usefulness of this as it will not generate information not known already. A seasoned social worker when discussing the care plan generated by RAI-MH stated,

“I think it would probably be the kind of sketchy-looking thing that will just highlight issues which are known to people who have done these things and talked to the patient and done their OT assessments, gone to team meetings. They will never replace those.”

This seasoned social worker summed up the difference between “ticky box”

documentation and narrative documentation well when reporting that the RAI-MH provides a limited or distorted snapshot while a narrative psychosocial assessment provides a whole picture of the person.

“The snapshot isn’t even black and white, its kind of pixels that don’t come together to make a picture. Social work assessments are combined to make a whole picture of the person.”

### **Responses to the RAI-MH**

While the participants appeared to have varying responses to the introduction of the RAI-MH, it appears that those asked to complete it did so or in the case of a very recently hired employee are about to begin completing it. Participants described responses that included immediate compliance and discontentment with compliance. Interestingly, none of the participants described resistance although they did mention colleagues who had or were resisting completing the RAI-MH. A newly graduated social worker stated,

“I just learned and started using it.”

When she was hired, the RAI-MH had already been implemented on the unit. This new social worker was trained by a colleague who was already completing the RAI-MH and it is understandable that she may follow the style of practice she observed initially. One wonders if her response or immediate compliance would have been similar if she was hired to work alongside a social worker who was resisting completing the tool or if she had been mentored or supervised by such a social worker. A seasoned social worker stated,

“I think we have muttered about what a pain it is and how annoying it is to have to do.”

While this employee may have grumbled and complained when it was initially introduced, she currently completes the document.

A newer employee who was also hired after the RAI-MH had been implemented offered another interesting perspective when she stated,

“I don’t believe I could delay using it. Primarily the reason I feel rushed to

start using it and feel obligated and compelled is that I see the rest of the team using it and they don’t really enjoy themselves. So I feel it is only fair that I do my part.”

Again, one wonders what her response would have been if she worked with a peer who was resisting and noncompliant with regards to the RAI-MH. Participants indicated that those social work colleagues who had exhibited resistance through delaying beginning to use the tool were in a different or safer position than them. Those rumored to be resistant were long-term employees that had seniority, job security and the respect of their managers. Thus it becomes clearer why some employees would not feel in a position to resist completing the RAI-MH, especially the newly graduated employees.

Another participant reported that a burning issue forwarded to the social work practice council was a request for statistics to be simplified for social workers. However, to my knowledge this is yet to be addressed by our peers on the council.

It appears nursing staff on the units where the participants work are completing the RAI-MH. Interestingly, while a very limited number of psychiatrists complete their portion of the tool, participants described a situation where a few psychiatrists who were initially completing the RAI-MH grouped together and began refusing to complete the tool. When asked the reason for this change, the participant responded the doctors claimed their colleagues in other units were not completing the tool, their day was busy enough and the tool did not add to their treatment of patients. As far as the participant knows, there has been no response from the manager and now nurses complete the psychiatrist’s section. It is interesting that social workers who are able to advocate on behalf of clients have difficulty advocating on behalf of their own professional group. Perhaps they assume the exercise would be futile as physicians are in a more powerful and valued position than the social work profession within healthcare.

The seasoned social workers were resistant in that they were not overly

concerned with completing the tool as accurately as were the newly graduated workers. If the answers were not known, they chose the default or if it was a question they did not wish to ask they chose the default. For example one chose the default “no” when answering the question about sexual abuse in the family other than the patient. They talked about completing the tool as quickly as possible, sometimes not very accurately and then they moved on to what they considered their real jobs, clinical care, which emphasizes attention to relationships and process. It appears that for these workers the RAI-MH and other computerized statistic gathering tools were not the focus of their work but irritations to be scratched as quickly as possible.

### **Power and surveillance**

It appears the introduction of computerized monitoring and assessment tools such as STAR, GRASP MISTro and the RAI-MH has followed the typical or expected path with regards to power and surveillance as described by Foucault (1979) when he describes the panopticon (See page 38). The government mandated the use of the RAI-MH and within a short time threatened hospitals who did not complete the tool with fines. Managers began enforcing the use of the RAI-MH firstly by providing a positive rationale and then with monitoring to ascertain which individuals were not completing the tool. Monitoring was accompanied by reminders/prompts such as emails, notes, phone calls, incomplete RAI-MH’s listed or discussed in team offices or at team meetings. Eventually staff began to monitor each other and themselves. This participant highlights the effects of monitoring by those in authority when she states,

“No everybody does it. Nobody likes it but everybody does it. You will be centered out ...the nurse manager will go to the charge nurse and then the charge nurse will address it.”

She goes on to state how this monitoring leads to one eventually learning to monitor themselves.

“You get a list. It is pointed out to us that you are falling behind. Then we have to clean house on the RAI list. .... Yes but now we print our own lists. Every morning we print an incomplete list and go through and see which ones need a JOPS (*social work section*). I circle mine and cross hers (*social work colleague*) off with a little star and give her a copy ..... Yes we are pretty on top of it.”

Some participants were concerned that the statistics gathered could eventually lead to job loss. Thus they feel a sense of insecurity and judge it makes sense to comply with new documentation requirements and eventually monitor their own work performance to ensure they are meeting the statistical requirements stated by their manager.

“When they gather their stats, if they are not pleased with the stats I can very likely see them deleting a position .... I definitely think that is possible. I think it makes staff feel insecure as well if we know that we have to account for our day every single day.”

When we work in a panopticon and are subjected to an atmosphere where benchmarking and potential downsizing are regular rumours at a workplace, of course it will lead to feelings of insecurity, a fear of job loss, comparisons to our peers within and outside our profession and a fear of being seen as incompetent or unable to cope with changing demands and job requirements. For some of us perhaps the surveillance and monitoring that result from “ticky box” practice leads eventually to a feeling of security as we know what exactly is expected of us and also how we can increase our statistics by seeing more people and meeting the “thin” needs of clients in such a climate of assembly-line mental health care. As we continue to improve our statistics with an ever increasing workload, it is easy to see how we are forced to eventually use less and less critical thinking skills and clinical judgment. As we become deskilled we may become easier to replace with someone with less education and experience but who is still able to meet the administrative tasks required by the employer. Tasks that are convenient to quantify and measure.

### **Impact on patient care**

All the participants reported that increasing documentation requirements takes time away from patient interactions including individual therapy, groups and more informal interactions.

“I just do with the patient what needs to be done. .... There is some stuff I don’t do anymore now that I have a full load and full everything. I used to spend quite a bit of time doing stuff ... and I had less paperwork to do..... Socializing with them ... playing pool with them or doing something. I have always found when working with younger people especially, when they don’t have to actually look at you, when they are busy doing something, there is more conversation. It is a whole different way of knowing somebody. More informal. .... They aren’t thinking about it as being clinical. It’s not so forced. It’s not “these are the things I need to know and if you go in chronological order it will be easier for me.”

This participant is discussing the therapeutic relationship and building rapport which in turn will enhance the therapeutic relationship. As noted earlier in the literature review, it is this therapeutic relationship that is key in the recovery of clients. Therefore, there is a concern that a climate that values the completion of “ticky box” social work may result in initial interviews being determined by documentation requirements such as the RAI-MH. With increased workload and therefore less time spent in interactions or “on the floor”, another area that the participants were concerned would be negatively affected is the time spent with patient’s families.

“It definitely takes times away from patients. ....It takes time away from the patient’s family as well because they always want more time than we can give them. .... We spend less time on the floor. We spend less time investing in and interviewing patients.”

One of the newly graduated social workers lamented,

“The more we start reporting to secure funding the less we are actually helping.”

This insightful comment is a reminder of the classical article conducted by Ng (1990) when she explored the introduction of government funding to grass roots



community organizations. The introduction of this funding led to increased documentation and thus monitoring by government which in turn led to a change in the nature of some of the work being done by community organizations as they began to strive to meet the necessary requirements to obtain and keep government funding. In the specific agency Ng explored, one of the unfortunate outcomes of this was that less time was spent with service users and more time was spent on documentation linked to funding. Thus, this social worker is keenly aware of the dilemma of practicing social work while meeting the ever increasing demands of government funding that has encouraged the intensification of managerialism in social work and healthcare. Therefore, while it is easy to measure numbers of admission and discharges and thus patients served over a fiscal year it is much more difficult to measure the role of the therapeutic relationship in recovery.

A seasoned social worker discounted the impact of the RAI-MH and the data generated by it and therefore its usefulness in contributing to patient care. However, she did acknowledge that the time spent completing the tool impacts patient care negatively.

“I don’t think the data has impacted patient care. I think doing the data impacts on patient care. Those are separate. I don’t think clinical decisions are changed by it.”

The seasoned social workers appeared to try and limit the impact of the requirements to complete the RAI-MH when they interviewed patients. They reported that they continued to conduct their interviews and style of interview as they had done so previously and then use that same information later to complete the RAI-MH on the computer. However, it appeared the newly graduated social workers were more guided by the questions asked on the RAI-MH when they conducted their interviews with patients and some of them used a hard copy of the RAI-MH as a guide when conducting interviews with patients. A seasoned social worker when asked if the RAI-MH has changed her initial interview with

patients stated,

“It hasn’t because I don’t let it. I look for the information that I want to look for my assessment. I’m not actually thinking about what the RAI questions are.”

A newly graduated worker commented,

“Sometimes I’ll just ask them the question, that there is a questionnaire that I have and that the questions may not apply to you but to just bear with me.”

Another newly graduated social worker acknowledged the direct influence completing the RAI-MH had on her initial interview with patients when she stated:

“Yes, I did have a hard copy, but now doing it so often we know what the questions are. You can either work it into the conversations giving your social work or your psychosocial questions. Sometimes I just ramble on, are you worried about anyone else’s health? Have you ever lived anywhere other than Canada?”

It appears the introduction of computerized documentation has indeed influenced the initial interview for some social workers as they strive to complete the many documentation requirements made of them.

There has been some discussion more recently among colleagues, outside of the social work profession, who are taking this one step further by conducting their initial interviews at the computer with the RAI-MH software open and then systematically going through the questions with the patients in an attempt to be more efficient and gain more control over increasing workloads. The participants in this study were all critical of this style of interview.

“It makes sense to do it. It would be most effective, but I don’t think it would have a good effect on the patients I work with. ... Clients often have little nuances to them I don’t want to miss. ... Some of them are psychotic and paranoid and quite ill and it might disturb them to see me inputting information.. I think they are mostly used to the traditional style interview where two people sit across from each other and just speak.”

Another participant believed this style of interview would have a negative impact

on engaging the client or building the therapeutic relationship when she stated,

“You are not going to be engaging anybody with that. Even when we do interviews and we take notes we are very cautious about why we are taking notes. So to sit at a computer and just type it in would be really disengaging and disempowering for the poor client. .... I can certainly see the efficiency. Maybe one of the ways to do it would be to have the patient on the computer themselves.”

This last comment about having the client complete the computer questionnaire themselves may seem initially to be ridiculous especially with severely mentally ill patients. However, it does lead one to consider whether there are other ways of meeting the requirements of the government without jeopardizing the therapeutic relationship. If it is viewed as a demographic exercise that determines funding could it be completed by a staff member using data written by the interdisciplinary team in the patient chart as participants clearly state the data gathered in the RAI-MH is also written elsewhere, for example in the social work psychosocial assessment or in the psychiatrist’s admission note? Or when clients are admitted, could it be completed by a staff member who explains it is a form to be completed upon admission and then the psychiatrist’s diagnosis copied from the chart after the initial interview. This staff member therefore would not necessarily have to be the patient’s social worker or nurse but someone whose primary responsibility is to complete this funding formula form. If the true purpose of the form is linked to funding, then acknowledge this and take out all the questions added to make it a supposedly comprehensive assessment tool for the healthcare team.

Mental illness can be a chronic or recurrent illness and thus unfortunately some individuals are admitted more than once, sometimes regularly. Some participants referred to the revolving door syndrome in mental health hospitals and the usefulness of the statistics gathered by tools such as the RAI-MH.

“Outcome is not that your patients get better and stay well. Outcome is that your patients are coming back to you but you have a good rapport with them when they are back again. You are able to move forward and have a healthy discussion about what worked and didn’t work last time they were in. That is success for me. I think that knowing that the funding

source is looking at statistics, asking us to categorize our work and our daily activities and our patients makes me kind of nervous that they are setting a standard when they don’t work front line with us. They aren’t social workers on inpatient units!”

While there has been an increasing dialogue within mental health hospitals about length of stays, this dialogue has been initiated by powers outside of the local site, the government. Statistics and numbers are increasingly important and time frames for length of stays has been introduced especially in acute mental health units. Therefore, for some individuals, success may be measured by number of admissions, discharges and shortened length of stays when the reality for frontline staff is that an individual’s “thicker” needs may not be met during a short admission. There are some excellent community resources that may assist in addressing “thicker” needs. However, there are often long wait lists and specific eligibility requirements for different services and thus patients maybe discharged without adequate follow up services. Deinstitutionalization was a worthy goal but community resources need to be abundant for this policy to work well. Thus, the expectation for acute wards is that a patient will be discharged or transferred to tertiary care within 18 days of admission. As there are not always beds available in tertiary care, this could potentially lead to patients being discharged earlier than may be sufficient to adequately stabilize their illness and address their many psychosocial needs. There are always stories circulating of the patient discharged on a Friday and staff expecting to see them admitted again by the Monday. It appears that as we play the numbers game patient care is impacted. With this scenario, it makes sense that social workers are concerned about quickly meeting the “thin” needs of patients especially in an acute care setting. Thus when looking at the statistics it may look like the mental healthcare system is becoming more efficient at providing services in our communities but one wonders what the quality of these services will be over time as “thin” needs continue to be addressed at the expense of longer stays that may address the “thicker” needs of clients with more chronic mental health issues.

### **Critical analysis and deskillling**

There appeared to be some differences between the responses of the seasoned workers and some of the newly graduated social workers with regards to providing a critique of the RAI-MH. It seems the seasoned social workers used a more critical lens when analyzing the implementation of the RAI-MH and perhaps this was gained through practice experience working within the system and thus this analysis had become more honed over time. I would also add that the seasoned social workers are in a safer position with regards to job security than the newly graduated workers and this may have restricted some of what these new workers revealed or stated to the researcher.

Some of the newly graduated participants were able to critique the questions on the tool itself or the accuracy with which it was completed but overall viewed the introduction of the RAI-MH as positive. However, it appeared their critique did not include questions around why the tool would be used at all, whether it could impact the therapeutic relationship and if the potential for deskillling is a possibility in a climate of such “ticky box” practice. A participant stated,

“I think it has the potential to be a very useful piece..... I think the important thing is that people are filling it out properly ... It is only going to be effective if people are using it properly.”

There was some criticism that such a tool may standardize the patient and increase workload but no comments critiquing the use of the tool at this practice site in the first place.

“Anytime that you have drop down boxes and categories you do run the risk of depersonalizing things and just having a generic patient. I think it would be nice either more selections or more specific options or maybe having the option of typing something in. But then that would be more work so I don’t know.”

However, one of the newly graduated participants did take a critical stance when commenting on measuring the type of work professionals do and how some of it

is difficult to measure quantitatively (Tilbury 2004).

“I think a lot of our work can’t be captured through those stats well. For example, if a patient is crying or upset and you are just consoling them. That is a lot. It is very draining and it is very comprehensive. Maybe they are seeing we are doing a lot of that and their interpretation of that is that we are not being productive enough. I can see us feeling insecure. Should we be showing more or doing more? Should we be showing that we are... or should we be actually doing it? Whatever that entails. How we display our work?”

A seasoned worker also highlighted the difficulty of accurately measuring and reflecting statistically her work when she stated,

“I think there is a difference between the activity that goes on in the programs that is not seen .... STAR only counts for how many people I see in a day, what if I spent 4 hours with that person in the afternoon ..... and I only see 3 patients that day because I’ve spent that time (with the 1 patient). There is no way of capturing how many hours I’ve spent in the STAR system.”

She goes on to comment on a lack of professional autonomy when statistics become a primary concern and they impact the number of social work positions at the hospital while her experience and knowledge as a frontline worker is discounted or not even requested.

“You have to prove that you are actually working whereas before there was an element of not having to prove I was working . ....I think there have been social work positions not filled in this hospital because there has been a “why do they need that many?” kind of thing when other programs have this many and blah blah. .... No one has come around and asked us any questions about our workload ..... I have worked in a bunch of different places and I have some information I could share.”

This idea of many aspects of the helping professions being difficult to measure has been discussed by Tilbury (2004) earlier in the literature review. Knowing this, should social workers be resisting the trend to quantify their relationships with clients or should they play the game of statistics by giving the funding source what they need and then continuing their practice as they have traditionally

done?

This seasoned social worker highlighted her concerns regarding increased “ticky box” documentation and how this may lead to a decrease in critical analysis.

“I worry about the fact that patient care is becoming “ticky boxed”. That people aren’t thinking. That people don’t have to think like they used to think. If they just tick a box and the plan of care comes down and I don’t actually have to think through the plan of care. I wonder how that will impact on patient care. .... Our critical thinking isn’t used because if I just have to tick the information and then the computer spits it out “this is what the plan should be for this person”. I think we lose critical thinking skills.”

This participant goes on to state how she thinks this will impact the role of social workers in the hospital and how this change will impact new social workers who come to work at the hospital and she further laments/complains about the lack of supervision or mentorship for new social workers.

“I certainly think it (social work) can become deprofessionalized, for sure if all we are doing is plugging in information and then doing the plan. The critical thinking piece that we do and the whole systems approach that we take and the way we think as social workers which is different from other members of the team would become less important. If all we are doing is ticking boxes and the voice of the social worker wouldn’t necessarily be as strong as new social workers come in. Lack of supervision and department heads. There are brand new social workers in this hospital who have no social work supervision at all. Some on units where there are only new social workers. There is not a seasoned social worker to guide them at all.”

This participant goes on to express that there is not only the potential for the social work profession to become deskilled but also the other helping professions on the interdisciplinary team. She also stated that some workers may prefer a “ticky box” approach to their practice as it is easier.

“I think that for people who don’t work as hard as others it is easier, so I think they like it. I think there are people who would like that. But I don’t. .... You don’t have to think then. You just do what’s on the page.”

I have tried to represent the various experiences and opinions of the social

workers interviewed for this research project. All were concerned about an increase in documentation requirements that has lead to duplication of patient information as requirements for various sources are met. This in turn leads to less time for patient care. All appeared to prefer to address patient needs rather than spend time on documentation. There appeared to be some differences in responses to the RAI-MH between the seasoned social workers and the newly graduated social workers and possible reasons for this have been highlighted and will be explored further in the Discussion.



## **Discussion**

The RAI-MH was introduced in Ontario claiming to be a computerized tool to meet two broad purposes. Firstly, it is a comprehensive assessment and treatment planning tool that can be used by all disciplines in the healthcare team. Secondly, it will improve efficiency and be used to determine case-mix funding to determine resource allocation more accurately. The literature and the participants provide the following critique.

### **Assessment and Treatment Planning.**

The findings reveal that while social workers are completing the RAI-MH they do question the accuracy of the information collected. There were critiques regarding the details or style of the document itself. Participants have some concerns about the questions asked and their inability to answer them accurately at times due to the information not being available yet and therefore having to guess or select an answer as there is no “I don’t know yet” option. Also, the participants disagreed with some of the questions asked and the lack of options available to select what would best fit with the population they worked with. For example, in the section regarding employment there is no disabled option only employed or not employed. There was a difference of opinion between how the seasoned workers and the newly graduated workers viewed the RAI-MH and its potential. The seasoned workers were much more critical of the RAI-MH while the newly graduated workers believed it could be very useful if it was completed accurately. The participants reported that the document standardizes and objectifies patients as it condenses complex interrelated concepts, such as history of illness, personal history and relationship with others and reduces them to simplistic answers. This may hinder or prevent staff from considering a deeper more thorough analysis about the patient, their story or the experiences the patient considers important with regards to their hospital admission (Campbell &

Gregor 2002, Gustafson 2000). There is the potential that the document will be used inappropriately during the initial interview as staff become fearful of not completing the document on time or not being able to meet workload demands and thus the goal may become completing the form rather than listening to the patient’s experience or story (Campbell & Gregor 2002, Gustafson 2000).

All the participants agreed that less time was being spent on patient care than previously due to increased documentation and they referred to ‘just doing what needs to be done’ for patients. While they did not state directly that patients were not receiving the best social work care, or the same care they had received prior to the introduction of computerized auditing documents and the RAI-MH requirements, it was implied that in a culture that emphasizes efficiency (shorter admissions), with increased workloads, meeting the “thin” needs rather than the “thicker” needs of patients is at times inevitable (Aronson & Sammon 2000). However, if a patient’s “thicker” needs are addressed and met this may lead to a better quality of life and therefore contribute to the stabilization of their illness and decrease hospitalizations.

The seasoned social workers attempted to try and limit the impact of documentation requirements when they interviewed new patients by not changing the style of the initial interview. It appears they follow best practices in social work that emphasize the importance of psycho-social assessments where engagement and purposeful conversational interviews will lead to a gathering of complex data about the patient as well as build rapport or the therapeutic relationship. However, some of the newly graduated social workers reported the RAI-MH did influence the style of their initial interview with patients and that the interview was guided by those questions required by the RAI-MH. The literature suggests that the initial interview with a clinician is crucial in the development of the therapeutic relationship and therefore may affect outcome or recovery. If indeed the RAI-MH requirements lead to a style of interviewing that is more documentation focused rather than the patient presenting their issues in a meaningful way to the

professional this may have a negative impact on the therapeutic relationship (Gustafson 2000, Bordin 1976, Nolan & Badger 2005). Further, a failure to truly understand the client’s perspective due to interviews dictated by documentation requirements as well as increased workloads may lead to rushed interactions where important information is missed and empathy is limited. Reynolds & Scott (1999) state that empathy, which is regarded as the main ingredient in a therapeutic relationship, may not be possible if there is high workload, lack of time, poor skills mix and rapid discharges. Thus, an assembly-line style of care may result in poorer outcomes for patients over the longer term.

A climate that emphasizes the importance of documentation and workload measures to secure funding may result in a change in the service provided to clients. This is well documented in the classic study by Ng (1990) and by others in child welfare in Ontario (De Montigny 2003, Parada 2004). Ng found that government funding led to increased documentation and so monitoring by government which resulted in less time spent with service users. While it is easier to measure the number of admissions, discharges and the number of patient contacts it is much more difficult to measure the therapeutic relationship and its impact on recovery. The RAI-MH may assert that it measures recovery from admission to discharge as most assessment tools focus on symptom reduction. However, we also know that severe mental illness often leads to many psychosocial issues including financial issues, housing issues and relationship issues which are more difficult to measure and usually change over the longer term. Thus, often clinically significant change happens over the long term (Saakvitne & Gamble 2002). Further, Segal (1999) states that in the U.S. system of managed care they have found shortened psychiatric stays result in less time for clinicians to work with patients on psychosocial issues and results in an increased probability the client will be readmitted. Again addressing the “thin” needs of clients may result in readmission. This revolving door syndrome may ensure good statistics that reflect shortened lengths of stays, which would appear

admirable on league tables that compare various hospital sites, but are often not in the best interests of patients who may require longer lengths of stays to adequately address “thicker” needs. Also, over the long term this is not advantageous as there will be increased costs connected to this short sightedness such as increased use in other resources in our communities such as community health services, Ontario Works and perhaps the criminal justice system.

The RAI-MH claims it can generate a treatment or care plan from inputted data which is a role traditionally performed by the interdisciplinary team and the patient. Thus the hospital’s promotion of the recovery model, where patients are involved in their care and recovery through setting goals and treatment planning, now appears redundant as a computer programme can provide a treatment plan based on inputted data by professionals. Further, the RAI-MH provides a treatment plan that is very general as it highlights that the patient may have housing or financial issues which is all information that is already known to the healthcare team. The researchers (Hirdes et al 2002) claim the tool aims to organize information to support decision-making by clinicians but it does not replace their clinical judgment. An examination of a RAI-MH care plan completed on admission only serves to further highlight that it is redundant as it does not give the depth and richness that is often included in the care or treatment plan developed by the team. As for it supporting clinical decisions, I would question if the team would even bother to look at it as it offers no new information or ideas for treatment.

### **Efficiency and Funding**

The findings and current literature contest whether MDS tools such as the RAI-MH do lead to a more efficient provision of health services. All the participants agreed that the RAI-MH as well as other documentation and auditing requirements has increased their workload so that they have less time to spend

with patients. The RAI-MH was hailed as an instrument that would decrease documentation, however, this is not the case so far. This duplication of information may be regarded as inefficient and therefore costly as it uses resources that would be better spent elsewhere.

It may be argued that employees are less efficient and effective when they work in an unsupportive environment that has a climate of fear regarding possible job losses in the future and where statistics or workload measures dominate. The implementation of the tool followed a predictable path with regards to ensuring compliance via surveillance. Participants reported that all the computerized statistics gathering mechanisms (STAR, GRASP MISTro and RAI-MH) led to feelings of insecurity for themselves or their colleagues as they believed the data would eventually lead to job losses both within their profession and the other helping professions in the future. This is also reflected in the literature which suggests a culture of efficiency may lead to job dissatisfaction but also potentially job loss (Munro, 2004, Braverman 1974).

A stated goal of the RAI-MH was to promote the use of a case-mix funding formula to enable the efficient and equitable allocation of resources. However, there has been some debate in the literature from the U.S. on the accuracy of MDS tools such as the RAI-MH (Teresi & Holmes 1992, Ouslander 1997, Crooks et al 1994 and Casten et al 1998). The participants also noted concerns about the accuracy of the data inputted on the RAI-MH at their workplace. This raises concerns as the RAI-MH is to be used to determine funding and resource allocation (staff) which may impact directly on patient care. Further, if the RAI-MH can generate a funding algorithm based on diagnosis or severity of symptoms inputted does this mean that if symptoms are less severe then less money will be allocated to that particular patient’s care? Or will a diagnosis of schizophrenia be allocated more resources than a diagnosis of depression and therefore will a diagnosis of schizoaffective disorder become more common? Is it possible that professionals may be tempted to exaggerate symptoms or manipulate diagnosis

to ensure adequate funding and ultimately job security? Or will patients be discharged when their symptoms are not severe enough to obtain optimal funding? The literature on U.S. nursing home MDS’s and league tables has indicated that this manipulation of data is possible (Simmons et al 2004).

Hirdes et al (2002) also suggested the RAI-MH enhances the integration of health information across settings which sounds like this would again lead to more efficient services provided to clients. However, this then leads to questions about confidentiality. For example, what would happen if a patient does not wish their RAI-MH assessment to be given to their G.P. or to group home staff? It is one thing to give a list of medications but quite another to share the personal information captured on the RAI-MH. This issue is complicated as currently it is not the practice to inform clients about the completion of the RAI-MH.

It appears that while the goals of assessment, treatment, efficiency and funding are all worthy goals they also lead to many questions which continue to be contested in the research literature. While patients’ short term needs may be met, one wonders about the revolving door syndrome in mental health care which in the long run is probably more costly.

### **Implications for social work practice and education.**

The findings also raised the concern that the critical lens or analysis utilized by social workers and also the autonomy of social workers may deteriorate in a culture of document-focused social work and therefore a deskilling of the profession may result. The literature suggests that as managerialist control intensifies, skillful work or practice is broken down into smaller measurable parts and as workload also increases this may lead to a deskilling of the workforce (Braverman 1974, Aronson & Sammon 2000, Parada 2004)

The findings also suggested that some workers may prefer a document focused and routinized practice as it is easier and requires fewer critical skills on

their part (Rhodes et al 2006). It may also feel safer as they know exactly what their employer requires of them. This culture of document and audit focused practice leaves one wondering what type of person will be attracted to social work practice in the future. Will it be the “pencil pusher” who is comfortable standardizing clients and spending 80% of their time completing documents, someone who thrives on the power over clients that these documents have the potential for or someone who is compliant and easily co-opted into the system? It is important that these issues are addressed by schools of social work as it is their role to train social workers to come to practice with a critical lens. It is also important to ensure students have some background knowledge on how and when to use resistance or push against the system without being ostracized, disciplined or fired. In other words how to work within the system without being totally co-opted by the system. Transformative social work practice is difficult when workers feel isolated, overwhelmed by increasing workloads, powerless, fear job loss and ultimately they may become immobilized (O’Neill 2005). These may all be considered barriers that prevent change or transformative practice. Immobilization may impede a social worker from reflecting, critiquing and creatively transforming practice so they can continue what they consider good practice while also meeting system or workplace requirements. Parada (2004), when discussing child welfare suggests that social work has two options when it comes to managerialist technologies. The first is accommodation, which may result in deprofessionalization as social work becomes a narrow technical discipline. Or secondly, social work can continue to resist at micro and macro levels allowing us to address social injustice and strive for autonomy in our work. The goal of resistance and transformative practice is ultimately to ensure our patients or clients receive the best care or services possible.

The findings and the literature also suggest the importance of mentors or supervisors in the transition from social work student in an educational system to social worker in a complex workplace system. A seasoned participant voiced her

concerns regarding the potential for social workers to become less skilled as their role becomes “plugging in information” in a document focused system and that unfortunately new graduates did not have supervisors to guide them in what their role could and should be. This role values the development of a critical lens or a critical analysis of practice. Pare & Le Maistre (2006) discuss the importance of the relationship between the seasoned practitioner and the new social worker as each influences the other in positive ways. The experienced social worker supervises the gradual transformation of the new graduate into an effective professional while the new worker may offer new ideas to challenge and revise the way things are done at a particular workplace. Further, they argue that unsuccessful induction of a new worker can lead to stagnation for the individuals and the organizations. Social work education should not assume that the supervising or mentoring of new graduates is automatic as at this worksite it does not occur or it occurs in a very informal ad hoc way. The new employees in this study perhaps found themselves in the position of adjusting to their new role in an unsupportive, demanding workplace that emphasized efficiency and compliance and did not provide experienced social work mentors or supervisors to offer guidance. One can understand how new employees may find themselves in the unenviable position of trying to meet the demands of their new employer while also attempting to engage in the good practice encouraged during their social work education.

One of the limitations of this study was its omission of patient or consumer voices. While the social work participants described how they believed the implementation of the tool impacted patient care it would be beneficial to also explore patients’ experiences. The data from the RAI-MH is being used for research purposes. Apparently, names will be removed but the RAI-MH’s will contain partial health card numbers. Therefore, will the data be used to track patients’ use of healthcare services over time? Will this data be accessed for free from CIHI or will there be a cost to researchers? Should patients be informed



their information is being stored, tracked and used for research purposes? Thus, it appears from a consumer perspective there is a decrease in control over personal information and this does not suggest a recovery or empowerment approach to healthcare. Over the past few years, there has been increasing pressure for hospitals to promote a recovery model of care for mental health, that encourages collaboration when setting treatment goals, however, this now appears redundant as patients become statistics to determine funding and commodities whose data can be accessed without their knowledge. As patients become aware of the RAI-MH will it be possible for them to refuse to allow their data to be used for research? Professionals may find themselves in a very difficult position especially when they reflect on the work of Anthony (2000) or Beresford (2000). Beresford (2000) reminds us of a slogan adopted by the disabled people’s movement, “Nothing about us without us”.

This research was at one hospital and involved only social workers. It would be interesting to include the experiences of the other helping professions both at this site and other sites. Consideration should also be given to the small sample who voluntarily participated in the study and perhaps more importantly to those social workers who did not volunteer to be a part of this research. This leads one to consider whether some social workers at the site did not volunteer because they knew the researcher and the Social Work Specialist who assisted with recruitment. Perhaps they might be reluctant to be involved for fear that their practice would be judged or their practice compared to other social workers. I would also be aware of which units they worked on and also know some of their colleagues and managers. Thus, they may have worried that confidentiality would be an issue. Perhaps they did not wish to be participants because they are in fact resisting in their own quiet ways and were concerned that they would be “outed” and then forced to comply with completing the RAI-MH. Thus, safety and feelings of powerlessness may have been an issue for those who decided not to participate.

This study was qualitative in its approach and as with all qualitative research the findings cannot be generalized or considered reliable or valid or hold up to positivist scrutiny in the way that “double blind”, quantitative approaches to research can. Although the sample size was small, it did encompass a range of social work positions and perspectives, and as such, the findings offer important initial insight into mental health social workers’ opinions and experiences with the RAI-MH. This study was exploratory in nature and can be viewed as an entry point into a new and emerging area of study in Canada. It was an attempt to gather in-depth interview data in the hope that richness would be achieved that could then lead to further research into this interesting area of study. While the Hirdes et al (2002) study and others who subsequently used RAI- MH data used a quantitative approach to their research there was a gap in the literature regarding frontline staff’s experiences of using the tool and its impact on patient care that this study has attempted to begin to address.

Future research is needed to explore if the RAI-MH does indeed impact the therapeutic relationship and patient care. Would patients report a difference depending on whether the staff member conducted their traditional initial interviews (where the RAI-MH was completed later) or where a hard copy of the RAI-MH was used during the initial interview or where the RAI-MH was completed while the staff member worked on the computer version of the tool with them present? Rather than frontline professionals completing the tool could it be completed by a staff member in a more administrative role and thus it may viewed as a demographic information gathering tool for funding purposes rather than an assessment tool used by the healthcare professionals?

When change occurs often the question that arises is “who benefits”? It appears that researchers may benefit from accessing such large data sets. However, we should remember that patients are individuals who are seeking the help of a healthcare specialist and should be the target of benefits while subjects are people who are solicited to participate in studies. It appears that the Ministry

of Health and Long Term Care and the interRAI researchers may have overlooked this very important distinction.

The government may benefit as data from the RAI-MH will be used to determine funding levels and therefore resource allocation. However, the question remains as to whether there will be a benefit to patients. It is currently disputed in the literature whether using MDS’s does indeed improve the quality of service provided and improve client outcomes (Simmons et al 2004, Mor 2005).

As social workers struggle with significantly increased and more complex case loads, resulting from neoliberalist policies that keep the marginalized living in poverty, they are also required to spend more of their time on ‘ticky box’ practice. Unfortunately, they may at times be pressurized into concentrating on the “thin” needs of clients. Increased workload leaves little time and energy to work therapeutically with patients, to reflect on practice and actively challenge current political policies through collective activism. Activist groups such as those who highlight poverty and affordable housing issues do link client issues to broader social conditions. Aronson and Sammon (2000, p.185-6) also argue that restrictive managerial cultures confine what is done, written, spoken and ultimately thought within their organizations. The bottom line is patients may receive inadequate service in a culture of “ticky box” practice as not only are they standardized and objectified but workers will have less time to spend with them to form a therapeutic or advocacy based relationship that can address their “thicker” needs.

## **Conclusion**

While Hirdes et al (2002) have researched the RAI-MH as an assessment and funding tool and there is research using data derived from MDS’s/RAI’s in nursing homes in the U.S. there has not yet been research to explore the potential impact on frontline staff and more importantly whether this then impacts patient care or the therapeutic relationship. This research attempted to address this gap in the literature through exploring the experiences of frontline social workers almost two years after the RAI-MH was mandated in Ontario.

It appears that social work is becoming more challenging as managerialism permeates the social services with its culture of audit and cost efficiency. Beresford and Croft (2004) argue that during the 1990’s there was an increasing trend towards a social control role and a weakening concern with social justice and equality within the profession of social work. However, they are hopeful that the future will move more towards emphasizing what they believe are keys to encouraging more liberatory social work. These are a renewed commitment to practice, addressing diversity, and involving service users. Walton (2005) states that social workers need to use their knowledge of individual misery and social distress to inform policies and social reform and research is needed to underpin knowledge. I am hopeful that my exploring the impact of audit and computerized assessment tools will add to this knowledge and encourage social workers to continue to work in a profession that requires constant juggling as they attempt to serve two masters, social control and social justice as well as the influence of documents or” ticky box” practice.

## References

- Absolon, K. & Willett, C (2005). Putting Ourselves Forward; Location in Aboriginal Research. In Brown, L. & Strega, S (ed) *Research as Resistance: Critical, indigenous, and anti-oppressive approaches*. Canadian Scholars’ Press, Toronto.
- Alanen, H.M., Finne-Soveri, H., Noro, A. and Leinonen, E. (2006). Use of antipsychotic medications among the elderly residents in long-term institutional care: a three year follow-up. *International Journal of Geriatric Psychiatry*. (21), 288-295.
- Aronson, J. (1999). Conflicting Images of Older People Receiving Care: Challenges for Reflexive Practice and Research. In S. Neysmith (ed) *Critical Issues for Future Social Work Practice with Aging Persons*. New York: Columbia University Press.
- Aronson, J. & Sammon, S. (2000). Practice Amid Social Service Cuts and Restructuring: Working with the Contraindications of “Small Victories”. *Canadian Social Work Review*. 17 (2), 169-187.
- Anthony, W.A. (2000). A Recovery Orientated Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation Journal*. 24(2), 159-169.
- Audit Commission (2002). Recruitment and Retention: A Public Service Workforce for the Twenty-first century, London Audit Commission. In Munro, E. (2004) The Impact of Audit on Social Work Practice. *British Journal of Social Work*. (34), 1075-1095.

- Babbie, E. (2004). *The Practice of Social Research*. Thompson Wadsworth.
- Baines, D. (2004). Seven kinds of Work - Only One Paid: Raced, Gendered and Restructured Work in Social Services. *Atlantis*. 28(2), 19-28.
- Bates-Jenson, B.M., Simmons, S.F., Schnelle, J.F. and Alessi, C. (2005). Evaluating the Accuracy of Minimum Data Set Bed-Mobility Ratings Against Independent Performance Assessments: Systematic Error and Directions for Improvement. *The Gerontologist*. 45(6), 731-738.
- Beckett, C. (2003). The Language of Siege: Military Metaphors in the Spoken Language of Social Work. *British Journal of Social Work*. 33: 625-639.
- Beresford, P. & Evans, C. (1999). Research Note: Research and Empowerment. *British Journal of Social Work*, 29, 671-677.
- Beresford, B. (2000). Service Users' Knowledge and Social Work Theory: Conflict or Collaboration? *British Journal of Social Work*. 30, 489-503.
- Beresford, B. & Croft, S. (2004). Service Users and Practitioners Reunited: The Key Component for Social Work Reform. *British Journal of Social Work*. 34, 53-68.
- Bjorkgren, M.A., Fries, B.E., Hakkinen, U. and Brommels, M. (2004). Case-mix adjustment and efficiency measurement. *Scandinavian Journal of Public Health*. 32, 464-471.
- Bordin, E. (1979). The generalizability of the psychoanalytical concept of the working alliance. *Psychotherapy Theory, Research and Practice*. 16,

- 252-260 In Howgego, I., Yellowlees, P., Owen, C., & Meldrum, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case Management. *Australian and New Zealand Journal of Psychiatry*. 37, 169-183.
- Brandt, H.E., Ooms, M.E., Deliëns, L., van der Wal, G. and Ribbe, M.W. (2006). The last two days of life of nursing home patients – a nationwide study on the causes of death and burdensome symptoms in the Netherlands. *Palliative Medicine*. 20, 533-540.
- Braverman, H. (1974). Labour and Monopoly Capital: In Young, R.M. (2005). <http://human-nature.com/rmyoung/papers/blmc1.html> and In Yates, M. (2005). <http://www.monthlyreview.org/199yates.htm> and In Greenbaum, J. (2005). <http://www.monthlyreview.org/199greenbaum.htm>
- Brodie, J. (2002). The Great Undoing: State Formation, Gender Politics, and Social Policy in Canada. In C. Kingfisher (ed) *Western Welfare in Decline: Globalization and Women’s Poverty*. Philadelphia: University of Pennsylvania Press.
- Broody, H. (2003). *Stories of Sickness*. Oxford University Press. Oxford. In Nolan, P. & Badger F. (2005) Aspects of the relationship between doctors and depressed patients that enhance satisfaction with primary care. *Journal of Psychiatric and Mental Health Nursing*. 12, 146-153.
- Campbell, M. & Gregor, F. (2002). *Mapping Social Relations: A Primer in Doing Institutional Ethnography*. Aurora, Ontario: Garamond Press.

Casten, R., Lawston, M., Parmelee, P. and Kleban, M. (1998). Psychometric characteristics of the Minimum Data Set I: confirmatory factor analysis. *Journal of American Geriatric Society*. 46, 726-735. In Lum, T.Y., Lin, W. and Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *Journal of Gerontology*. 60A (5), 634-659.

Canadian Institute for Health Information (CIHI).

<http://secure.cihi.ca/cihiweb/dispPage.jsp?cw>

Connolly, M. (2003). Qualitative Analysis; A Teaching Tool for Social Work Research. *Qualitative Social Work*. 2(1), 103-112.

Corbin, J.M. & Strauss, A.L. (1998). Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. Sage Publications Inc. In Rubin, E.R. & Babbie, A. (2005). Research Methods for Social Work. Thomson Wadsworth.

Crooks, V.C., Schnelle, J.F., Ouslander, J.P. and McNees, M.P. (1994). Use of the Minimum Data Set to rate incontinence severity. *Journal of American Geriatric Society*, 43, 1363-1369. In Lum, T.Y., Lin, W. and Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *Journal of Gerontology*. 60A (5), 634-659.

Degenholtz, H.B., Kane, R.A., Kane, R.L., Bershadsky, B. and Kling, K.C. (2005). Predicting Nursing Facility Residents’ Quality of life using External Indicators. *Health Research and Educational Trust*. DOI:10.1111/j.1475-6773.2005.00494.x



De Montigny, G.A.J. (2003). Textual Regulation of Child Welfare. *Canadian Review of Social Work Policy*. 52, 33-50.

Dozier, C., Teague, G., & Fallot, R. (1999). Effective Treatment Relationships for Persons With Serious Psychiatric Disorders: The Importance of Attachment States of Mind. *Journal of Consulting and Clinical Psychology*. 67(5), 725-733.

Drake, B. & Yadama, G. (1996). A structural equation model of burnout and job exit among child protective service workers. *Social Work Research*, Vol. 20, No. 3, p.179-183. In Regher C., Leslie, B. and Howe, P. (2002). An Exploration of Supervisor’s and Manager’s Responses to Child Welfare Reform. *Administration in Social Work*. 26(3), 17-36. Haworth Press, Inc.

Fabricant, M. & Burghardt, S. (1992). “The Crisis and Transformation of Public Social Services,” In *The Welfare State Crisis and the Transformation of Social Service Work*. Armonk. NY.

Foucault, M. (1979). Discipline and Punish: The Birth of the Prison. In Moffat, K. (1999). “Surveillance and Government of the Welfare Recipient.” In A. Chambon et al (eds) *Reading Foucault for Social Work*. New York

Frasier, N. (1989). “Struggling Over Needs: Outline of a Socialist and Feminist Critical Theory of Late Capitalism.” In *Unruly Practices: Power, Discourse and Gender in Contemporary Theory*. Minneapolis: University of Minnesota Press.

Geanellos, R. (2004). Nursing based evidence: moving beyond evidenced based

practice in mental health nursing. *Journal of Evaluation in Clinical Practice*. 10 (2)..

Geddes, J.R., Freemantle, N., Mason, J., Eccles, M.P. & Boynton, J. (2003).

SSRI's versus other antidepressants for depressive disorders. The Cochrane Library 2. Update Software. In Nolan, P. and Badger F.

(2005) Aspects of the relationship between doctors and depressed patients that enhance satisfaction with primary care. *Journal of Psychiatric and Mental Health Nursing*. 12, 146-153.

Glaser, B. & Strauss, A.L. (1967). The discovery of grounded theory. Chicago.

Aldine. In Rubin, E.R. & Babbie, A. (2005). *Research Methods for Social Work*. Thomson Wadsworth.

Globerman, J., White, J., & McDonald, G. (2002). Social Work in Restructuring

Hospitals: Program Management Five Years Later. *Health and Social Work*. 27(4), 274-283.

Greenbaum, J. (2005). On Twenty-five Years with Braverman's Labour and Monopoly Capital (Or. How Did Control and Coordination of Labor Get into the Software So Quickly? ).

<http://www.monthlyreview.org/199greenbaum.htm>

Gustafson, K. (2000). Home Care Before and After Reform: A Comparative

Analysis of Two Texts in Action. In D. Gustafson (ed) *Care and Consequences: The Impact of Health Care Reform*. Halifax: Fernwood.

Healy, K. (2000). *Reconstructing Critical Practices. Social Work Practices:*

*Contemporary Perspectives on Change*. London: Sage

- Hirdes, J.P., Smith, T.F., Rabinowitz, T., Yamauchi, K., Perez, E., Telegdi, N., Prendergast, P., Morris, J., Ikegami, N., Phillips, C. & Fries, B. (2002). The Resident Assessment Instrument-Mental Health (RAI-MH): Inter-Rater Reliability and Convergent Validity. *The Journal of Behavioral Health Sciences & Research*. 13(52), 419-432.
- Hood, C., Rothstein, H., and Baldwin, R. (2001). *The Government of Risk, Understanding Risk Regulation Regimes*, Oxford, Oxford University Press.
- In Munro, E. (2004) *The Impact of Audit on Social Work Practice*. *British Journal of Social Work*. 34, 1075-1095.
- Hostick, T. & McClelland, F. (2002). “Partnership”: a cooperative inquiry between Community Mental Health Nurses and their clients. *Journal of Psychiatric and Mental Health Nursing*. 9, 111-117.
- Howgego, I., Yellowlees, P., Owen, C., & Meldrum, F. (2003). The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry*. 37, 169-183.
- Iskowitz, M. (2006). Research Revolution. *Medical Marketing & Media*; February 2006; 41, 2; ABI/INFORM Global p.46.
- Laine, J., Noro, A., Finne-Soveri, H., & Hakkinen, U. (2005). Patient – and ward – level determinants of nursing time in nursing facilities. *Journal of Health Services Research & Policy*. 10(4), 226-231.
- LaSala, M. (2003). When interviewing “family”: Maximizing the insider advantage in the qualitative study of lesbians and gay men. *Journal of Gay and*

*Lesbian Social Services*. 15(1), 15-30.

- Lum, T.Y., Lin, W. & Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *Journal of Gerontology*. 60A(5), 634-659.
- Martin, L. (2005). Assessing the needs of adults with intellectual disability in different settings: Development and evaluation of the interRAI-Intellectual DI (interRAI-ID). *Dissertation Abstracts International Section B: The Sciences and Engineering*, 66(6B).
- Mauthner, N. & Doucet, A. (1998). Reflections on a voice-centred relational method: Analyzing Maternal and Domestic Voices. In Ribbens, J. & Edwards, R. *Feminist Dilemmas in Qualitative Research*. Sage Ltd. U.K.
- Mead, N. & Bower, P. (2000). Patient-centeredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine*. 51, 1087-1110. In Rhodes, P., Langdon, M., Rowley, E., Wright, J., & Small, N. (2006). What Does the Use of a Computerized Checklist Mean for Patient-Centred Care? The Example of a Routine Diabetes Review. *Qualitative Health Research*. 16 (3), 353-376.
- Moffat, K. (1999). "Surveillance and Government of the Welfare Recipient." In A. Chambon et al (eds) *Reading Foucault for Social Work*. New York
- Mor, V., Berg, K., Angelelli, J., Gifford, D., Morris, J. & Moore, T. (2003c). The quality of quality Measurement in U.S. Nursing Homes. *The Gerontologist*. 43(2), 37-46. In Mor, V. (2005). Improving the Quality of Long-Term Care with Better Information. *The Millbank Quarterly*. 83(3),

333-364.

Mor, V. (2005). Improving the Quality of Long-Term Care with Better Information. *The Millbank Quarterly*. 83(3), 333-364.

Munro, E. (2004) The Impact of Audit on Social Work Practice. *British Journal of Social Work*. 34, 1075-1095.

Neale, M. & Rosenheck, R. (1994). Case manager, caseload, and alliance factors in intensive case management outcome. Unpublished manuscript. In Dozier, C., Teague, G., & Fallot, R. (1999). *Journal of Consulting and Clinical Psychology*. 67(5), 725-733.

Neuman, L. (1997). *The Meanings of Methodology. Social Research Methods: Qualitative and Quantitative Approaches*. Boston. Allyn & Bacon. P.60-67.

Newland, P.K., Wipke-Tevis, D.D., Williams, D.A., Rantz, M.J., & Petroski, G.F. (2005). Impact of Pain on Outcomes in Long-Term Care Residents with and without Multiple Sclerosis. *Journal of American Geriatric Society*. 53, 1490-1496.

Ng, R. (1990). "State Funding to a Community Employment Centre; Implications for Working with Immigrant Women." In Ng et al (eds). *Community Organization & the Canadian State*. Garamond Press.

Nolan, P. & Badger F. (2005) Aspects of the relationship between doctors and depressed patients that enhance satisfaction with primary care. *Journal of Psychiatric and Mental Health Nursing*. 12, 146-153.

Office of the Inspector General. Nursing Home Resident Assessment Quality of Care. Publication OEI-02-99-00040. Washington DC: U.S. Department of Health and Human Services; (2001). IN Lum, T.Y., Lin, W. and Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *Journal of Gerontology*. 60A(5), 634-659.

Ohayon M. (2006). Methodology and Assessments: the tools of the trade. *Journal of Psychiatric Research*. 40. 187-188.

O’Neill, L. (2005). Social Work 726. “Ticky Box” Social Work: Client Centred Versus Document Centred Social Work.

O’Neill, L. (2006). Social Work 736 Midterm Paper.

Ontario Public Service Employee’s Union (OPSEU). (2001), February 19. Kids remain at risk, study shows. Toronto, ON.  
[www.opseu.org/news/Press2001/feb192001.htm](http://www.opseu.org/news/Press2001/feb192001.htm).

Ouslander, J.G. (1994). Maximizing the Minimum Data Set. *Journal of the American Geriatric Society*. 42, 1212-1213 In Simons, S.F., Cadogan, M.P., Cabrera, G.R., Al-Samarrai, N.R., Jorge, J.S., Levy-Storms, L., Osterweil, D. and Schnelle, J.F. (2004). The Minimum Data Set Depression Quality Indicator: Does It Reflect Differences in Care Process? *The Gerontologist*. 44(4), 554-564.

Parada, H. (2004). Social Work Practices Within The Restructured Child Welfare System in Ontario. *Canadian Social Work Review*. 21(1).

Pare, A. & Le Maistre, C. (2006). Active learning in the workplace: transforming individuals and institutions. *Journal of Education and Work*. 19(4), 363-381.

Parton, N. (2004). Post-Theories for Practice: Challenging the Dogmas. In L. Davies and P. Leonard (eds.) *Social Work in A Corporate Era: Practices of Power and Resistance*. Burlington: Ashgate Publishing Ltd.

Peplau, H. (1994). Psychiatric mental health nursing: challenge and change. *Journal of Psychiatric and Mental Health Nursing*. 1, 3-7. In Hostick, T. & McClelland, F. (2002). “Partnership”: a cooperative inquiry between Community Mental Health Nurses and their clients. *Journal of Psychiatric and Mental Health Nursing*. 9, 111-117.

Piven, M., Ammarell, N., Bailey, D., Corazzini, K., Colon-Emeric, C., Lekan-Rutledge, D., Smith, Q. & Anderson, R. (2006). MDS Coordinator Relationships and Nursing Home Care Processes. *Western Journal of Nursing Research*. 28(3), 294-309.

Potts, K. & Brown, L. (2005). Becoming an Anti-oppressive Researcher. Brown, L. and Strega, S. (eds) *Research as Resistance: Critical, Indigenous, & Anti-oppressive Approaches*. Toronto: Canadian Scholars’ Press.

RAI-MH (2005) User Training Documents and RAI-MH Instrument.

Regher C., Leslie, B. & Howe, P. (2002). An Exploration of Supervisor’s and Manager’s Responses to Child Welfare Reform. *Administration in Social Work*. 26(3), 17-36. Haworth Press, Inc.

- Reynolds, W. & Scott, B. (1999). Empathy: a crucial component of the helping relationship. *Journal of Psychiatric and Mental Health Nursing*. 6, 363-370.
- Rhodes, P., Langdon, M., Rowley, E., Wright, J., & Small, N. (2006). What Does the Use of a Computerized Checklist Mean for Patient-Centred Care? The Example of a Routine Diabetes Review. *Qualitative Health Research*. 16(3), 353-376.
- Rubin, E.R. & Babbie, A. (2005). *Research Methods for Social Work*. Thomson Wadsworth.
- Saakvitne, K. & Gamble, S. (2002). Risking Connection With Our Clients: Implications for the Current State of the Therapeutic Relationship. *American Psychological Association*. p. 439-443.
- Segal, S.P. (1999). Social work in a managed care environment. *International Journal of Social Welfare*. 8: 47-55.
- Seto, M.C., Harris, G.T. and Rice, M. (2004). The Criminogenic, Clinical, and Social Problems of Forensic and Civil Psychiatric Patients. *Law and Human Behaviour*. 28(5), 577.
- Simmons, S.F., Cadogan, M.P., Cabrera, G.R., Al-Samarrai, N.R., Jorge, J.S., Levy-Storms, L., Osterweil, D. and Schnelle, J.F. (2004). The Minimum Data Set Depression Quality Indicator: Does It Reflect Differences in Care Process? *The Gerontologist*. 44(4), 554-564.
- Smith, D. (1987). In Gustafson, K. (2000). Home Care Before and After Reform: A Comparative Analysis of Two Texts in Action. In D. Gustafson (ed) *Care*



*and Consequences: The Impact of Health Care Reform.* Halifax:  
Fernwood.

Stein, J.G. (2001). *The Cult of Efficiency.* Toronto: Anansi

Strauss, A.L. & Corbin, (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park. CA. Sage. In Rubin, E.R. & Babbie, A. (2005). *Research Methods for Social Work.* Thomson Wadsworth.

Teresi, J. & Holmes, D. (1992). Should MDS data be used for research? *Gerontologist.* 32, 148-149. In Lum, T.Y., Lin, W. and Kane, R.L. (2005). Use of Proxy Respondents and Accuracy of Minimum Data Set Assessments of Activities of Daily Living. *Journal of Gerontology.* 60A (5), 634-659.

Tilbury, C. (2004). The Influence of Performance Measurement on Child Welfare Policy and Practice. *British Journal of Social Work.* 34(2).

Treasury Board of Canada. *Quality Service – Benchmarking and Best Practices: An Update.* (2007).

[http://www.tbs-sct.gc.ca/pubs\\_pol/oepubs?TB\\_o/10QG2-7E.asp](http://www.tbs-sct.gc.ca/pubs_pol/oepubs?TB_o/10QG2-7E.asp)

Walton, R. (2005). Social Work as a Social Institution. *British Journal of Social Work.* 55, 587-607.

Whiteside, M. (2004) The challenge of interdisciplinary collaboration in addressing the social determinants. *Australian Social Work.* 57(4).

Won, A., Lapane, K.L., Vallow, S., Schein, J., Morris, J.N., and Lipsitz, L.A.  
(2006). Long-Term Effects of Analgesics in a Population of Elderly Nursing  
Home Residents With Persistent Nonmalignant Pain. *Journal of  
Gerontology*. 61A(2), 165-169.

Yates, M. (2005). Braverman and the Class Struggle.

<http://www.monthlyreview.org/199yates.htm>

Young, R.M. (2005). Braverman’s Labour and Monopoly Capital.

<http://human-nature.com/rmyoung/papers/blmc1.html>

Appendix 1 Participant Information Sheet

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**Participant Information Sheet**

Title: The experiences of frontline mental health staff in using  
computerized reporting tools.

Investigators: Laura O’Neill, B.Sc., B.S.W., M.S.W. (Candidate), Sheila  
Sammon, B.A., M.S.W., Ian Smith, Ph.D.

Name of Institutions: McMaster University  
1280 Main Street, West, Hamilton, Ontario.

St. Joseph’s Healthcare Hamilton,  
100 West 5<sup>th</sup>, Hamilton, Ontario.

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You are being invited to participate in a research study conducted by Laura  
O’Neill, a student of the School of Social Work at McMaster University, Hamilton.  
Results of this research project will be submitted to the Faculty of Graduate

Studies and Research in partial fulfillment of the requirements of the degree  
Master of Social Work.

If you have any questions or concerns about this project, please contact my  
research supervisors;

Professor Sheila Sammon 905- 525-9140 Ext. 23780

Dr. Ian Smith, 905-522-1155 ext. 5542

In order to decide whether or not you wish to be involved in this research project,  
you should understand what is involved and the potential risks and benefits. This  
form gives detailed information about the research study and this will be  
discussed with you. Once you understand the study you will be asked to sign this  
consent form if you wish to participate. Please take your time to make this  
decision.

### **What is the purpose of this research?**

Over the past few years there has been an increase in the use of computerized  
reporting systems within healthcare for both assessment and accountability.  
These include STAR, GRASP and more recently the Resident Assessment  
Instrument - Mental Health (RAI-MH). In the fall of 2005 the Ministry of Health  
and Long Term Care mandated the use of computerized reporting systems for all  
adult mental health inpatient beds in Ontario. There is also a pilot project  
exploring the potential implementation in outpatient mental health services. The  
reporting tool used at this site is the RAI-MH and the information is submitted to  
the Canadian Institute for Health Information (CIHI). I am interested in the impact  
of using computerized tools such as the RAI-MH on frontline staff. I am interested  
in the impact on staff as they adapt their practice to accommodate these

reporting tools but also whether staff believes there is an impact on how patient care is provided.

### **What will my responsibilities be if I take part in the study?**

If you volunteer to participate in this study you will be asked to meet with myself, Laura O’Neill, to participate in a single interview that will last one hour. It is a semi- structured interview and so I will ask broad questions and you will also have an opportunity to describe narratively your experience. You will be asked questions about the impact of computerized reporting tools on your day-to-day work. The questions will include the following, your role and if and how you have adapted your practice to accommodate computerized reporting tools, whether this has had an impact on how service is provided to patients and so forth. The interview will be taped and transcribed with your permission.

### **Where will the interview take place?**

The interview place will be arranged at a time and place that is most convenient for you. This can be arranged on site or off site.

### **How many people will be in this study?**

This is a qualitative study and it is hoped that there will be approximately 5 to 7 participants.

### **What are the possible risks and discomforts?**

Your name, employer or work location will not appear on any part of this project. Your confidentiality will be secured by not using names or other identifying

personal information. People may be identifiable by the views they express. Every caution will be taken to avoid participants being identified. For this reason you can choose the level of your participation. You are not required to respond to any questions you do not want to.

### **What are the possible benefits for me and/or for society?**

Your participation in this study could lead to a better understanding of the role of computerized reporting system in health care. Also, this study may help in directing future research on the impact of computerized reporting systems and therapeutic relationships.

While you may not directly benefit from this research it is hoped that when the research is completed it will be disseminated via presentations at the hospital. Thus you will hear how mental health staff feels about the computerized reporting tools and how they have attempted to adapt their practice to meet these new demands.

### **What information will be kept private?**

Participants will not be named in the study and personal identifiers will not be used. Any information obtained in connection with this study that can identify you will remain confidential and will only be disclosed with your permission or as required by law. The interview will be taped and the tape will be transcribed. The data will be stored in a locked filing cabinet in a locked room and will be destroyed when the study is completed. The study will be completed prior to August 31, 2007. Myself, Laura O’Neill, as well as my supervisors, Sheila Sammon and Dr. Ian Smith will have access to the data.

If this study is published your name, work location or employer will not be used and no information that discloses your identity will be released.

### **Can participation in the study end early?**

You can choose whether or not to participate in this study. You are under no obligation to participate. If you do volunteer to be a participant in this study you can withdraw at any time without consequences of any kind. You may also request the removal of your data from the study without consequences of any kind up until the first draft is written. You may also refuse to answer any questions you do not wish to answer and still remain in the study. The researcher may withdraw you from the research if circumstances arise which warrant doing so.

### **Will I be paid to participate in this study?**

There is no monetary compensation for participating. A summary of the results will be available to you upon request at the end of the study.

### **What are my rights as a research participant?**

You may withdraw your consent at any time and discontinue participation without reprisal. You may request to have your data withdrawn, returned or destroyed at any time. The study has been reviewed and received ethics clearance through the St. Joseph’s Healthcare Hamilton Research Ethics Board. If you have questions regarding your rights as a research participant, please contact:

Office of the Chair of the Research Ethics Board

St. Joseph’s Healthcare Hamilton at 905-522-1155, Ext. 3537

**Where can you call if you have any questions or problems related to this study?**

If you have any questions about this research study now or later, please contact:

Laura O’Neill

905-522-1155 Ext. 5524 or [oneill@stjosham.on.ca](mailto:oneill@stjosham.on.ca)

Dr. Ian Smith Ext. 5542 or [ismith@stjosham.on.ca](mailto:ismith@stjosham.on.ca)

St. Joseph’s Healthcare Hamilton  
Centre for Mountain Health Services  
100 West 5<sup>th</sup>, Hamilton, Ontario  
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Sheila Sammon

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McMaster University  
1280 Main Street West, Hamilton, Ontario  
L8S 4L8



## CONSENT STATEMENT

### SIGNATURE OF RESEARCH PARTICIPANT

**I have read the preceding information thoroughly. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.**

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

### SIGNATURE OF INVESTIGATOR:

In my judgment the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in a research study.

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_

Appendix 2 Letter of Information

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**Letter of Information**

**To be given to the Social Work Specialist to distribute via email to potential participants. Also to be used by the researcher if contacted by phone by a potential participant and will be used as a guide by the researcher for the preamble prior to giving out the informed consent package.**

The purpose of this research is to explore the personal experiences of staff working in the area of mental health. In particular I am interested in the impact of computerized reporting systems that have been implemented over the past couple of years, on your practice as frontline staff. For example, the Resident Assessment Instrument - Mental Health (RAI-MH) was mandated by the Ministry of Health and Long Term Care in the fall of 2005 and I am interested in the impact on frontline staff. It has been approximately one year since this site implemented the RAI-MH and as yet there has been no research in the literature to elicit the experiences and opinions of frontline workers on the impact of this tool on their practice. This research is an attempt to address this gap in the literature and in so doing increase our understanding of computerized reporting systems within mental health. Therefore, I believe your knowledge and experience of this subject will be a valuable asset in exploring the recent trend to mandate computerized reporting systems in healthcare.

In participating in this study you will be asked to meet with myself for one interview that will last approximately one hour. You may choose the meeting place (on site or off site wherever is most convenient for you). During the interview you will be asked questions about computerized reporting tools and your practice. The session will be taped and transcribed.

Your participation in this research will be kept confidential. Every care will be taken to respect your privacy; no identifying information will be kept or included in any reports generated from this research. All the information you provide will be kept in a locked filing cabinet in a locked office that only I, Laura O’Neill, or my supervisors Sheila Sammon and Ian Smith will have access to.

You have the right to withdraw from the study at any time and in doing so you can also request to have your data withdrawn from the study without reprisal. You have the right to withdraw your data from the study up until the first draft is written. You have the right to refuse to answer any question asked of you. The interview will be taped with your permission so that the information can be accurately transcribed. At the completion of this study all transcripts and tapes will be permanently destroyed. The data will be destroyed prior to August 31, 2007.

It is important that you feel **no obligation** to participate in this study. If you are interested in participating please read the consent package, ask questions and if you are agreeable sign the informed consent package that will be provided before the interview proceeds.

This research is being supervised by Sheila Sammon, Professor in the School of Social Work at McMaster University and Dr. Ian Smith, St. Joseph’s Healthcare

Hamilton. The results of this research project will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Social Work.

Should you need any more information regarding this study, please contact:

Laura O’Neill, RSW, 905-522-1155 Ext. 5524 or [oneilll@stjosham.on.ca](mailto:oneilll@stjosham.on.ca)

Sheila Sammon, 905-525-9140 Ext. 23780 or [sammon@mcmaster.ca](mailto:sammon@mcmaster.ca)

Dr. Ian Smith, 905-522-1155 ext. 5542 or [ismith@stjosham.on.ca](mailto:ismith@stjosham.on.ca)

If you have any inquiries regarding your participation in a research study, please feel free to contact

Office of the Chair of the Research Ethics Board, St. Joseph's Healthcare  
Hamilton at 905-522-1155 ext. 3537

Or Office of the Chair of the Hamilton Health Sciences/McMaster University,  
Research Ethics Board at 905-521-2100 ext. 42013

## Appendix 3 Interview Guide

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### **Interview Guide**

This interview is being conducted to learn more about the impact of computerized reporting systems, such as the Resident Assessment Instrument - Mental Health (RAI-MH), on your day-to-day work with patients. You have received, reviewed and signed a consent form to participate in this interview. The interview will be taped and transcribed with your permission.

Broad areas for questions and probes include the following:

1. What computerized reporting tools do you currently complete?
2. Describe the impact of these tools on your daily work?
3. What are the benefits of these tools?
4. What are the disadvantages of these tools?
5. Who can you talk to about the use of these tools?
6. Are there sources of tension in your work related to computerized reporting tools and if so what are they?
7. Does the use of standardized forms increase work demands on you and does this impact patient care? If so how do you manage this?
8. In what way has the collection of this data impacted clinical decisions, by you, by others, by managers, by administration?

# Appendix 4

## SECTION O. ROLE FUNCTIONING AND SOCIAL RELATIONS

FAMILY ROLES	Belief that relationship(s) with immediate family members is disturbed or dysfunctional. 0. Belief not present 1. Only patient believes 2. Family/friends/others believe 3. Both patient and family/friends/others believe	
SOCIAL RELATIONS AND INTERPERSONAL CONFLICT	Presence of potential problems with social relation. 0. No 1. Yes a. Patient reports having no confidant b. Family/close friends report feeling overwhelmed by patient's illness c. Patient is persistently hostile toward or critical of family/friends d. Patient is persistently hostile toward or critical of other patients or staff e. Family/friends are persistently hostile toward or critical of patient f. Staff reports persistent frustration in dealing with patient g. Family/friends require unusual amounts of facility staff time	
EMPLOYMENT STATUS	Current employment status. 0. Employed 1. Unemployed, seeking employment 2. Unemployed, NOT seeking employment 3. Other 4. Unknown	
RISK OF UNEMPLOYMENT/DISRUPTED EDUCATION	Factors that increase current risk of unemployment or disruption of education. 0. No 1. Yes 8. Not applicable a. Increase in lateness or absenteeism over the last 6 months b. Poor productivity or disruptiveness at work/school c. Expresses intent to quit work/school d. Persistent unemployment or fluctuating work history over the last 2 years	
TRADE-OFFS	During the last month, because of limited funds, made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary health care, adequate food. 0. No 1. Yes	
SOCIAL RELATIONSHIP	0. Occurred within last 3 days 1. Occurred within last week 2. Occurred within last month 3. Last occurred more than one month ago a. Participation in social activities of long-standing interest b. Visit by a long-standing social relation/family member c. Telephone or email contact with long-standing social relation/family member	

## SECTION P. RESOURCES FOR DISCHARGE

AVAILABLE SOCIAL SUPPORTS (Family/close friends)	Presence of one or more family members (or close friends) who are willing and able to provide the following types of support after discharge from formal care programs/setting. 0. Not needed 1. Regular 2. Occasional 3. No a. Help with child care, other dependents b. Supervision for personal safety c. Crisis support d. Support with ADLs or IADLs	
DISCHARGE READINESS	Presence of indicators of discharge readiness 0. No 1. Yes a. Patient expresses/indicates preference to return/to remain in the community b. Patient has a support person who is positive towards discharge/maintaining residence in community	

## SECTION P. RESOURCES FOR DISCHARGE (cont'd)

3	PROJECTED TIME TO PLANNED DISCHARGE	How long patient is expected to stay in current setting or under the care of this service prior to planned discharge (count from date of admission, including that day). 0. 1-7 days 1. 8-14 days 2. 15-30 days 3. 31-90 days 4. 91 or more days
4	OVERALL CHANGE IN CARE NEEDS	Change in psychiatric symptoms as compared to one month ago or since last assessment (if less than one month ago). 1. Deteriorated—symptoms are more frequent and/or severe 2. No change 3. Improvement in symptoms 4. Marked improvement
5	LIVING ARRANGEMENT	Code for initial arrangement expected at discharge. 0. Deceased 1. Private home/apartment 2. Rented room 3. Board and care/assisted living/group home/mental health residence 4. Facility for those with an intellectual disability 5. Psychiatric unit/hospital 6. Homeless (with or without shelter) 7. Long-term care facility (nursing home) 8. Rehabilitation unit/hospital 9. Hospice 10. Acute unit/hospital 11. Correctional facility 12. Other 13. Unknown
X 140	DIS-CHARGED TO FACILITY NUMBER	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Prov/Terr      Facility Number (See manual for province/territory codes.)

## SECTION Q. PSYCHIATRIC DIAGNOSTIC INFORMATION

1	DSM-IV PROVISIONAL DIAGNOSTIC CATEGORY	Select up to three provisional DSM-IV diagnoses determined by the psychiatrist/attending physician and rank them in order of importance as factors contributing to this admission. Code "1" for most important diagnosis, "2" for the second most important, "3" for the third most important (Note: 2 and 3 coded if applicable)
	a. Disorders of childhood/adolescence	
	b. Delirium, dementia, and amnesic and other cognitive disorders	
	c. Mental disorders due to general medical conditions	
	d. Substance-related disorders	
	e. Schizophrenia and other psychotic disorders	
	f. Mood disorders	
	g. Anxiety disorders	
	h. Somatoform disorders	
	i. Factitious disorders	
	j. Dissociative disorders	
	k. Sexual and gender identity disorders	
	l. Eating disorders	
	m. Sleep disorders	
	n. Impulse-control disorders not elsewhere classified	
	o. Adjustment disorders	
	p. Personality disorders	