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Judgements of Social Care Professionals on Elder Abuse Referrals: A Factorial Survey

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Abstract

Guidance in the UK requires the co-ordination and standardisation of services to protect adults from abuse. However, there remains considerable ambiguity about the basic concepts of abuse and vulnerability. This paper reports an empirical study of factors in professional decision making in relation to identifying and reporting abuse of older people. A systematic review and a panel of expert practitioners were used to identify factors that might influence professional recognition and reporting of elder abuse. These factors were incorporated into a questionnaire that included randomised factorial survey vignettes and additional questions on decision making. Sets of unique vignettes were completed by 190 social workers, nurses and other professional care managers across Northern Ireland in 2008, giving 2,261 randomised vignettes used as the units of analysis. Recognition and reporting were influenced by case factors specific to the abuse event while contextual factors did not significantly influence recognition or referring of abuse. This study has shown that the factorial survey can be a powerful tool to investigate professional decision making. It provides an insight into practitioners' responses to complex ethical dilemmas. The findings are considered within the context of current policy and the need for further research is discussed.

Keywords: Decision making, elder abuse, factorial survey, professional judgement, Northern Ireland, referral, social work

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Context

The last three decades have seen a growing interest in the concept of elder abuse in professional practice, academic literature and the popular media. Studies have attempted to estimate prevalence (Thomas, 2002) and identify risk factors (Campbell and Browne, 2001; Acierno *et al.*, 2010) but relatively little is known about the appropriate means to address this phenomenon. Despite the growth of national, regional and local directives, the definition and recognition of adult abuse remain problematic (Dixon *et al.*, 2010; Killick, 2011) and implementation has varied (Cambridge *et al.*, 2010). Potential recipients of protection services have had little opportunity to influence policies and procedures and recent consultation suggests that people find terminology such as 'vulnerable adult' to be disempowering (Department of Health, 2009; Magill *et al.*, 2010).

Previous studies highlight the complexity of the decision-making process in adult protection (Lithwick *et al.*, 1999; Wilson, 2002) and suggest that investigations are not always conducted in a consistent manner (Johnson *et al.*, 2010; Anetzberger, 2001). Some research suggests that professionals are uncomfortable working with the potential ambiguity or ethical dilemmas, presented by adult protection, preferring the clarity and certainty of 'black and white' concepts (Saveman *et al.*, 1996; Wilson, 2002). Landau (1998) highlighted the potential for confusion within complex social situations and this has been supported by studies indicating that the understanding of abuse is contextually specific (Mills *et al.*, 1998) and culturally specific (Jang *et al.*, 1999; Malley-Morrison, 2000; Anme, 2004). Therefore, inconsistent professional decision making may be the result of terms and concepts that require greater specificity in light of the potentially wide range of interpretations brought to bear on the subject.

The literature on decision making in social work more generally is limited and not particularly helpful in its current state of development to inform professional practice despite recent initiatives (Taylor, 2010; Carson and Bain, 2008). Models drawn from the literature on subjective utility theory (balancing benefits and harms, and incorporating probabilities; Taylor, 2006*a*) seem to have limited resonance in social work decision making in general. Whilst actuarial prediction is used to some extent in the USA, it is little employed in the UK, although more general approaches to considering risk factors have been used more widely (Brearley, 1982*a*, 1982*b*). The work on heuristics and biases in decisions has had little impact beyond increased awareness of possible bias (Kahnemann *et al.*, 1982). The emerging *naturalistic decision-making* school of thought holds promise as a way to conceptualise social workers supporting client decision making (Beach and Connolly, 1997) but is in an early stage of development. Perhaps the most relevant modelling for our current purpose is the work on decision policies (Hammond, 1996) that conceptualises individuals, as

formulating their own policies in order to simplify the many complex decisions with which they are faced whether at work or at home.

There is some evidence that, in the absence of clear guidelines, practitioners develop their own strategies to address such complexity in professional decision making. The level of professional autonomy or discretion in adult protection has been investigated using concepts developed by Michael Lipsky (1980). Lipsky observed public service organisations and found that individual workers devise strategies to manage client demand and ration resources when faced with uncertainty and pressure. Lipskey contrasted formal 'top-down' policies with these 'street-level' policies. Northway and colleagues (2007) found that formal policy did not always have a direct impact on practice. Following the introduction of adult protection procedures in Wales, they identified greater awareness and commitment but a lack of clarity and consistency. Clark-Daniels and Daniels (1995) examined Alabama Social Workers' responses to individual allegations of elder abuse to test Lipsky's concept of 'service-rationing'. They found that practitioners' decisions were influenced by contextual factors like resource limitations, but in 'complex and unexpected ways' (Lipsky, 1980, p. 470). Daniels and colleagues (1999) have identified a crucial paradox in the field of elder abuse and adult protection in that definitions are broad, subjective and vague whereas practitioners are required to act in a manner that is mandatory, inflexible and specific. Preston-Shoot and Wigley (2002) examined the effectiveness of adult protection procedures in one local authority and found that the guidance failed to recognise the complexity of the abuse situations. On occasions, staff identified abuse but decided not to report it because of the client's wishes or other contextual information. Thus, there would seem to be a need for a more systematic and analytical approach to defining abuse that can explore professionals' decisions.

Models of elder abuse

There are various models that can be used to conceptualise risk and harm in relation to older people. Much of the study of risk in relation to older people (Taylor, 2006*b*) relates to issues such as admission to long-term care and hospital (Taylor and Donnelly, 2006*a*) and the management of support services in the home (Taylor and Donnelly, 2006*b*). We will consider here models developed from child abuse and from domestic violence, as they have been used to assist in conceptualising problems and services in relation to abuse of older people. We consider them in light of concepts drawn from aging research and theory.

Central to the complexity of decision making in child abuse cases is the ability to measure the level or probability of harm that is present. This is simple in cases at either extreme, but problematic in the 'grey area'

between. In legislation and policy, practitioners and agencies are required to establish a 'threshold' of significant harm that defines the level at which harm becomes unacceptable, although research suggests that decisions are not made on a one-dimensional measure of seriousness but include a number of factors (Platt, 2006; Calder, 2008).

Straka and Montminy (2006) compare strengths and weaknesses of the domestic violence and elder abuse paradigms in meeting the needs of older women who are suffering abuse. They suggest that the domestic violence model is based on principles of empowerment and recognises the specific issues faced by women. However, it tends to be reliant on hostels as a means of support and this is less appropriate to older women. The elder abuse model has developed some expertise relating to the needs of older people but has had limited success in addressing causes of abuse other than family carer stress.

Compared to the fields of child protection and domestic violence, adult protection is relatively new. Professionals, and particularly social workers, undertake a range of functions that can be seen as conflicting (Manthorpe *et al.*, 2008; Lymbery and Postle, 2010). Definitions and concepts remain ambiguous and policies are open to interpretation. With respect to older people, we need to understand better professional conceptualisations of abuse and the practical ways in which policy is implemented. This study sought to assist in the development of a more sophisticated understanding of vulnerability and abuse that would enable practitioners and agencies to respond sensitively and effectively with more robust decision making.

Method

This study investigated the decisions of social workers, nurses and other professional care managers in relation to the abuse by informal carers of older people living in the community in order to:

(1) measure the impact of client, professional and employer factors on the identification and reporting of suspected abuse of older people;

(2) study the consistency of decision making in the protection of older people; and

(3) study whether investigating professionals exercised discretion in their reporting behaviour and the relationship between recognition and reporting behaviour.

The factorial survey approach was used to incorporate case, practitioner and agency factors within a questionnaire that was used to survey selected professionals across Northern Ireland.

Factorial survey

The factorial survey method presents each respondent with a random set of vignettes (case scenarios) containing factors that have been assigned random levels. It is used to study the effect of a large number of factors on specified decisions using true-to-life vignettes attractive to professional participants and giving real-world (Ludwick and Zeller, 2001) or 'ecological' (Banister *et al.*, 1994) validity. The method, developed by Rossi and Nock (1982), has been shown to be a powerful tool that combines the benefits of both experimental and survey designs. By randomly assigning values to the variables, multiple unique vignettes can be produced. Each respondent is randomly assigned a set number of these vignettes and asked to use the information to score one or more dependent variables, in this case regarding their decision on identifying and reporting the abuse portrayed in each vignette. This randomisation provides a rigorous instrument with high internal and external validity (Ludwick and Zeller, 2001; Taylor, 2006*a*). The large numbers of vignettes completed allow a realistic range of factors to be studied, in this case twelve factors relating to the older person and the abusive event. The method has been developed and used to study social work decisions (Wallander and Blomqvist, 2005; Taylor, 2006*b*) and decisions by teachers and health care workers relating to child abuse (Webster *et al.*, 2005; Taylor *et al.*, 2008), 'good enough parenting' (Taylor *et al.*, 2009) and self-neglect in adults (Lauder *et al.*, 2006).

One criticism of vignette studies is that respondents may respond in ways that do not fully represent the way in which they would behave in real life. However, there is evidence to counter such criticism. A study by Peabody *et al.* (2000) found that vignettes gave more robust results than data extracted from professional files by comparison with how professionals made decisions when faced by an actor in the role of a patient or client (regarded as the gold standard for this purpose). By comparison with the more common factorial experiment, the factorial survey embodies more factors and is therefore more realistic and more likely to elicit a response true to real-life behaviour.

Case, practitioner and agency factors

Twenty-three case, practitioner and agency factors were identified during a systematic literature review (Killick and Taylor, 2009). To ensure construct validity, these were tested with two groups of expert practitioners at a regional adult protection conference. Levels of each factor were randomly assigned to vignettes and, where appropriate, null categories were included (see Figure 1). Null categories allow the factor to be removed from the vignette entirely from the perspective of that respondent. Randomised vignettes

Your client is a [65 / 74/ 86 / 93] year old [male / female] who has
[eczema / diabetes / severe arthritis / had a minor stroke / had a major stroke]
[he / she] [is very confused and / can sometimes be confused and / shows no confusion and/ NULL] [is placid / is demanding / is aggressive / is often violent]

[He / She] is looked after by a daughter who [copes well although she / finds the role stressful and / is under immense stress and/ NULL] [abuses alcohol / has a mental illness / is financially dependent / has unrealistic expectations]

The daughter admits that she [roughly handled him / shook him by the shoulders / punished him with a slap / hit him in the face with a fist] on [one / two / three / many] occasion/s.

[The client wishes action to be taken / The client consents to an investigation / The client does not wish action to be taken/ NULL]

[The daughter will be devastated if an investigation is initiated / The daughter will give up the caring role if an investigation is initiated / The daughter will make a formal complaint if an investigation is initiated / NULL]

[A range of support services are currently available / There is a six month waiting list for services / There are no available day care or respite places / NULL]

To what extent do you perceive this to be abuse?

Not Abuse 0 1 2 3 4 5 6 7 8 9 Abuse

How likely would you be to refer this case for investigation?

Not 0 1 2 3 4 5 6 7 8 9 Very

Likely Likely

Figure 1 Vignette structure

were produced using SPSS syntax (Winchell, 2003) and twelve were assigned to each questionnaire. Six standardised vignettes were also included in each questionnaire to allow testing for variance and validity. In total, each questionnaire had sixteen vignettes. Additional questions were included to gather demographic data and general information relating to decision making. These questions related to factors that could not be incorporated into vignettes. The vignettes and factors (independent variables) are illustrated in Figure 1.

Dependent variables

To provide sufficient variance in the dependent variables, this study used ten-point scales. These measured the respondents' perception of abuse (0 = Not abuse to 9 = Abuse) and the likelihood of reporting for investigation (0 = Not likely to 9 = Likely). These allowed the relationship between practitioner perceptions and practitioner actions to be studied,

addressing a criticism of vignette studies mentioned above that perceptions and actions may differ.

Respondents and ethical approval

Social care services to older people living in the community are primarily provided by teams of social workers and other professional care managers (who co-ordinate multi-professional complex care; Taylor, 1998) for whom the identification and reporting of abuse are small but important roles. At the time of the research (2007), it was estimated that, in the Health and Social Care Trusts in Northern Ireland, there were approximately 400 social workers, nurses, care managers, team leaders and managers working in providing publicly funded community social care services (including care management) for older people. This relatively small population allowed the entire eligible group to be surveyed. Ethical approval was granted by the Office of Research Ethics (NI) as well as by the ethics committees of the individual Trusts.

Analysis

Multiple regressions and hierarchical regressions were used to identify the independent variables (case factors) that significantly influenced each of the dependent variables (recognition and reporting). Separate one-way analysis of variances (ANOVAs) were then conducted to further investigate the relationship between independent variable levels and the dependant variable. A number of effect size statistics are confounded by sample size. The proportion (percentage) of variance explained (R^2) was used as a measure of effect size independently of sample size (Keppel *et al.*, 1993) to measure the variation in a decision that is explained by a particular factor.

The analysis provided standardised coefficients (Beta) that are a measure of the contribution of each variable to the model. A large value indicates that this independent variable has a large effect on the dependant variable. The *t*-value indicates the impact of each independent variable and Sig (p) values indicate the level of statistical significance.

Results

One hundred and ninety valid questionnaires were returned, representing 48 per cent of the total estimated targeted population of 400 professionals. Some did not complete all twelve vignettes and, in total, 2,261 vignettes were provided as the unit of analysis. The 190 respondents were distributed across the Trust areas of the four Health and Social Services Boards that

commission services and determine policies. One hundred and thirty-two (73 per cent) of respondents had undergone professional social work training, and 40 (22 per cent) had professional nurse training. More than half (103) of respondents had over ten years of experience and 90 per cent had taken part in recognised Adult Protection Training. However, 30 per cent had only the lower-level awareness training. For each regression, a summary of the model is presented followed by a table of regression coefficients. Regression identifies a base category for each variable and provides comparisons for the remaining categories. Hence, base categories are not reported in the regression tables.

Recognition of abuse

The regression model is summarised in Table 1. The coefficient of determination (R^2) indicates the variance in the dependent variable (practitioners' judgement about the presence of elder abuse) explained by the model. The model was significant in predicting abuse ($R^2 = 0.183$; $R^2_{adj} = 0.170$; $F(35, 2225) = 14.268$; $p < 0.001$), explaining 17 per cent of the variance.

Regression coefficients (Table 1) indicated that three of the twelve independent variables were significant ($p < 0.001$). The greatest influence was from *type of abuse*, which had four categorical levels. Category 1 ('roughly handled') was used as the base category and each of the other categories showed a significant difference. However, category 2 ('shook by the shoulders') had a much smaller increase in effect from the next lower category than category 3 ('punished with a slap') or category 4 ('hit in the face with a fist').

All values of the variable *frequency of abuse* significantly influenced respondents' recognition of abuse. Category 1 ('on one occasion') was used as the base category and recognition increased with frequency through category 2 ('on two occasions') and category 3 ('on three occasions') to category 4 ('on many occasions').

The two highest categories of the variable *victim wishes* produced significantly different responses from the base null category 4 (i.e. no expressed wishes or consent in the vignette). Respondents rated *abuse* higher with category 1 ('the client wishes action to be taken') and category 2 ('the client consents to an investigation') than when this variable was absent from the vignette.

Deciding on need for investigation

Identical analysis was conducted for the dependent variable REFER (willingness to refer the case for investigation). The model was significant in predicting referring behaviour ($R^2 = 0.154$; $R^2_{adj} = 0.140$; $F(35, 2225) = 11.544$; $p < 0.001$). The model explained 14 per cent of the variance.

Table 1 Regression coefficients of Model 1: perception of abuse

		B	Std	β	*t*	Sig.
	(Constant)	6.033	0.214		28.207	0.000
Age	74	0.154	0.102	0.036	1.514	0.130
	86	0.148	0.102	0.034	1.444	0.149
	93	0.177	0.102	0.041	1.729	0.084
Gender	Female	0.120	0.072	0.032	1.659	0.097
Condition	Diabetes	0.190	0.115	0.040	1.653	0.098
	Severe arthritis	−0.011	0.113	−0.002	−0.096	0.923
	Minor stroke	0.039	0.113	0.008	0.343	0.732
	Major stroke	0.043	0.113	0.009	0.382	0.702
Capacity	Very confused	0.009	0.102	0.002	0.090	0.928
	Sometimes confused	−0.028	0.102	−0.007	−0.278	0.781
	No confusion	−0.054	0.102	−0.012	−0.532	0.595
Behaviour	Demanding	−0.064	0.102	−0.015	−0.628	0.530
	Aggressive	−0.030	0.103	−0.007	−0.296	0.767
	Often violent	−0.141	0.104	−0.032	−1.356	0.175
Carer stress	Copes well	−0.168	0.102	−0.038	−1.649	0.099
	Finds the role stressful	−0.048	0.100	−0.011	−0.483	0.629
	Is under immense stress	−0.042	0.103	−0.010	−0.414	0.679
Carer factor	Has a mental illness	−0.206	0.102	−0.048	−2.016	0.044
	Is financially dependent	−0.095	0.103	−0.022	−0.917	0.359
	Has unrealistic expectations	−0.098	0.102	−0.023	−0.954	0.340
Type	Shook by the shoulders	0.273	0.103	0.063	2.662	0.008
	Punished with a slap	1.088	0.102	0.252	10.714	0.000
	Hit in the face with a fist	1.488	0.102	0.343	14.585	0.000
Wishes	Wishes action to be taken	0.323	0.102	0.076	3.158	0.002
	Consents to an investigation	0.206	0.104	0.047	1.976	0.048
	Does not wish action to be taken	0.062	0.103	0.014	0.600	0.548
Outcome	Daughter will be devastated	−0.077	0.105	−0.018	−0.735	0.463
	Daughter will give up caring role	−0.112	0.103	0.026	1.085	0.278
	Daughter will make a formal complaint (adverse3)	0.038	0.103	0.009	0.364	0.716
Resources	Range of support services available (resources1)	0.068	0.102	0.016	0.665	0.506
	Six-month waiting list	−0.066	0.102	−0.015	−0.652	0.514
	No available day-care or respite (resources3)	−0.009	0.102	−0.002	−0.090	0.929
Frequency	Two	0.929	0.103	0.214	9.026	0.000
	Three	0.919	0.103	0.212	8.916	0.000
	Many	1.324	0.103	0.308	12.910	0.000

Regression coefficients (Table 2) indicate that the same three independent variables were significant ($p < 0.001$) as for *recognition of abuse*. The greatest influence on the decision to refer for investigation was the *frequency of* abuse, followed by *type of abuse* and *victim wishes*.

Over and under-reporting

The majority (72 per cent, $n = 1{,}627$) of vignettes had identical recognition and reporting scores, although only 23.2 per cent ($n = 44$) of respondents provided identical scoring in every vignette. This indicates that, in specific

Table 2 Regression coefficients of Model 2: willingness to refer

Model		B	Std	Beta	*T*	Sig.
	(Constant)	5.940	0.261		22.794	0.000
Age	74	0.207	0.124	0.040	1.669	0.095
	86	0.039	0.125	0.008	0.315	0.753
	93	0.139	0.125	0.027	1.118	0.264
Gender	Female	0.158	0.088	0.035	1.790	0.074
Condition	Diabetes	0.137	0.140	0.024	0.976	0.329
	Severe arthritis	0.047	0.138	0.008	0.341	0.733
	Minor stroke	0.004	0.138	0.001	0.027	0.979
	Major stroke	0.119	0.138	0.021	0.862	0.389
Capacity	Very confused	0.154	0.125	0.030	1.239	0.215
	Sometimes confused	0.094	0.124	0.018	0.755	0.450
	No confusion	−0.054	0.124	−0.010	−0.438	0.662
Behaviour	Demanding	−0.145	0.124	−0.028	−1.170	0.242
	Aggressive	−0.031	0.125	−0.006	−0.250	0.802
	Often violent	−0.096	0.127	−0.018	−0.758	0.449
Carer stress	Copes well	−0.212	0.124	−0.040	−1.709	0.088
	Finds the role stressful	−0.142	0.122	−0.028	−1.170	0.242
	Is under immense stress	0.072	0.125	0.014	0.578	0.563
Carer factor	Has a mental illness	−0.227	0.125	−0.044	−1.819	0.069
	Is financially dependent	−0.124	0.126	−0.024	−0.984	0.325
	Has unrealistic expectations	−0.169	0.125	−0.033	−1.355	0.176
Type	Shook by the shoulders	0.185	0.125	0.035	1.480	0.139
	Punished with a slap	0.865	0.124	0.167	6.991	0.000
	Hit in the face with a fist	1.290	0.124	0.248	10.374	0.000
Wishes	Wishes action to be taken	0.422	0.125	0.083	3.391	0.001
	Consents to an investigation	0.300	0.127	0.057	2.362	0.018
	Does not wish action to be taken	−0.556	0.126	−0.108	−4.432	0.000
Outcome	Daughter will be devastated	−0.206	0.128	−0.039	−1.616	0.106
	Daughter will give up caring role	−0.055	0.126	0.011	0.438	0.661
	Daughter will make a formal complaint (adverse3)	0.020	0.126	0.004	0.163	0.871
Resources	Range of support services available (resources1)	−0.013	0.125	−0.003	−0.107	0.915
	Six-month waiting list	−0.190	0.124	−0.037	−1.529	0.127
	No available day-care or respite	0.046	0.125	0.009	0.368	0.713
Frequency	Two	1.082	0.125	0.208	8.622	0.000
	Three	1.161	0.126	0.224	9.249	0.000
	Many	1.408	0.125	0.274	11.271	0.000

circumstances, respondents were prepared to differentiate between their recognition of abuse and their willingness to report, based on contextual factors, including the wishes of the clients. We computed a variable *autonomy* that represents the difference in recognition and responding behaviour (referral score minus recognition score).

Analysis of this variable shows that practitioners are more likely to under-report (17.4 per cent, $n = 393$) than over-report (10.7 per cent, $n = 241$). Further regression analysis shows that practitioner autonomy is influenced by the wishes of the client—'the client does not wish action to be taken', professional training and Board area. Given the complexity of the process, it is not possible to define over or under-reporting as

'good' or 'bad'. The findings illustrate the dilemma faced by practitioners who seek to balance a client's right to choice with their own duty to protect citizens. It may be good practice to refer a case based on the client's request, irrespective of the nature of the incident. In such cases, the respondent would rate their reporting higher than their recognition. Such over-reporting has not been identified in child abuse research and it may indicate a sophisticated decision process rather than a lack of knowledge.

Discussion

Study limitations

The 190 questionnaires returned represent 48 per cent of the estimated 400 relevant professionals in the Health and Social Care Trusts. It is possible that the individuals who chose not to participate were less confident in their decision making or less enthusiastic about the value of research. Equally, it may be that those who did not respond were the busiest at the time at which the survey was conducted. However, it should be noted that, with this method, a 48 per cent return rate ($n = 190$) provides 2,261 vignettes as the unit of analysis so the findings can be deemed to be relatively robust in terms of the modelling conducted.

The method used, like any vignette-based research, is open to criticism that it is unlike real-life situations and therefore not a valid measure of decision making. Critics of the survey method argue that it measures hypothetical decision making rather than the actual process. It is not possible for vignettes to fully incorporate the work demands, complexity, uncertainty and emotional pressures that practitioners face as part of their day-to-day role. Equally, the content of vignettes is open to interpretation or misinterpretation by respondents. The variance explained by the models (i.e. using the R^2 statistic) was acceptable for social care research, where a number of factors cannot be taken into account; however, it should be recognised that a large proportion of variance was left unexplained.

The key findings were:

(1) recognition of abuse was influenced particularly by type of abuse, and also by frequency of abuse and victim wishes;

(2) reporting of abuse was influenced particularly by frequency of abuse and also by type of abuse and victim wishes;

(3) contextual case factors (age, gender, health condition, etc.) did not significantly influence recognition or referring of abuse;

(4) while there was some consistency in recognition and referring in extreme cases, there was disparity in the more ambiguous vignettes;

(5) the majority of vignettes evoked identical ratings on both abuse and recognition scales; however, in 25 per cent of cases, referring behaviour was higher or lower than abuse recognition.

The influence of case factors

The most influential factors were related to the actual abuse, with type and frequency of abuse being the most influential factors for recognition and reporting. This finding is echoed in existing studies of elder abuse (Bell *et al.*, 2004; Wolf and Pillemer, 2000) and child abuse (O'Toole *et al.*, 1999; Garrett, 1982). Victim wishes were also found to be significant. Together, the factors of type and frequency explain less than 17 per cent of the variance in decisions but they do seem to represent a 'fast and frugal heuristic' (Gigerenzer and Goldstein, 1996) used by practitioners to assist in decision making. Heuristics have been described as a quick and easy, but largely unconscious, process for decision making (Tversky and Kahneman, 1974). In extreme circumstances such as 'hit in the face with a fist on many occasions', the type and frequency heuristic is effective but Lauder and colleagues' (2006) concern about applying global judgements to specific settings is equally apt.

Client wishes

The client's wish for, consent to or request for an investigation had a direct impact on recognition and referring behaviour. The client's wish for no action to be taken had an impact on referring behaviour but this was shown to be dependent on the capacity of the individual. ANOVA indicated a significant interaction ($F(9, 2245) = 3.710$, $p < 0.0005$). This suggests that client choice is respected where the individual is decisionally competent. In particular, practitioners seem to be influenced by a client's request for an investigation but not by their reluctance to participate in further action. This may reflect a recognition of the possible presence of coercion or fear.

Despite being identified in qualitative research (see above), contextual case factors have not been shown to have a statistically significant impact on abuse recognition or referring behaviour. Age, gender, condition, capacity, client behaviour, family carer stress, family carer factors or adverse outcome have not played a role in explaining the variance in the dependent variables. This may be a literal interpretation of the broad definition of *vulnerability* that is used in UK policy and guidance (Department of Health, 2000). Further research is required to establish whether professionals would be prepared to classify older people as not vulnerable in certain circumstances.

Consistency in recognition and referring

Standardised vignettes included in the survey tool allowed the consistency of rating to be evaluated on identical vignette factors. Analysis of these vignettes indicated a reasonably high level of consensus in the most abusive cases (cf. Garrett, 1982) but much less consensus for more ambiguous cases. This challenges the assertion about a general lack of consistency in 'identifying, documenting and reporting abuse of older people' (Richardson *et al.*, 2002, p. 335) but suggests that existing policies and definitions fail to adequately address the complexity of some cases.

The inconsistency in recognising and reporting abuse may indicate that current definitions are inadequate or poorly understood. A lack of consistent application of policies is reported in much of the literature (Mathew *et al.*, 2002; Sumner, 2002; Manthorpe *et al.*, 2005; CSCI, 2008; McCreadie *et al.*, 2008). As regional guidance has only recently been introduced, it is understandable that discrepancies might be noted. The findings illuminated the inconsistency of reporting that needs to be further investigated.

Practitioner autonomy

There was a tendency for respondents to provide identical ratings on abuse and recognition scales indicating that they perceived the level of abuse and the need to report as identical. However, some practitioners were prepared to under-report (17.4 per cent, $n = 393$) or over-report (10.7 per cent, $n = 241$) based on the wishes of the client, training and board area. The presence of under and over-reporting suggests that some practitioners are engaging in ethical dilemmas relating to the most appropriate response to identified abuse. Webster and colleagues (2005) found that teachers over-reported on only 4.2 per cent of vignettes relating to child abuse but under-reported in a much larger number of vignettes (33.2 per cent). They point out that over-reporting is in line with policy requirements in the USA, where teachers and other 'mandated reporters' are required to report suspicions as well as confirmed abuse. Similar policy requirements exist in Northern Ireland, where 'everyone working with vulnerable adults has a duty to report suspected, alleged or confirmed incidents of abuse' (Regional Adult Protection Forum, 2006, p. 21), although guidance in other regions of the UK has no such mandating of reporting.

Webster and colleagues (2005) related the high prevalence of under-reporting to characteristics of the teacher and the school. Similar 'barriers' to reporting have been identified in studies of doctors' reporting of elder abuse (Anetzberger, 2001; Rodriguez and colleagues, 2006) where a mistrust of protection services and reluctance to cede control were important factors. The majority of participants in this study undertake occasional

investigations as part of a wider support role. The presence of both under-reporting and over-reporting suggests that some practitioners are engaging in ethical dilemmas relating to the most appropriate response to identified abuse.

Binary perceptions of abuse

A substantial group of respondents provided maximum scores for abuse (20 per cent) or referral (15 per cent) in every randomised vignette, although most used the rating scale to differentiate levels of abuse and referring behaviour. It would seem that a substantial minority of respondents perceive abuse as black and white rather than as a spectrum to which thresholds are to be applied (Collins, 2010). This may indicate that they are particularly *risk averse* (Taylor, 2006*a*). Gambrill (2005) has described this process and highlighted the potential dangers:

> The tendency to use a binary classification system, in which people are labelled as either having or not having something (for example, as being an alcoholic or not), obscures the many patterns to which vague terms may refer and isolates those labelled from normal people (Gambrill, 2005, p. 169).

This binary classification may be a literal interpretation of the requirement to report suspected, alleged or confirmed abuse. In contrast, the majority of respondents seemed to conceptualise abuse in order of severity to the victim. Extreme cases were rated higher than more ambiguous or complex cases in which contextual factors might be influential.

Implications for practice

As adult protection services develop, they have the potential to establish a range of services in addition to limited investigative processes. Douglas (2004) recommends engaging with clients to construct a 'middle way' that balances support and protection. Such an approach could only be initiated on a top-down basis, and would require commitment and courage from professional and agency leadership. The effective protection of adults also requires a responsive service that can offer support and services at the early stages of abuse (Brownell, 2005; Manthorpe, 2006). Lithwick *et al.* (1999) adapted the 'harm reduction model' previously used in relation to substance abuse, to provide a 'conceptual base for interventions' (Lithwick *et al.*, 1999, p. 108). This model emphasises the importance of a 'value-neutral' approach that does not judge the client or the family carer. Lithwick suggests that a resolution rather than a blame orientation would assist professionals and participants in supporting change. The client-centred ethos of harm reduction promotes choice and ensures that the process is conducted at a pace that is acceptable to the individual. Most

importantly, the harm reduction model allows a range of policies to be tailored to address specific aspects of abuse. Some progress in developing 'mid-range' policies to assist in applying global guidance to practice has been achieved in a Scottish government publication (Kalaga and Kingston, 2007). The authors provide comprehensive definitions and characteristics for sub-categories of abuse and analyse the necessary response for each, including *primary* or preventative interventions, *secondary* investigative interventions and *tertiary* remedial interventions.

Conclusions

This study has shown that the factorial survey can be a powerful tool to investigate professional decision making contributing to an empirical as well as theoretical understanding of the process. The models used were helpful in explaining some of the variance in professional decisions about abuse. Event factors like type of abuse, frequency of abuse and victim wishes were shown to have a statistically significant effect. There was evidence of complex interactions between other factors that will require further investigation.

It seems that, in clear or extreme cases, practitioners are prepared to follow procedural guidance but, when faced with complex ethical dilemmas, they may act more autonomously, using their assessment and relationship skills to weigh up the available information (Preston-Shoot and Wigley, 2002). The finding of variance in professionals' recognition and reporting of abuse is important and requires further study. Further research could also be conducted to clarify the judgements that protection workers make and the complex ways in which case, practitioner and agency factors interact.

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