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Recognizing, Reporting and Responding to Abuse, Neglect and Self-neglect of Vulnerable

Adults: An Evaluation of the ReAct Adult Protection Worker Basic Curriculum

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Abstract

Abuse and neglect of vulnerable adults is a significant problem, the identification and management of which is increasingly being made the legal responsibility of healthcare professionals. In response, some jurisdictions have developed training to assist professionals in these duties. This study evaluates the ReAct Adult Protection Worker Basic Curriculum training from British Columbia, Canada. 157 participants, 109 training completers and 48 Non-completers, answered a survey evaluating their confidence, knowledge, and applied knowledge in identifying, reporting and investigating cases of suspected abuse, neglect and self-neglect of vulnerable adults. Comparisons of training Completers to Non-completers showed significant gains in Completers' perceived confidence and knowledge but no improvement in applied knowledge. The type of healthcare professional being trained and the length of training did not impact learner improvement. The results suggest ways in which both training and evaluation can be improved (e.g., supervised practice) to increase and detect gains in knowledge and practice.

Keywords: Adult protection, program evaluation, vulnerable adults, abuse and neglect prevention

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The measure of a good society is in how it treats its most vulnerable members. This idea

has been repeated and attributed to various religious and political leaders overtime (e.g., Hubert

H. Humphrey, Pope John Paul II) and yet we are still only just beginning to understand and

combat the abuse of vulnerable adults. For the purposes of this paper "vulnerable adult" is

attributed to criteria from s. 44 of British Columbia's *Adult Guardianship Act* (1996, c.6) as

anyone who has reached 19 years of age who is at risk for abuse, neglect or self-neglect due to a

disease, illness, injury, or any other condition that prevents them from seeking support and

assistance. The prevalence of abuse and neglect among adults is difficult to measure (Aylett,

2009; McDonald, 2011; Sugita & Garrett, 2011; World Health Organization, 2002). To the best

of our knowledge no studies have examined the prevalence of abuse and neglect of vulnerable

adults as defined above. One group of vulnerable adults that has been the subject of such research

is the elderly. Research focusing on the elderly in the United States suggests that 1 in 10 older

adults are abused or neglected and that only 1 in 23 report the abuse (Dong, 2015; Lachs &

Pillemer, 2015; National Center on Elder Abuse Administration on Aging, n.d.). A 2015 national

survey in Canada conducted by the National Initiative for the Care of the Elderly (NICE) found

that 8.2% of community dwelling, cognitively lucid adults aged 55 years or older plus had

experienced mistreatment (McDonald, in press).

The abuse and neglect of vulnerable adults can have devastating physical, mental, and

financial effects including death and is typically perpetrated by those known to the victim, such

as their family (Brennan, 2012; Department of Justice, 2015; Dong et al., 2009; Friedman, Avila,

Shah, Tanouye, & Joseph, 2014; Futures Without Violence, 2010; WHO, 2002). Owing to their

vulnerabilities, vulnerable adults tend to have limited social contacts, but are typically in contact with healthcare professionals. As a result, healthcare professionals may be the only individuals outside of the family to have regular contact with victims (Friedman et al., 2014; McGarry, Baker, Wilson, Felton, & Bannerjee, 2015; Sugita & Garrett, 2011). Given this contact, there is a need to provide education and training programs for healthcare professionals to raise awareness so that adult protection concerns can be identified, reported, and investigated.

In response to this significant social issue many government agencies have implemented adult protection legislation. In Canada, adult protection laws generally fall under the purview of the Provinces and Territories (Canadian Centre for Elder Law, 2011). In force since 2000, Part 3 of the province of British Columbia's *Adult Guardianship Act* designates agencies to investigate reports of adult abuse, neglect or self-neglect[1]. This mandate requires a Designated Agency to follow up to determine if the adult is (a) experiencing abuse, neglect or self-neglect and (b) unable to seek support and assistance due to illness, disease, injury or any other condition that prevents the adult from making decisions about the abuse or neglect. If the adult meets these two criteria, the Designated Agency must use the most effective and least intrusive forms of support to assist the adult.

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[1] British Columbia's *Adult Guardianship Act* provides definitions for "adult", "abuse", "neglect" and "self-neglect". "Adult" means anyone who has reached 19 years of age. "Abuse" means the deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm, or (b) damage or loss in respect of the adult's financial affairs, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors. "Neglect" means any failure to provide necessary care, assistance, guidance or attention to an adult that causes or reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage or loss in respect of the adult's financial affairs, and includes self-neglect. "Self-neglect" means any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short period of time, serious physical or mental harm or substantial damage or loss in respect of the adult's financial affairs, and includes (a) living in grossly unsanitary conditions, (b) suffering from an untreated illness, disease or injury, (c) suffering from malnutrition to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired, (d) creating a hazardous situation that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of property, and (e) suffering from an illness, disease or injury that results in the adult dealing with his or her financial affairs in a manner that is likely to cause substantial damage or loss in respect of those financial affairs.

Designated Agencies identified in the Adult Guardianship Act include Community Living British Columbia and five health authorities: Vancouver Coastal Health, Providence Health Care, Fraser Health, Interior Health, Island Health, and Northern Health. Although the *Adult Guardianship Act* stipulates that Designated Agencies must follow up on adult protection reports, it fails to outline (a) who within the Designated Agencies is responsible for following-up reports, (b) investigation processes Designated Agencies must use to follow-up reports, and (c) whether those conducting the follow-up must be trained in adult protection investigation.

Despite the gaps within the legislation, practice has moved forward. Healthcare clinicians identified to conduct adult protection investigations (also known as Designated Responders) presently come from a variety of professional backgrounds including social work, nursing, and occupational therapy. These clinicians, although originally hired to perform healthcare jobs (e.g. hospital social worker, home care nurse, or mental health clinician), were now required to conduct adult protection investigations. Because the *Adult Guardianship Act* is silent on who can be Designated Responders, each health authority makes their own operational decisions as to which health care clinicians may conduct adult protection investigations. For example, Vancouver Coastal Health has a structured process regarding how these decisions are made along with a formal framework of education that is embedded in its adult protection policy.

To ensure that Designated Responders know how to follow-up on reports of suspected abuse and neglect and have the necessary competencies to meet the requirements of the *Adult Guardianship Act*, the ReAct Adult Protection Worker Curriculum (Prashad, 2011) was developed in 2010 and adopted by all health authority Designated Agencies in British Columbia in 2011. Funded in partnership between Vancouver Coastal Health and Fraser Health, the curriculum was developed in consultation with practice and operational leaders at Vancouver

Coastal Health and members of the Adult Guardianship Provincial Advisory Committee. The curriculum was based on adult learning principles (Cafarella, 2002) and intended to be delivered in person to a cross-sectoral (acute, mental health and community), inter-disciplinary audience (social workers, nurses, occupational therapists etc.) using a Train-the-Trainer approach. Multi-modal learning activities were incorporated including lecture, small and large group discussion and activities, role play, reflective writing, case studies, quizzes, and video clips (Renner, 2005).

The ReAct curriculum is comprised of 11, 3½ hour modules divided into three levels: basic, intermediate and advanced[2]. Each module has a standardized set of learning objectives and each level has a standardized set of competencies. The learning objectives and core competencies were informed by cumulative practice experience and recommended by a working group of Adult Protection Specialists, Social Work Professional Practice Leaders and Older Adult Mental Health Program Managers from three different health authorities and then vetted at a provincial working group for the *Adult Guardianship Act* in British Columbia. The six Basic Curriculum Modules include: (1) A mandatory pre-requisite online module that defines the different types of abuse and neglect per the Adult Guardianship Act, how to identify risk factors, the role of the Designated Agency, and what to do if a health employee becomes aware of abuse, neglect, and self-neglect; (2) An overview of the health authority's Abuse and Neglect Policy, the dynamics of abuse, a recommended response process and available clinical tools; (3) A review of conducting investigations including the influence of legislation on interviewing and documentation, the influence of family dynamics, factors to consider when interviewing, how to keep safe, and screening tools; (4) An examination of self-neglect including the legal definition,

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[2] For the full ReAct Adult Protection Worker Curriculum syllabus, please contact react@vch.ca.

indicators and the application of clinical tools; (5) A review of financial abuse that includes legislative options, understanding the dynamics of financial abuse, differentiating approaches for capable and vulnerable adults, when to refer to the Office of the Public Guardian and Trustee, and the application of clinical tools; and (6) An overview of care planning for vulnerable adults including when care planning is indicated per the legislation, what to do when an adult declines the care plan, and when to implement more formal measures under the legislation. The five core competencies of the basic curriculum covered in these six modules and evaluated in the present study are: (1) recognize indicators of abuse; (2) understand dynamics of abuse, neglect, and self-neglect; (3) understand factors that make an adult vulnerable; (4) understand statutory obligations of the Designated Responder as an employee of a Designated Agency; and (5) understand when to report to a Designated Responder Coordinator and coordinate further investigation. In response to operational concerns about the length of the curriculum, a condensed version of the course was also developed which lasts 13 hours instead of 17.5 hours.

While the ReAct Adult Protection Worker Basic Curriculum filled a gap for practical training in British Columbia, the efficacy of the curriculum still required evaluation. Previous research evaluating other adult protection education has shown increases in learner knowledge, attitudes and comfort in identifying and reporting suspected abuse. However, the studies conducted to date have some limitations. Many studies only examined learners' self-perceived gains in knowledge and comfort, much of the education examined has been short in duration, and studies have yet to identify significant changes in learner behaviour over time as a result of training.

The first of six studies in this area was conducted by Richardson, Kitchen, and Livingston (2002). The study examined whether the same educational content designed to improve the

management of elder abuse was better relayed though an educational course or printed material.

Learner improvement was measured pre- and post-training. Learners were 64 nurses, care

assistants, and social workers. Results revealed improvements in knowledge around ensuring the

safety of the abused senior, recording and reporting the abuse for the group attending the

education course, and a deterioration in knowledge for the group reading the printed material. A

ceiling effect was also noted, where participants with more knowledge prior to the intervention

improved less, leading the investigators to suggest that baseline knowledge be considered in

training.

A second study by McCauley, Mollie, and McNutt (2003) evaluated the efficacy of

videotaped role plays demonstrating approaches that clinicians can use to deal with encounters

involving interpersonal violence. Participants were 120 physicians, and 172 nurses and social

workers from four academic medical centers. The use of video significantly improved short-term

knowledge and attitudes about child, elder, sexual, and domestic violence and was highly-rated

by the participants.

Third, Sugita and Garrett (2012) explored the knowledge translation effects of a 4-hour

symposium using pre-and post-test surveys querying knowledge and attitudes about elder abuse.

Participants were 130 oral health care providers. Results showed significant increases in self-

reported awareness and knowledge of elder abuse and neglect and how to report it, as well as

self-reported comfort in identifying elder abuse and neglect.

Fourth, Cooper, Huzzey, and Livingston (2012) examined the impact of an intervention

consisting of a 28-minute lecture and DVD presentation aimed at increasing the trainees' ability

to recognize and query elder abuse with their clients. Testing was done pre-and post-intervention

and follow-up at three months was conducted to identify whether changes had occurred in learners' practices. Participants were 40 psychiatry trainees in the UK. Results showed increases in levels of knowledge and vigilance post training that were also retained at follow-up. However, participants were not more likely to ask their clients about abuse, nor did they detect more cases of abuse post training. Cooper and colleagues suggest that to change physician behaviour, more complex interventions (i.e., role plays, communication skills training, and discussions) are required since training must challenge physician concerns about asking their clients if they are experiencing elder abuse.

Fifth, Campbell (2014) examined the impact of a one-day Adult Support and Protection training on learner knowledge on Scotland's adult protection legislation. Participants were surveyed to identify their favored method of training which was then used for the one-day training. Participants were 18 community nurses. Findings showed increases in knowledge immediately following training. The study, however, did not measure knowledge application.

Finally, Du Mont, Kosa, Yang, Solomon, and Macdonald (2017) studied the efficacy of an evidence-based 8-hour didactic session with case studies to improve participant knowledge of elder abuse and competence in delivering care. A repeated measures design was used. Participants were 18 elder abuse nurse examiners in Ontario, Canada. Pre- and post-test comparisons showed post-test increases in self-reported knowledge, perceived competence and satisfaction with the mode of training. Trainee suggestions for future training included more complex case studies that also queried legislation and increased instructional time for certain subjects. Future studies will include evaluation of application of knowledge gained.

Current study. The present study adds to the existing literature by testing actual and perceived improvement among health professionals attending a lengthy multi-method training program that seeks to improve confidence, knowledge, and case management skills including how to identify, report and investigate cases of suspected abuse, neglect and self-neglect of vulnerable adults. Specifically, the ReAct basic curriculum will be evaluated to determine if learners who complete the basic curriculum demonstrate more of the five core competencies of the curriculum than those who have not completed the basic curriculum.

The ReAct modules that comprise the basic curriculum were selected for evaluation as they were completed by the largest number of clinicians. While the legislation is silent on the minimum requirement to conduct adult protection investigations, the basic curriculum is considered by the curriculum's working group and now within one health authority's Abuse and Neglect policy to be the minimum training required to conduct adult protection investigations. Over the two years of its implementation, feedback has prompted three questions related to the curriculum that will be examined herein. First, can those who have completed the basic curriculum demonstrate the five core competencies necessary to identify, report, and investigate cases of suspected abuse, neglect, and self-neglect of vulnerable adults? Second, from a professional practice perspective, do all professionals types require the same level of training? Third, can the basic curriculum be condensed so as to reduce the amount of time clinicians are away from their duties without impacting their attainment of the core competencies?

Method

Overview

An online survey was developed to evaluate the ReAct basic curriculum by comparing the confidence, knowledge and applied skills of respondents who had completed the

basic curriculum to those respondents who had not completed the basic curriculum. ReAct staff did not select individuals for training. Instead individuals were identified by their operational managers as Designated Responders and then self-selected with permission from their manager to attend the training. Those who completed the basic curriculum will hereafter be referred to as *Completers* and those who had not yet completed any modules in the basic curriculum will be referred to as *Non-completers*. The survey queried respondents' perceived competence and knowledge related to the adult protection content of the curriculum, their actual knowledge about the content, and their ability to apply that knowledge.

Procedure

Checkbox (version 4.7) web survey software was used by the researchers to develop and distribute the survey. Survey respondents were made aware of the survey via emails sent out between April 2014 and July 2015. The ReAct Adult Protection Worker Curriculum has been taught in four health authority Designated Agencies within British Columbia. Vulnerable Adult Specialists from each authority were responsible for distributing emails inviting participation within their authority. All authorities received the same survey. The survey took approximately 30 minutes to complete and could be paused and resumed by respondents. In return for participating, respondents who wished to identify themselves to the researcher were placed into a draw for two iPad Airs and three 25 dollar Starbucks gift cards. Participation was voluntary and the names of respondents who identified themselves were only known by the researcher. Ethical approval was not required for the present study because in Canada the Tri-Council Policy no longer requires ethical approval for program evaluation research. Ethical guidelines were however followed in the administration of the study.

Assessment

The survey included demographic questions and an assessment portion that tested respondents' perceptions, knowledge and applied skills related to material from the curriculum. The test portion of the survey was developed through a four-step process that involved consultation and collaboration with health authority stakeholders who were familiar with British Columbia's adult guardianship legislation and adult protection practice. The first step in test construction was a meeting between the Director of ReAct, the researcher, and ReAct course instructors from one health authority to identify which core areas of knowledge from the curriculum should be tested. Second, in consultation with the researcher, ReAct's Director completed a draft version of the test. Third, the draft test was presented to a group of 5 clinical practice leaders and based on their input the test was revised. Fourth, the ReAct Manager who had been blind to test construction thus far completed the test. Revisions were made based on the Manager's feedback to increase the clarity of the test questions.

The test was constructed to evaluate three aspects. First, perceived competence and knowledge about the material covered in the curriculum was examined. Perceptions were tested by having respondents make seven self-ratings of their competence and knowledge on a 10-point Likert scale, where 0 represented 'no' competence or knowledge, 5 represented 'some' competence or knowledge and 10 represented 'a great deal of' competence or knowledge. For example, respondents were asked "How much knowledge do you have about the indicators of abuse, neglect and self-neglect?".

Second, respondents' level of actual knowledge about the material covered in the curriculum was assessed. The method of assessment was 20 multiple choice questions, 18 of which had four response options and two of which had two response options. Questions reflected content covered in the course that specifically related to the stated learning objectives of each of the 5 modules in

the basic curriculum. The learning objectives of each module are clearly stated at the beginning

of the module and are summarized again at the end. All health authorities and instructors teaching

these modules have agreed to maintain the learning objectives for consistency and

standardization. By focusing the questions on the learning objectives, variations in responses due

to different instructor styles or health authority practices was minimized. To avoid question

recognition, the questions used in the study were different than any of those appearing in the

knowledge quizzes administered at the end of each module. The questions were equally reflective

of the modules that make up the basic curriculum.

Third, knowledge application was assessed using vignettes. The use of vignettes in

evaluation studies has been shown to provide a practical method of assessing applied knowledge

without cueing the participants (Richardson, Kitchen, & Livingston, 2003). Respondents were

given one of two vignettes involving the abuse, neglect, or self-neglect of a vulnerable adult.

Respondents then prompted to answer nine questions related to how they would investigate,

assess and care plan in the situation presented. One of the vignettes developed reflected the type

of case that would be seen by an acute care clinician (e.g., hospitals) and the other reflected a

case that would be seen in community care (e.g., home and community care centers).

Respondents were asked to identify the type of work they did (i.e., acute or community) and were

then presented with the vignette that best reflected their typical caseload. For example,

respondents who worked in community care responded to the following elder abuse vignette:

> An 85 year old widow has been living alone in her self-owned apartment and receiving home
> support services. Her memory is impaired, and she needs help with meals and personal care.
> She wishes to remain in her own apartment. Following a mild stroke she falls and fractures
> her hip. During her hospitalization, her grandson appears and states that he has made
> arrangements to move into her apartment to care for her. Once at home, the grandson limits
> the amount of home support and is hostile to staff when they come to the apartment. His

grandmother gave him power of attorney to manage the finances. The apartment is cluttered and smells of urine. Bills are unpaid. The client is sleeping on the couch. The grandson has placed towels under her to manage the incontinence.

Application of knowledge was assessed through respondents' answers to nine questions about the vignette. The questions reflected the process of investigating, assessing and care planning for a vulnerable adult. Answers were graded by the ReAct Manager using a structured grading scheme. The ReAct Manager was blind to whether respondents had completed the basic curriculum. Answers to the nine questions were compared in three ways. First, scores on the nine questions were summed to create a total score where higher total scores indicated that more correct answers were given. Second, the number of incorrect statements made in each response were summed to create a total score where higher scores represented more incorrect statements. Third the entire response was then assessed for evidence of the five core competencies that the ReAct basic curriculum was designed to teach. This overall competency rating was graded out of five, with a point awarded for evidence of each competency. To assess interrater reliability, a subsample of the vignette responses ($n = 24$, 15%) were graded by a second rater who was also blind as to whether respondents had completed the basic curriculum. The interrater reliability of scenario total scores and overall competency ratings, as indexed by intraclass correlation coefficients calculated using a two-way mixed effects (absolute agreement) model, was $ICC_1 = .96$ and $ICC_1 = .88$, respectively, indicating excellent agreement[3].

Data Analysis

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[3] Per Fleiss (1986) ICC > .75 is excellent; .60 < ICC < .75 is good; 40 < ICC < .60 is moderate; ICC < .40 is poor.

Data were analyzed using SPSS (Version 22). Statistical tests used included independent samples t-tests, frequency and chi-square analyses. Initial analyses of the multiple choice responses revealed two outlier responses in the Completers sample. Both respondents scored two points out of a possible 20 on the multiple choice questions and provided no response to the vignette questions. Based on chance alone, respondents should have answered six multiple choice questions correctly. A decision was made to treat the responses as non-valid and remove them from the sample since there was a concern about the genuineness of the responses. Nevertheless, to guard against bias, all significance tests were run with and without the outliers. Results showed that their removal had no influence the significance of the results.

Demographic Characteristics

A total of 109 Completers and 48 Non-completers responded to the survey. Checkbox defined incomplete responses as those where the respondent did not go through the entire survey and click finish. Information on response rates was only available for three of the five health authorities since two health authorities did not record and could not retrieve information regarding the number of individuals to whom they sent the survey. The overall response rate of 27%. Just over half of respondents were social workers ($n = 84$, 54%), 34% ($n = 54$) were nurses, 3% ($n = 5$) were occupational therapists and 9% ($n = 14$) identified as 'other' which included professions such as physical therapist and case manager. Profession differed significantly between Completers and Non-completers, $\chi2$ (3, N = 157) = 15.12, $p = .002$, $\varphi = .31$, where social workers were more likely to be Completers ($p = .007$) and respondents of 'other' professions were more likely to be Non-completers ($p = .001$). Respondents had spent an average of 6.5 years in their profession ($SD = 5.57$, range: 0-32). Years of experience did not differ significantly between Completers ($M = 7.06$, $SD =5.59$, range: 1-32) and Non-completers

($M = 5.22$, $SD = 5.37$, range: 0-20), $t(154) = 1.90$, $p = .059$. Most respondents (86%, $n = 107$) had previous training in elder abuse or had experience using the *Adult Guardianship Act* to protect vulnerable adults in British Columbia. Completers (70%, $n = 76$) were not more likely to have previous training than Non-completers (65%, $n = 31$), $\chi2$ (1, N = 157) = .41, $p = .524$.

Results

Comparison of Completers and Non-completers

Across the seven questions asked about perceived knowledge and competence, Completers rated themselves as having significantly more knowledge and competence than did Non-completers (Table 1). Effect sizes for all seven tests were large in size. Ratings of perceived knowledge ranged from 0 to 10 (out of 10) for both Completers and Non-completers. Both groups also felt most confident in their knowledge of the factors that make adults vulnerable to abuse. Ratings of perceived competence ranged from ranged from 0 to 10 for Completers and Non-completers with both groups showing the highest confidence in their competence to assess an individual's risk for harm due to abuse, neglect or self-neglect.

Completers ($M = 14.91$, $SD = 2.59$, range: 7-20) answered significantly more multiple choice questions correctly than did Non-completers ($M = 12.46$, $SD = 2.18$, range: 8-18), $t(155) = 5.72$, $p < .001$, $d = .92$. The question answered correctly most often by both Completers and Non-completers was "Self-neglect is a lifestyle choice that gets out of hand over time, and therefore does not meet the criteria for intervention under the Adult Guardianship Act" (Answer: False). The question most often answered incorrectly by both groups was "Which of the following is not a common factor in adults who self-neglect?" (Answer: History of mental illness). The question that showed the greatest improvement from training (i.e., had the greatest

difference between Completers and Non-completers) was "Tools available to Designated Agencies to intervene in situations of adult abuse and neglect include: (indicate all that apply)" (Answer: A mandate to respond, Power to investigate, and Court orders). The question that showed the least improvement was "Interviewing adults to determine if they can seek support and assistance is not indicated when" (Answer: D All of the above, this included: A The adult appears depressed, B The adult has mobility impairments, and C The adult has already been declared incapable)

Three measures of knowledge application were gathered and compared across respondents. First, a total score was calculated for the nine questions pertaining to the vignette. Completers had an average total score of 21.60 (SD = 10.64, range: 0-53) and Non-completers had a total score of 22.25 (SD = 8.95, range: 3-41), the difference in scores was not significant, $t(153)$ = -.37, p = .714. Second, statements included in open ended vignette responses that were incorrect given the vignette presented were totaled for each respondent. On average Completers (M = .41, SD = .77, range: 0-4) and Non-completers (M = .38, SD = .73, range: 0-3) included less than one incorrect statement in their responses. There was no significant difference between Completers and Non-completers in the amount of incorrect information given, $t(155)$ = -.29, p = .774. Third, overall competency ratings, rated out of five with a point given for each of the five core competences of the curriculum, were compared. Completers demonstrated an average of 3.23 (SD = 1.50, range: 0-5) competencies and Non-completers demonstrated 3.40 (SD = .97, range: 1-5) competencies, there was no significant difference in overall competency scores, $t(150)$ = -.70, p = .487.

Professional Type

Comparisons of professional type were run separately for Completers and Non-completers to separate any professional differences related to prior knowledge from knowledge acquisition via the curriculum.

Completers. Completers were separated into three groups based on their profession: social worker ($n = 66$, 61%), nurse ($n = 35$, 32%) and other professional ($n = 8$, 7%). Of the seven questions queried regarding perceived knowledge and competence, significant differences were found between groups for six questions (Table 2). In each of the six instances post hoc comparisons using Tukey's HSD revealed that social workers reported significantly more confidence in their knowledge and competence than did nurses. The significant differences found were medium to large in size (Cohen, 1988; Miles & Shevlin, 2001).

No significant differences were found between the multiple choice scores for the three groups, $F(2, 108) = 2.18$, $p = .118$. Knowledge application scores also did not differ between professional types. There was no significant difference in the total scores for the nine vignette questions by profession, $F(2, 106) = .16$, $p = .849$. There was also no difference in the amount of incorrect information provided by professional group, $F(2, 108) = .35$, $p = .354$. Professionals did not differ in the number of competencies of the basic curriculum they demonstrated, $F(2, 103) = .31$, $p = .737$.

Non-completers. Non-completers were separated into the same three groups based on their profession: social worker ($n = 18$, 37%), nurse ($n = 19$, 40%) and other professional ($n = 11$, 23%). Of the seven questions queried regarding perceived knowledge and competence, significant differences were found between groups for four questions (Table 2). In each of the four instances post hoc comparisons using Tukey's HSD revealed that social workers reported

significantly more confidence in their knowledge and competence than did the other professional group. Significant differences were medium to large in size (Cohen, 1988; Miles & Shevlin, 2001).

No significant differences were found between the multiple choice scores for the three groups, $F(2, 47) = 1.86$, $p = .167$. Knowledge application scores also did not differ between professional types. There was no significant difference in the total scores for the nine vignette questions by profession, $F(2, 47) = 2.38$, $p = .104$. There was also no difference in the amount of incorrect information provided by professional group, $F(2, 47) = .47$, $p = .626$. Professionals did not differ in the number of competencies of the basic curriculum they demonstrated, $F(2, 47) = .06$, $p = .946$.

Condensed Program

Just over half of respondents who completed the ReAct program attended the full program (57%, $n = 62$), and 45% ($n = 46$) attended the condensed program, information on the type of program completed was missing in one ($< 1\%$) case. Respondents who completed the full program ($M = 8.22$, $SD = 6.29$, range: 1-32) had significantly more years of experience than did respondents who completed the condensed program ($M = 5.54$, $SD = 4.11$, range: 1-16), $t(106) = 2.52$, $p = .013$, $d = .50$. Respondents who completed the full program (77%, $n = 62$) were also more likely to have previous training than respondents who had completed the condensed program (59%, $n = 46$), $\chi2$ (1, N = 108) = 4.36, $p = .037$, $\varphi = .20$. Completers of the full program (60%, $n = 62$) did not have significantly more experience than Completers of the condensed program (65%, $n = 46$), $\chi2$ (1, N = 108) = .34, $p = .557$.

No significant differences in self-rated knowledge and competence were found between respondents who completed the full program and those who completed the condensed program (Table 3). Multiple choice scores for those who completed the full program ($M = 14.71$, $SD = 2.69$, range: 7-20) also did not differ significantly from those who completed the condensed program ($M = 15.28$, $SD = 2.34$, range: 9-19), $t(106) = -1.15$, $p = .251$.

Total scores for the nine vignette questions did not differ significantly between respondents who attended the full program ($M = 22.97$, $SD = 9.75$, range: 0-47) and those who attended the condensed program ($M = 20.21$, $SD = 11.37$, range: 0-53), $t(104) = 1.34$, $p = .183$. Respondents who completed the full program ($M = .37$, $SD = .68$, range: 0-3), did not provide more incorrect information than respondents who competed the condensed program ($M = .48$, $SD = .89$, range: 0-4), $t(106) = -.71$, $p = .479$. Overall competency ratings for the five competencies also did not differ significantly between respondents who completed the full program ($M = 3.23$, $SD = 1.51$, range: 0-5) compared to those who completed the condensed program ($M = 3.30$, $SD = 1.44$, range: 0-5), $t(101) = -.23$, $p = .816$.

Discussion

Improving the identification, reporting, and investigation of cases of suspected abuse, neglect, and self-neglect of vulnerable adults is an important and necessary target for healthcare and other agencies. The education and training of professionals who encounter vulnerable adults and are charged with implementing laws around adult protection is the best way to achieve this target. The present study investigated a comprehensive curriculum designed for this purpose. The results revealed positive gains among Completers of the training as well as areas for improvement for the both the training and how such training is evaluated.

Results showed that Completers of the ReAct basic curriculum perceived themselves as being more competent and knowledgeable than did Non-completers of the curriculum, and the effect size for this finding was large. Both groups felt most knowledgeable and competent in the area of risk, specifically the identification of risk factors and the completion of risk assessments. Completers also showed higher levels of knowledge as indexed by their significantly higher multiple choice scores, again the effect of this improvement was large in size. The vignette task used to approximate knowledge application did not reveal significant differences between Completers and Non-completers. Total scores for vignette responses, incorrect information, and overall competency ratings did not differ between groups. Potential reasons for this and suggestions for future practice and research are discussed in more detail below. One unique and positive finding related to the knowledge application results is the low amount of incorrect information included in both Completer and Non-completer responses. This finding suggests that among healthcare workers there is a low level of misinformation related to adult protection. This is very positive as it suggests that program developers and trainers do not need to spend valuable training time countering false beliefs.

When Completers and Non-completers were compared separately based on their profession, the only difference identified was that social workers perceived themselves as being more knowledgeable and competent than did nurses in the case of Completers and other professionals in the case of Non-completers. Comparisons of actual knowledge and knowledge application showed no differences by professional type. The results may reflect differences in the professional focus of social workers in healthcare. Social workers in healthcare examine the psychological, social and spiritual aspects of problems including a focus on the dynamics of family systems as well as examining legislation, regulation, and local protocols (BC Association

of Social Workers, no date). Thus, social workers may feel more confident in the ReAct training content as it bears many similarities to their day to day practice. Although nurses and other professionals may perceive the designated responder role and the ReAct training as a new skill set and thus feel less competent, the results show them to be no less capable. This message could therefore be reinforced during training since adult protection research suggests that increased confidence will lead to increased action (Pike, Gilbert, Leverton, Indge, & Ford, 2011).

No significant differences were identified between Completers who attended the full training and those who attended the condensed training, even though Completers who took the full training had significantly more years of experience and training in elder abuse. The difference in experience may be due to the full basic curriculum being offered for the first two years and the condensed curriculum offered after that timeframe with likely a greater number of newer clinicians taking up the condensed training. These findings therefore suggest that the condensed version of the training is at least equivalent to the full training in terms of learner outcomes. We would suggest that updated training based on the results of this study include or use the condensed format as it will result in time savings for clinical staff who will need to spend less time away from patients.

Several factors should be considered when interpreting the findings of this study, particularly those related to the non-significant findings for the knowledge application test. First, testing knowledge application is a difficult task (Campbell, 2014). In the present study, we chose to use vignettes as their use has been suggested and supported in previous research (Du Mont et al., 2017; Richardson et al., 2002). Despite this support, it is important to note that vignettes are by no means a fool proof test of application and thus may have failed to identify true gains among the learners examined herein.

A second factor that may have influenced results is a bias in participant self-selection. Both Completers and Non-completers self-selected to take part in this study. The number of Completers who agreed to participate was more than double the number of Non-completers. It is possible that many Non-completers felt less adept (given their lack of training) and thus chose not to participate. Thus, our sample may have included Completers with a range of skills but only Non-completers who were the most confident and skilled in the areas examined. This hypothesis is at least somewhat supported by the results of the study. Specifically, the range of scores for Completers was always equal to or larger than the range for Non-completers, indicating that although Non-completers did not outperform Completers, individual Completers also had the lowest scores. As such, the self-selection of participants may have resulted in a comparison of Completers to a reasonably skilled sample of Non-completers which may have skewed results against the ReAct adult protection basic curriculum.

Third, we had some concerns that there could be regional effects in the findings because although the ReAct training is standardized and based on the legislation in British Columbia, actual deployment of the curriculum and adult protection practice vary somewhat across the five health authorities in the province and these differences were not considered in the survey development or grading of responses. As such, we examined the results and found no significant differences in multiple choice scores across the five regions as well as no differences in the vignette total scores, the amount of incorrect information provided or the overall competency ratings across the five regions.

This study had some limitations that should also be considered when interpreting the results. The response rate was lower than that of similar studies reviewed in the introduction (although no participation was found for McCauley et al., 2003) which ranged from 81% to

100%. The difference is likely due in part to the fact that previous studies conducted their evaluations at the time of intervention. This methodology would have likely increase the response rate but was not available herein for two reasons: (1) the decision to run the evaluation was made after training was already in place, and (2) respondents included non-completers who did not participate in an intervention. As second factor that may have decreased the response rate was the length of the survey. The survey platform, Checkbox, revealed that many individuals started the survey but failed to complete it. Given the high volume and acute caseloads of the professionals surveyed, the survey may have been too time consuming thus resulting in lowered participation or answer fatigue. This limitation may have had the greatest impact on the vignette section which appeared at the end of the survey and was arguably the most difficult section to complete. In future, a shorter survey that counterbalanced the three sections so that each appeared first, second and third for different participants could increase survey completion rates and limit the impact of answer fatigue.

Counterbalancing the three survey sections may also have resolved another limitation of the study which was that Non-completers may have been primed to the vignette section by the first two sections of the survey. This order effect may have impacted results by giving Non-completers a greater understanding of what the survey was about and the language around adult protection. In particular, the multiple choice section included terminology, risk factors, and other information that could have primed Non-completers more so than Completers who had prior experience with those terms and concepts.

Implications for Practice

The present study has implications for the ReAct curriculum as well as for the macro environment of conducting training related to vulnerable adult protection work.

Implications for the ReAct Curriculum. Pike and colleagues (2011) have suggested the importance of considering the context of training including climate of learning, climate of work environment, leadership, resources, policies, standards, user involvement, and resources to release to training and adequate staffing to cover those released for training. Further, Campbell (2014) suggests a systematic approach to evaluation where the evaluation is imbedded in the training. As this curriculum was originally created to be completely in-person, cross-sectoral, multi-disciplinary and then condensed in response to operational feedback, consideration may now be given to revising it to fully incorporate an evaluation method from the beginning, developing online modules for tenets of legislation and policy complemented with in-person modules at regular intervals and a standardized supervision framework where learners are supervised in practice with the process grounded with a supervisor's manual to ensure agreed upon standards. This curriculum and accompanying training materials could be made available online to all health authorities for implementation as appropriate to local operational needs.

Implications for vulnerable adult protection training. These results and those of previous studies suggest learner difficulties around knowledge application. This may be because as Cooper and colleagues (2012) suggested, this is uncomfortable work where there are barriers to getting involved and thus there is a need for training around communication skills. A teaching method that could therefore improve application is supervised practice. For instance, in the present study classroom learning translated to improvements in knowledge as evaluated by multiple choice tests. Multiple choice tests tend to reward understanding and memorization of concepts but not higher levels of learning such as application. Our learners did not see or practice applying legislation to their daily activities and failed to improve on the vignette part of the evaluation that approximated a real case of abuse. The use of consistent and standardized supervised practice as

a training method could show learners how the legislation translates to actual practice and how professionals communicate with victims, perpetrators, and other staff about vulnerable adult abuse. Witnessing and experiencing these activities could help learners to overcome barriers (e.g., language, comfort) and learn how to apply these important but complicated ideas, skills, and pieces of legislation into practice.

Implications for Research

Evaluating knowledge application through a survey methodology is a difficult task (Campbell, 2014). Although the suggestions made above may improve future attempts at survey based testing in this area, using different program evaluation methods and examining factors that may impact performance are other ways to improve program evaluation.

Coupled with the supervised training method suggested above, evaluation through supervision and actual case work would be an ideal way to measure improvements made during or following training. Evaluation could be done by the supervisor throughout the training period or could be done by reviewing the case records of a practicing professional. Comparisons pre and post training would be less applicable here but within group comparisons across the training period could be used to identify improvement. An examination of cases over time could also identify any knowledge loss and signal whether follow-up training is required.

Given the suggestion made here and in other studies that the lack of improvement in action and applied knowledge are related to external factors, future research should examine what external factors are acting as barriers and to what extent these barriers are impacting professionals and the work they do. Some potential barriers that we would suggest considering include: communication skills, the lack of a desire to get involved, liability concerns, concerns

regarding the time it takes to get involved and the resulting consequences to workload and other patients, and discomfort with issues related to violence or family dynamics. Further research opportunities for the curriculum may include observing the effect of consistent refresher training and access to clinical supervision so that skills may be reinforced on the job and confidence does not erode with time as suggested by Aylett (2009) and Pike and colleagues (2011). This would require a provincially standardized yet locally flexible framework for education and supervision in the practice of adult protection in British Columbia with a model of evaluation embedded into the framework such as Kirkpatrick's Four Stage Model of Evaluation which may include a pre and post test for the curriculum. As suggested by Giordano and Badmington (2007), a meaningful measure of the effect of education may be to make the training mandatory for formally identified adult protection workers throughout the province. This would require centralized resources supported by provincial regulations that mandate and standardize training competencies and local health authority policies that support those regulations and explicitly parallel the education appropriate to local operational needs.

Conclusion

Adult protection is an understudied area and as such professional training designed to recognize, report and respond to abuse is in its infancy. It is critical that as this field develops the training programs implemented are also evaluated, and ideally these two processes would be developed and undertaken together. The training evaluated herein showed learner improvement in confidence and knowledge and although applied knowledge gains were not found this may be reflective of wider problems in the assessment of applied knowledge. The results highlight areas where improvements could be made, not only for the ReAct Adult Protection Program but also for other adult protection programs and the evaluation of adult protection training. Future training

should try to approximate real world conditions and situations and where possible include

supervised practice and embedded evaluation.

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Table 1

Comparison of Respondents' Self-Rated Knowledge and Competence by ReAct Program Completion.

Perception Queried	Completers	Non-completers				
	M(SD)	*M (SD)*	*t*	*df*	95%CI	*d*
Knowledge about indicators of abuse, neglect and self-neglect	9.17 (1.42)	6.94 (1.97)	8.03*	155	[2.79, 1.69]	1.29
Knowledge about dynamics of abuse, neglect and self-neglect	9.02 (1.45)	6.77 (2.05)	7.86*	155	[2.81, 1.68]	1.26
Knowledge about factors that make adults vulnerable to abuse	9.29 (1.42)	7.32 (2.04)	6.91*	153	[2.53, 1.45]	1.12
Knowledge about documenting adult protection cases	7.86 (2.37)	5.13 (2.72)	6.37*	155	[3.59, 1.89]	1.02
Competence at assessing an individual's risk for harm due to abuse, neglect or self-neglect	8.64 (1.66)	6.58 (2.56)	5.99*	154	[2.73, 1.38]	.97
Competence at conducting investigation of abuse neglect and self-neglect in accordance with the Adult Guardianship Act	7.94 (2.04)	4.90 (2.81)	7.61*	154	[3.83, 2.25]	1.23
Competence at developing a support and assistance plan for vulnerable adult experiencing abuse, neglect or self-neglect	7.28 (2.25)	4.98 (2.80)	5.46*	155	[3.13, 1.47]	.88

Note. ReAct stands for Vancouver Coastal Health's ReAct Adult Protection Program

* *p* < .001

Table 2

Comparison of Completers' and Non-Compelters' Self-Rated Knowledge and Competence by Professional Type.

Perception Queried	Training completion status	Social Worker (SW) M(SD)	Nurse (N) M(SD)	Other (O) M(SD)	df	F	p	η^2	Tukey's HSD
Knowledge about indicators of abuse, neglect and self-neglect	Completer	9.53 (1.17)	8.49 (1.69)	9.25 (1.04)	2, 108	6.88	.002	.11	SW>N
	Non-completer	7.33 (1.53)	7.05 (1.78)	6.09 (2.74)	2, 47	1.43	.249	-	-
Knowledge about dynamics of abuse, neglect and self-neglect	Completer	9.44 (1.22)	8.23 (1.59)	9 (1.20)	2, 108	9.24	.000	.15	SW>N
	Non-completer	7.50 (1.47)	6.42 (1.71)	6.77 (3.03)	2, 47	1.96	.153	-	-
Knowledge about factors that make adults vulnerable to abuse	Completer	9.65 (1.34)	8.66 (1.71)	9.13 (1.13)	2, 107	6.16	.003	.10	SW>N
	Non-completer	7.94 (1.55)	7.22 (1.83)	6.45 (2.81)	2, 47	1.92	.159	-	-
Knowledge about documenting adult protection cases	Completer	8.35 (2.03)	7.09 (2.80)	7.25 (2.12)	2, 108	3.71	.028	.07	SW>N

	Non-completer	5.83 (2.83)	5.53 (2.53)	3.27 (2.20)	2, 47	3.77	.031	.14	SW>O
Competence at assessing an individual's risk for harm due to abuse, neglect or self-neglect	Completer	9 (1.45)	7.94 (1.94)	8.63 (1.19)	2, 107	4.89	.009	.09	SW>N
	Non-completer	7.78 (2.21)	6.37 (2.17)	5 (2.93)	2, 47	4.80	.013	.18	SW>O
Competence at conducting investigation of abuse neglect and self-neglect in accordance with the Adult Guardianship Act	Completer	8.43 (1.74)	7.14 (2.39)	7.38 (1.60)	2, 107	5.23	.007	.09	SW>N
	Non-completer	6.39 (2.75)	4.63 (2.41)	2.91 (2.30)	2, 47	6.69	.003	.23	SW>O
Competence at developing a support and assistance plan for vulnerable adult experiencing abuse, neglect or self-neglect	Completer	7.59 (2.25)	6.71 (2.22)	7.13 (2.17)	2, 108	1.78	.173	-	-
	Non-completer	6.11 (2.95)	4.79 (2.39)	3.45 (2.62)	2, 47	3.47	.040	.13	SW>O

Note. Other professional types include occupational therapist, physical therapist, and case manager.

Table 3

Comparison of Respondents' Self-Rated Knowledge and Competence by Type of ReAct Program Completed.

Perception Queried	Full program Completers	Condensed program Completers			
	M(SD)	*M (SD)*	*t*	*df*	95%CI
Knowledge about indicators of abuse, neglect and self-neglect	9.19 (1.47)	9.13 (1.38)	.28	106	[-.49, .62]
Knowledge about dynamics of abuse, neglect and self-neglect	8.94 (1.49)	9.11 (1.40)	-.61	106	[-.73, .39]
Knowledge about factors that make adults vulnerable to abuse	9.28 (1.59)	9.28 (1.33)	-.01	105	[-.56, .55]
Knowledge about documenting adult protection cases	8.02 (2.29)	7.59 (2.46)	.93	106	[-.48, 1.34]
Competence at assessing an individual's risk for harm due to abuse, neglect or self-neglect	8.74 (1.59)	8.48 (1.76)	.80	105	[-.39, .90]
Competence at conducting investigation of abuse neglect and self-neglect in accordance with the Adult Guardianship Act	8.00 (2.10)	7.80 (1.99)	.50	105	[-.60, .99]
Competence at developing a support and assistance plan for vulnerable adult experiencing abuse, neglect or self-neglect	7.29 (2.24)	7.20 (2.28)	.22	106	[-.78, .96]

Note. ReAct stands for Vancouver Coastal Health's ReAct Adult Protection Program