

# Feeling Safe? Feeling Vulnerable?

Exploring Older People's Views and Experiences of  
Safety and Vulnerability in Everyday Life

Final Report

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## Introduction

This report presents the findings of a study conducted by researchers at the University of Stirling in collaboration with Ceartas Advocacy, Kirkintilloch, and some of their members who are older people. The study ran from January 2017 to July 2019. The aims of the study were to explore what it means to feel safe, what it means to feel vulnerable, and how we can best research these experiences in the context of everyday life. We aimed to develop and share learning with other older people, carers, professionals and policy-makers; and also to pilot methods for a larger study in the future.

The study was prompted by developments in adult protection procedures, policy and legislation over the previous two decades: most significantly the Adult Support and Protection (Scotland) Act 2007 and its equivalents, for instance the Care Act 2014 in England. These developments have prompted some research, including our own (Altrum, 2011; Mackay et al. 2011, 2012; Preston-Shoot & Cornish, 2014; Sherwood-Johnson 2014). However, only a minority of this research focuses on older people's perspectives, and important gaps remain in our knowledge of these. Evaluations of policy implementation or practitioners' knowledge and skills in the procedural aspects of working with risk, in particular, can fail to connect with older people's own priorities, meanings and experiences of keeping safe (Sherwood-Johnson & Mackay, forthcoming). This study responded to these gaps.

Wider health and social care policy drivers include self-directed support and self-management aimed at increasing user control. However there is a tension between this body of policy and research, and that concerned with vulnerability, capacity and abuse because the two have developed in parallel with little interaction (Hunter et al 2012; Manthorpe et al, 2010). Similarly, whilst the wider field of ageing research includes studies of wellbeing (Hoban et al., 2011; Ward et al., 2012) and older people's perspectives on good care (Manthorpe et al., 2008), there is an urgent need to build bridges with the field of adult protection, in the context of which these issues become both more complex and far less well researched. One way we have sought to do this here is to focus on the nature and causes of 'safety', in a break from mainstream safeguarding research, which tends to focus on reactive interventions. We aimed to contribute to knowledge about the *prevention* of vulnerability, abuse and neglect, in particular by harnessing and disseminating older people's own insights and wisdom.

The research questions for the study were:

- What do 'safety' and 'vulnerability' mean to older people living in the community who are supported by health and social care services? How important is safety in their lives?
- What resources/sources of support do older people draw on to manage vulnerability and secure safety? What other factors impact on their safety/vulnerability?

- How might improvements be made in the ways that older people in the community are able to keep and feel safe?
- What might be the best methods of capturing this knowledge?

In the following section we describe how we used a participative methodology to explore these questions.

## Methodology

This section summarises work undertaken in each of the three stages of the project. The ethical and methodological learning that will we take forward into a future project is highlighted in the Findings section.

### Stage One

The aim of Stage One was to explore, through two focus groups with older people, their understandings of safety and vulnerability; and to discuss the methods we might use in the work with individual older people in Stage Two. Ethical approval was obtained from the University and Karen Heath, our named liaison worker, at Ceartas Advocacy Project recruited volunteers using the information sheet and consent form designed for this purpose.

#### *Participants*

The first focus group was attended by five older people, two of whom came with a supporter (a befriender and a carer). The second focus group was also attended by five people, two of whom attended the first. The variation in attendance in itself was not problematic though it did highlight the health issues and caring demands some of the participants from focus group one faced.

#### *Process*

In focus group one we used a range of tools to stimulate discussion: a collection of everyday objects; photographs and video clips developed by Age UK titled 'Older people talk about their desire to remain independent' to stimulate discussion, which was audio recorded for full transcription. The participants shared a range of experiences: the significance of a 'safe' home; accepting or otherwise other people's safety advice; relational tensions about perceived vulnerability within families but also with NHS and social care practitioners; and how past experiences of their own ageing parents and the way they had lived their lives up to this point might affect their views about safety and the choices they might now make.

In focus group two we used photographs to share the key themes that came out of the first group and this afforded the opportunity for new participants to add their own perspectives. Secondly, images depicting the possible range of research tools were used to gain participants' views of their potential use for Stage Two (see *Appendix One*). Most participants



*Figure 1: In focus group one we used a collection of everyday objects to stimulate discussion about safety and vulnerability.*

preferred methods that were around personally interacting, in a 'more conversational' way, with the researcher, rather than tools that they would use themselves. This reflects that most participants did not use mobile phones or computers; or/and had impairments that might make hard copy tools onerous or impractical to use. They were, mainly, not keen on filming or taking photographs. Some liked the idea of having notebooks to jot thoughts down but they did not wish to write a more formal diary. One suggestion by the researchers - drawing a life map - was welcomed as a few thought it would help them think about past events and how they might have affected perspectives on safety and vulnerability. Some people thought that it would be acceptable to show the researcher around their house and their community to get a sense of their daily lives; others just preferred meeting to discuss their thoughts. The researchers' suggestion of meeting with the older person and someone else who was significant in their life in terms of safety was welcomed by one participant who had paid carers but the others did not think that this would work for them.

## Stage Two

The aim of this stage was to work on a one to one basis with six older people to explore safety and vulnerability in everyday life using the methods identified in Stage One. Further ethical approval was required and successfully granted.



*Figure 2: In focus group two we used photographs to reflect the themes arising from the first focus group.*

### *Participants*

Six participants from the focus groups volunteered for this stage. Unfortunately one volunteer died shortly afterwards and another's participation was cut short in line with our ethical protocols regarding ongoing consent. This meant four participants completed the period of data collection.

### *Process*

Each participant was paired with either Kathryn Mackay or Corinne Greasley-Adams and met with them on a series of occasions over three months. They had control over the methods used to generate their data. Informal interviews were most commonly used, either individually or occasionally together, in the case of one married couple who both participated. Walking tours of participants' local areas and daily activities were also used with three participants and data were captured using photographs and researcher diaries alongside interview transcripts.

Following this one-to-one work, each participant met with both researchers to review their contributions. The purpose of this was to identify the key points arising from their data, to ensure the researchers had understood these accurately, and to agree which points could be carried forward for discussion in the collaborative analysis workshops at Stage Three.

### *Stage Three*

Two collaborative data analysis meetings were held, the first in August 2018 and the second in November 2018, and all the remaining Stage Two participants were invited. In the first meeting we presented the initial themes from the data. Participants then discussed anonymised quotations and debated under which theme they might place each quote. This helped to inform the full thematic analysis conducted by the researchers following this meeting. The second meeting presented the draft final themes and opened up discussion of possible research outputs.

Other aims of Stage Three were to write up the research report, develop outputs with the participants and start to disseminate findings, as well as to make longer-term plans for publications and developing a fuller research proposal. The fact that we had a small target number of participants for Stage Two meant by the end we were relying on three older people to help with this. We therefore had to balance what we would like from them and what they wanted or were able to do. As a result this stage was not as participative as the others.

### *Outputs*

- This report has been drafted by the researchers and a draft of the findings section has been reviewed by three participants with some small adjustments made.

- We have developed some audio recordings of participants talking about safety in their lives, to illustrate some of the key themes identified in the data, and to serve as a dissemination and training tool for professionals, carers and other older people. These will be available on a time-limited basis on the project website.
- A visual tool for use by professionals in conversations about risk is also under development, adapted from the resources we used to support research conversations with one of our participants. This will also be posted on the project website soon.
- A series of papers for publication in academic journals is under development, with the first to be submitted to the British Journal of Social Work in late 2019 or early 2020.
- We are continuing to explore avenues for publication to reach a practitioner audience: e.g. Professional Social Work and/or Community Care magazines.

#### *Dissemination to date*

- We spoke to a group of other older people about the project findings for the first time at the Kirkintilloch Dementia café on 29<sup>th</sup> March 2019. Two researchers (Fiona Sherwood-Johnson and Corinne Greasley-Adams) and two research participants attended. We used a summary of older people's safety strategies, and a series of quotations to stimulate discussion. Our input was positively received, with attendees engaging actively and further expertise in keeping safe shared amongst the group.
- We are presenting our findings to health and social care practitioners for the first time at the East Dunbartonshire Adult Support and Protection conference on 20<sup>th</sup> June 2019. We then aim to speak at other local multi-agency Adult Support and Protection conferences in subsequent years.
- We are planning an event at Stirling University on 25<sup>th</sup> June 2019, for practitioners all over Scotland to hear about and discuss the application of the findings.
- We have been accepted to present our findings at the national conference of the British Society of Gerontology in July 2019.
- We have also been accepted to speak at the Scottish national Action on Elder Abuse annual conference in September 2019.
- We plan to submit an abstract in response to the call for papers for the European Social Work Research Association annual conference in 2020.

## Findings

We present an overview of the findings here under the original research questions. In doing so we draw upon data from both focus groups in Stage One, the one to one exploration with participants in Stage Two, both data analysis workshops and the researchers' own reflective



diaries. Each participant has been given a pseudonym and other identifying information has been anonymised.

### 1. What do “safety” and “vulnerability” mean to older people living in the community who are supported by health and social care services? How important is safety in their lives?

We found that participants attached their own meanings to the concepts of safety, vulnerability and risk. Definitions were created in the context of particular relationships, communities and physical environments, and they were also influenced by changes in the participants’ lives and contexts over time. Below we discuss personal, relational and environmental factors that: a) influenced participants’ perspectives on safety, vulnerability and risk; and b) influenced the importance that participants placed on safety in their lives.

*Personal:* First, people’s own personalities and preferences influenced their definitions. For instance, vulnerability for Bob, one of the younger older people who participated, was about the personal qualities on which he prided himself:

But at this point in my life, I'm 65 this year, I do not feel vulnerable in any way, shape or form. And I think it's because of my mental attitude, if that's the right word to use. I think it's because my attitude in life, it's because, as I said earlier on, I was dragged up instead of brought up. ... that's gave me, well, if somebody comes to the door, they're not wanting to do it with me, I'll just tell them straight, I don't care.

*Bob, Focus Group 2*

People’s perspectives were also shaped by prior experience. For instance, Jean recounted an incident involving the loss of a wheel of her mobility scooter, to demonstrate the risk, as she perceived it, of becoming stranded; this incident had influenced her to always carry her mobile phone. Conversely, where events may have been particularly traumatic, some participants did not wish to speak about them and their impact on their thinking. For instance, Carol had had a fall, and consented that this appear in the dataset as an element of her past and a risk for some. However, she diverted discussion from her own experience of falling unless with certain trusted people, which seemed in itself to function as a safety measure for her. It is important to take from this that some factors impacting on people’s approach to risk and safety might be intensely private.

Another personal theme was the sense of security gained from remaining in a home that had been lived in for a long time rather than moving to what others might regard as a more suitable place. Jack had lived in an upstairs flat all his life and he felt strongly attached to it. Margaret speaks powerfully of this sense of home being stronger than the perceived vulnerability of isolation:

Researcher:	How do you, can we ask, how do you feel about living on your own, if I can ask that?
Margaret:	Actually, I quite enjoy it, but you're lonely at times.

Dave: Aye.  
Margaret: And you feel vulnerable.  
Dave: Aye.  
Margaret: But I don't want to give it up, yet.

*Focus Group 1*

This is a good example of the ways that participants sometimes prioritised their sense of who they were and what was important in their lives, over measures that others might consider to be advisable to reduce vulnerability.

Finally another aspect, shared particularly in Stage Two, was of participants becoming more aware of safety issues and perceived increased vulnerability as they got older, or as there were significant changes in their health. For example Jean spoke of being more wary now of asking strangers for help than when she was younger and in some ways this was reflected by others who talked of doing things for themselves to show that they were still independent. Jean and others also spoke about an increased sense of vulnerability when going out at night:

...it's dark and also I feel so much more less able because I get very tired in the evening as well, ... sort of at that particular time. But I don't know whether people feel...I don't know what it is that makes you feel more unsafe; probably because you get out of doing it. You don't do it very often. I expect there's young people who are out and about in the dark so often and as you get older you probably don't...

*Jean*

At the same time some participants spoke of ageist assumptions professionals had made about them: viewing them as more vulnerable and less independent than they were. In response participants had often resisted this label and either challenged the person directly or found ways around the presenting issue themselves. This will be discussed at a later stage in the findings.

*Relational:* Perspectives on risk, safety and vulnerability were also developed within relationships. For instance, Jane had been married to Harry for many years. The risks she focused on were often risks to Harry, such as the risk of his coming to physical harm, or having unmet needs for personal care, or being treated less than respectfully in a particular care facility. These were physical risks to him but emotional risks to her: she felt responsible as a carer and did not want to see him hurt. Similarly, Jane's close relationship with her son affected what vulnerability meant to her:

I mean, I do, at times, feel vulnerable. Like, this week, my son's away, and I know it's not right, but I feel a lost soul when he's away.

*Jane*

There was a practical element to this, in that this son was otherwise on hand to give a range of support to both Jane and Harry as required. However, Jane's turn of phrase here is also suggestive of something rather deeper: specifically, the inseparability of ideas about her personal safety, from her core sense of herself as connected to husband and son in caring relationships marked by give and take over time.

There was a strong sense of reciprocity in many participants' reports of their family relationships. That is, care was not one way: rather, family members supported each other, albeit in different ways and in ways that had changed over time. It was important to participants' sense of their own identities for this to continue. Relationships also extended to pets, and several participants spoke of the important role they played in their lives in terms of feeling safe but also being a source of comfort and joy:

I love her to bits, and she'll climb over and she just wants a cuddle.

*Jane*

The importance placed on pets is another example of people's emotional attachments and need to give as well as receive care being prioritised over more pragmatic considerations, like the extra expense and efforts involved in their care.

Whilst people's sense of safety often derived from the closeness of family, there was a sense that notions of risk, safety and vulnerability could also be a site of negotiation. At times some relatives could be seen as being more risk averse and viewing the participant as more vulnerable than they felt themselves to be:

Jane: And do you not drive now?

Margaret: Well, according to my sons, I can't do anything, you know what I mean.

Jane: Oh, I know the feeling.

*Focus group 1*

Participants then needed to make judgements about when to stand their ground and when to compromise, as we discuss further below.

People's relationships beyond the immediate family unit also helped to define them and their ideas about risk and safety. That is, some people knew their neighbours better than others; some people had wider networks than others through volunteering, community work and other connections; and some people placed greater significance than others on being part of and maintaining these types of connections than others. It is also worth noting a tendency to draw on the stories of others in the participants' families and wider communities, to make sense of safety, vulnerability and risk. Sometimes these could have an impact on how participants then acted. For example the house burglaries in the area or a friend with dementia who left the house to go for walk and died of exposure in nearby hills. In the former case the participant who spoke about this described how she would double and triple check that all doors and windows were locked prior to going to bed. The latter case was cited by Dave, who also had dementia, as a reason he was happy to carry his mobile phone with him at all times.

*Environmental:* People's perspectives on safety were also connected to their interactions with their own environments. For instance Carol used a wheelchair and she felt uncomfortable in crowded places:

Carol: Sometimes I bump into people and I don't want to. ...  
Researcher: Yes. So, that makes you feel bad.  
Carol: It makes me feel nervous.

For Jean it was particularly important to know her physical surroundings well, so she could negotiate them with her mobility scooter.

We found that some environments were particularly problematic for people with certain impairments. For instance, some participants felt particularly unsafe in a local shared space, because there is no defined edge to the kerb and the textures of the paving are difficult to make sense of, particularly for people with conditions affecting their vision. Elsewhere, facilities like crossing places could be less than accessible due to the positioning of the button or the lack of turning space afforded to wheelchairs and scooters. These issues were particularly highlighted by Jean who used a mobility scooter and had restricted mobility in her upper body. This meant she struggled to reach some crossing point buttons or to see some 'green men', nor did she feel she could check the traffic in all directions quickly enough, to make safe use of the shared space.

Changes in the physical environment could be significant as well. In particular, during the period of data collection there was a spell of intense wintry weather that made pavements very slippery, whilst the dumping of excess snow on the kerbside made traversing the road treacherous for scooter users and others. Some participants were stranded for a time at home, and different resources were drawn upon in different ways than usual: for instance, Jane's son took her out shopping and Jean went out in a taxi rather than her mobility scooter. Whilst resourcefulness, then, was not in short supply, this did serve to bring home the reliance of participants' key strategies for daily life on the features of a physical environment that could quickly change. Wheelie bins day and road works were other examples of temporary obstacles for wheelchair and buggy users.



*Figure 3: Aspects of the physical environment affected participants' sense of safety*

## 2. What resources/sources of support do older people draw on to manage vulnerability and secure safety? What other factors impact on their safety/vulnerability?

The above discussion about the meaning of safety and vulnerability has already begun to highlight that participants used their own resources; those within their families and within their communities to manage vulnerability and secure safety by their own definition of these terms. This section explores personal resilience, ingenuity and aptitude; the negotiation that takes within relationships; and connectedness within communities.

*Resilience and Resourcefulness:* Participants drew on a range of personal resources to manage the competing demands identified above and to keep themselves as safe as they wished to be. No other type of resource was commented on so commonly, in fact. Examples of personal resourcefulness included the development of strategies for managing particular risks, such as Sue's for overcoming memory problems in juggling her social and other commitments:

Write things down, when you remember them. ...Or if you get into a phone call and you want to do anything, write it on the calendar, right then and there, what you want to do, otherwise, you will forget it.

*Sue, Focus Group 2*

Similarly, when Jean experienced some incidents of not understanding what a person was telling her in social situations, she sought out support and devised a card, with help, that can be handed to the person she is with if she gets into difficulties. On one side it reads: "Sometimes I have difficulty following verbal instructions. Can you show me another way please?". On the other side it reads: "Please give me 5 minutes to sit quietly". It was particularly notable that Jean pursued this course of action after rejecting the advice of another professional, who advised her not to go out to anywhere that she wasn't known.

People's strategies for keeping safe were evident in the ways they had adapted their homes to reduce mobility and memory issues. Participants kept key things like diaries, phone books etc. close to where they most often chose to sit. Home itself was a significant source of feelings of safety for many participants, in both a practical and an emotional sense:

But it's easy to tell people, oh you need to go into a home, but then you take everything away from them.

*Jane*

Here Jane and others mean furniture, kitchens arranged just so and the smaller personal items such as photographs. Rather than move some participants had adapted bathrooms and had stair lifts installed. Physical aids, grab rails, specially adapted furniture, community alarm bracelets and call screening technology were all part of people's strategies for keeping and feeling safe.

Sometimes participants had developed considerable expertise in a particular area, in the course of devising their own strategies for keeping themselves safe. For instance, Jack's active involvement in various groups led him to become expert in various supports for older people: from types of call blockers and benefit entitlements to independently sourcing the type of footwear that met the professional advice for non-slip shoes but were comfortable to wear in the home. Similarly, Jean was able to advise others about various models of mobility scooters and walkers and further adaptations that might be made to these.

Other personal resources drawn upon by participants were emotional and/or psychological. For instance, there were suggestions in many participants' accounts of great adaptability and resilience in the face of change and loss:

Dave: But as time goes on, as I found out, you have to re-evaluate.  
Bob: That's what I was just saying, aye.  
Dave: You have to re-evaluate.  
Researcher: So what do you mean, Dave?  
Dave: Well, you say, well, I can't do that anymore, but I can still do this.

*Focus Group 2*

As might be expected, several participants whose strength of character generally kept them going nevertheless reported feeling vulnerable and despondent at times:

I can hold my own, but sometimes when I've got Harry to bed at night, I just sit here and I lock the door, and, och, I don't know, I feel sorry for myself, and I sit, bubbling. But you just have to dust yourself down, and get up and get on with it. There's nothing else for it.

*Jane*

The emotional impact of "holding [your] own" is not just a question of personal resourcefulness but also about the family, friends and support workers; and this is addressed in the next section.

*Navigation and negotiation:* In participants' relationships with relatives, friends and professionals, different people's definitions, priorities and means of keeping safe could be in alignment or could exist in tension. Participants were all engaged, then, in an active process of negotiating a path through this terrain. Sometimes, as we have seen, participants strongly resisted the identities and means of keeping safe proposed or imposed by others. For instance, Jane insisted on going out shopping with her son in the snowy weather, although he'd have rather she had stayed at home, whilst there was an ongoing tension for Harry between what he felt able to do and what his family felt that he could do. It was very important to some participants to do as much as possible for themselves. Meanwhile, other participants, in different contexts, had different perspectives on independence, age and the acceptance of support. For example, Carol had drawn on the support of paid workers for most of her adult life, and continued to do so in her later years without this challenging her sense of who she was.

Other negotiations took place internally, between participants' various priorities and concerns, of which keeping safe was only one. This sometimes happened in ways that were more instinctive and

often unquestioned. For instance, it was second nature to participants on a number of occasions, to behave in ways that would lessen the concerns of those they loved:

My wife, particularly, likes me to carry it [*phone*] with me at all times.

*Dave, Focus Group 1*

...there's fifteen stairs at the back of the house I can get down... I don't go... Jane doesn't like me going out.

*Harry*

There were also examples of participants balancing risks to themselves against risks to their significant others. For instance, Jane was well aware of the practical arguments for needing some time for herself, and had the offer of a holiday that she would have liked to take up. However, no substitute care arrangement proved suitable for Harry.

I said, I couldn't do that to him, I couldn't go to my bed and sleep at night, knowing that I'd put him into a place that he hated.

*Jane*

Here again we see the ways that people's core sense of themselves as connected in relationships could be prioritised above more pragmatic considerations to do with personal safety and wellbeing.

*Connectedness and Communities:* Participants lived in different towns and villages in a central Scotland local authority area. Some were active in various community groups and had no formal support services coming into the home; and some were more home-based due to their health or caring responsibilities. Some had connections with neighbours who were helpful even in minor ways such as putting out bins on pavements. There were a range of experiences of family contributions though most reflected on the relative lack of families living locally, and there was a general feeling that family support had declined since the networks participants had contributed to in their younger years.

My mother didn't... she lived on her own, but she had, for most of the time, she had two relatives living just round the corner, two of my aunts just lived round the corner. ...Plus, she came, we went over to see her every weekend, and then there were other times, she came over to see us.

*Dave, Focus Group 1*

So, I would say that, loneliness is a big part of old age. I mean, when I was young, we all went to our granny's on a Sunday, and everybody took something, and the kids all got fed first. You don't get that now, not to the same extent.

*Jane*

The broader contributions of communities to participants' sense of safety was wide-ranging and varied from individual to individual. There were examples of the community as an asset in keeping and feeling safe. For instance, Bob's experience of his hometown was that everyone looks out for each other, whilst Jean reflected on supportive attitudes and practical help from some shop assistants and

fellow shoppers when out and about. Nevertheless, there were also examples of gaps in community support and of risks arising from communities. For instance, Jack regretted having minimal contact with his neighbours, whilst Jean had experienced verbal harassment from local youths. As highlighted above, the accessibility of communities could be constrained by road and pavement design and poor weather.

Again like family relationships, there was a sense of reciprocity in many participants' accounts of their community connections. That is, friendships and relationships with neighbours were not cultivated in an instrumental way to meet participants' needs, but were mutually supportive with an emotional dimension. Furthermore, some participants gained a sense of purpose and connectedness from activities in their communities that were focused largely on supporting others. For instance, Jean had been involved in a lot of disability advocacy work and Jack volunteered for the Citizens' Advice Bureau. This re-emphasises the difficulty of separating individuals' own strategies for keeping themselves safe, from their roles in both giving and receiving care within a community of others.

### 3. How might improvements be made in the ways that older people in the community are able to keep and feel safe?

This section pulls together key points that the participants offered. There is a focus on messages for professionals and broader services, including aspects that participants valued and aspects that could change. More generally, it is also important for professionals and services to note that feelings of safety are strongly linked to a sense of identity, role and place, as detailed above.

*Professionals and home support workers:* Participants who had contact with NHS and social care services spoke of the importance of developing a relationship of trust, and of the importance of relational skills and values above qualifications and technical competence alone. Some support workers were experienced as unequivocally helpful. For instance, Carol worried about her finances at times, and really appreciated her support workers' assistance in managing these. Jean was impressed by the way staff at her Falls Clinic supported her independence. In other situations, participants' more mixed experiences of professional intervention helped to illuminate what they valued most. For instance, Jane reflected on her experiences with two health/social care workers:

And one came, and she was a young girl... And I've no doubt she's got all her qualifications, but it was like talking to a book, you know. And I thought, no, I don't really want this, I don't want bogged down with this. So I phoned [name], and I said to her, I don't think this is gonna work. I said, I don't feel a connection with this girl...whereas I've only spoken to you on the phone, but I feel I'm on the same wavelength.

Jane

Jane underlined on several occasions the over-riding importance of this type of connection to her, and was hugely appreciative of one social care particular worker, with whom she had a close relationship.



Other observations concerned consistency and timekeeping. Harry coped less well with too many new and different care workers. This was similar to Carol's experience, as good relationships and consistency of support staff were important to her too. If she had a new worker she would be less likely to get out and about in her community and it seemed only one support worker supported her to access her email.

Some participants like Jane and Jack were proactive in their interactions with professional services and workers. These negotiations arose because participants' priorities and perceptions did not necessarily match professionals' and/or services' own. For instance, Jane clearly felt that she valued qualifications in a worker less, and interpersonal connection more, than those allocating a worker to her. Jean had priorities over and above the completion of the tasks that homecare workers might take on:

I don't have any care, ...But I sort of feel more independent to organise my life, than when I had a carer coming in, you know....Even if it's more work, and it doesn't get always done, you know.

*Jean*

At times, these clashes of priority and/or perception played out in the context of a considerable imbalance of power. For instance, Bob felt that medical advice to curb physical activities like biking and jogging might be unduly risk averse, but nonetheless might go unquestioned by many older people. Harry described an occasion in hospital when he felt that a staff nurse was unjustifiably constraining his freedom, and using sectioning under mental health law as a threat. In these types of situation, participants characterised professional intervention as something to be struggled against, or at least to be managed carefully, in negotiating their preferred routes through matters of risk and safety. At such times the support of a family member and/or advocacy worker might be required to get older people's voice heard.

One explicit concern, and reason why some people did not use home supports, was the lack of confidentiality displayed by those workers.

Jack: And as they say, when carers come about your house, to keep personal things out of their road. It's better if you don't get carers belonging to where you are....

Jean: Yeah, I agree, because I was in the [named place] one time, and there was a group of carers using names, and they were talking about the people....That's enough to put me off, you know....I really wanted to confess to the local authority. Because they were using people's names, and discussing their homes, and all this kind of thing.

Jack: Oh, aye.

Jean: Which is awful, I feel they should not be doing that in a public place.

*Focus Group 2*

It is worrying if concerns of this type are deterring older people from taking up support which might otherwise support their safety.

*Community services:* Sometimes services such as Care and Repair fell short of expectations or were not experienced as suitable at all.

But when I phoned them – no, we don't do that, we don't do electrics, we don't do gas – that's understandable – and we don't do anything like that. ...there's a lot they don't do, and there's a huge waiting list.

*Jane*

Conversely, Jean had experience of Care and Repair services referring older people on to other trusted traders, if they couldn't do a job themselves. Consistency of this practice was felt to be important, particularly in the context of wider concerns about rogue traders taking advantage of older people.

The bus frequency and routes featured a lot in conversations by those who relied on them. One researcher witnessed, with Jack, the variability in bus drivers' responsiveness to mobility needs. For example there was a cursory response to Jack's observation about a broken bell. In one instance there was a bus service, now called My Bus, designed to help people get into a larger town, but the timings were awkward:

...we have the Dial-a-Bus but I tried to go to the supermarket twice and you've to wait an hour on them coming back. It's no use.

*Jack*

As highlighted above roads and routes through communities could be experienced as a source of risk or at least a barrier to independent journeys. This has implications for civic services. Jack was mindful of a busy road that lay along his usual route to town where there did not appear to be any safe crossing point. Poorly maintained pavements were experienced as a trip hazard, or made negotiation with a wheelchair or scooter difficult and uncomfortable, and routes could be blocked during times of heavy snow. It seemed at times priority to keep traffic moving could come at a cost to pedestrians. If pavements are an issue for older people then they will be so for children.

*Service delivery trends:* In a discussion of avoiding isolation, participants at one focus group also noted the negative impact on older people of reductions in low-level support such as regular visits from a community nurse. This reflects the wider service trend of reducing visits to individual homes and concentrating services in buildings which the public can phone but not necessarily easily access.

*Accessing money and banks accounts:* It is interesting to note that most participants preferred to go into banks and their removal from the communities the researchers visited had not yet occurred. This is a concern more widely across Scotland, however. In addition, whilst local post offices have been sited within shops, this was a cramped affair in one village visited, which raised concerns not only of accessibility but also of confidentiality. Several participants actively chose to withdraw money within shops rather than from cash machines in the street where they felt more vulnerable. Some of the busier supermarkets in some cities have stopped giving cash back if there is an external machine. Any roll out of such a policy to smaller communities could increase rather than decrease such vulnerability.

In summary this pilot study has also highlighted a number of important messages about health and social care professionals, more mainstream services and wider town and economic planning trends that might not necessarily support accessibility, safety and a sense of connection to communities. The dissemination and outputs developed so far, and planned, aim to raise awareness of these.

#### 4. What might be the best methods of capturing this knowledge?

This was a pilot project and we hope to apply for further funding so that we can explore these important issues in more depth in different types of communities. In so doing we would wish to involve older people as before but also involve frontline health and social care professionals as action researchers so some of the learning can be immediately applied to practice. This final findings section summarises what we have learnt about the research process of exploring safety and vulnerability in older people's everyday lives.

##### *Methodological*

- Participants were more at ease in sharing experiences as they cropped up naturally in conversation but also wanted the researcher to have some specific questions to guide their meetings.
- Having a choice of methods was important.
- No-one chose the life mapping exercise. Perhaps it might best be used, if at all, when trust has developed between the older person and the researcher.
- Three people chose the walkabout and it produced valuable insights into the nature of road crossings, shop accessibility and trust of carers them keeping safe.
- A distinctive approach was developed with one participant who had significant communication impairments. Both researchers were present and a three-way conversation was planned, using photographs, wherein the researchers also shared their interpretation of the photographs. This had the effect of easing the focus on the participant who engaged in a more relaxed way than before. This will be an important method going forward as we do not wish to exclude people who might need more time and support to participate.
- Our approach to the review at the end of the one-to one-phase evolved each time it was undertaken: lists of safety and vulnerability themes were prepared in advance after the reviewer had read all that person's data. With one person these were shared with photographs. There are still questions about whether in a larger project the introduction of a reviewer who had not been met before might close down rather than open up discussion. The roles of both reviewer and the paired researcher need to be clear beforehand as the participant naturally looks to the paired researcher. Again in practice more of a three way conversation was developed.
- The review proved to be a good finishing point. Participants were able to withdraw information which on hindsight they didn't want to go forward; they were able to see how many valuable insights they had given; and they and researchers were able to reflect on the learning from the process.



Busy places

We spoke about being out and about in busy places. You said you didn't really like being in places where there was a lot of hustle and bustle.



Money

Some people have concerns about money and being victims of scams. You were not worried about this as you have support to manage your finances.

*Figure 4: We developed visual prompts to support conversations and review with one participant*

### *Ethical*

- This project confirmed the variable nature of consent and consideration needs to be given to the feelings of the person in how we finish the contact.
- Two participants shared very personal information. This highlighted how trust had been created in circumstances where the older people may not have had confidantes. Reflective diaries, discussion with the other researcher and seeking advice from a more experienced colleague was important in thinking this through. The researcher involved continually

checked in with the participants about what she felt they might or might not want to share. This helped them become quite adept at saying this is *not for the tape but it is important because it's about how I feel right now or what's worrying me*.

- The review was therefore important ethically not just to confirm what information could be used but also because it marked the end of the one- to- one research relationship. Invitations to take part in Stage Three helped to remove the focus from the one-to one back to the group as a whole.

## Discussion and conclusions

This study has identified that older people attach different meanings to the ideas of 'safety' and 'vulnerability', depending on their own characteristics, their relationships and their environments. Approaches to keeping safe have also often been influenced by key events in people's own lives and in the lives of others they know or whose stories they have heard. This variability in people's meanings and approaches with respect to safety and vulnerability, mirror similar levels of variability in older people's approaches to the subjects of previous related research: for instance elder abuse (Anand et al. 2013), risk (Mitchell & Glendinning, 2008) and independence (Hillcoat-Nalletamby, 2014; Rabiee, 2013).

The study has demonstrated the personal skills, ingenuity and resilience that older people were commonly drawing upon to keep themselves as safe as they wished to be. Other resources that they drew upon often resided in people too: for instance, committed carers and family members, supportive communities and professionals with whom they felt able to engage. Nevertheless, a degree of active negotiation was often required, by the older person themselves or/and on their behalf, to marshal these resources into their most useful form. Participants demonstrated skill and adaptability in this as well: for instance in negotiating with family members about the levels of risk that they felt able to tolerate, or advocating for what they needed with service professionals. In other instances, these potential sources of support could also be experienced as barriers to feeling safe: for instance, where professionals breached confidentiality or where family or community were less able to be supportive than the older person might have wished. The types of negotiation we witnessed in this study echoed the types of negotiations between older people and carers over risk observed by Clarke (2000), and the wealth of experience in negotiating risk that older people had built up over a lifetime observed by Bornat and Bytheway (2010). We have identified some particular ways in which professionals and services might develop their capacity to support older people's sense of safety, which are summarised below.

One important overarching finding is that navigating all this takes effort on the older person's part, and it also takes an emotional toll. Hence participants were drawing on great stores of their own strengths and resilience in weighing up their options and holding their own as need be, developing coping strategies, planning for environments not designed to be accessible to them, further adapting mobility aids etc. etc. Participants might experience a sense of empowerment on negotiating these complexities successfully, and indeed several people had developed significant expertise in aspects of

doing so, as we have discussed above. Equally, they might be left feeling drained, frustrated, disempowered or bereft, for instance where safety measures advocated or imposed by other people diminished the individual's own sense of identity and worth. These aspects of the findings echo Barnes et al.'s (2013) observations about organisational and emotional labour in the maintenance of well-being in old age.

A second important overarching finding is that participants seldom used the terms 'safety' or 'risk' at all, unless asked about these directly. That is, they did many things to keep themselves safe, by their own definition of this idea; however, these strategies were not clearly separable from participants' wider strategies for living well, in ways that kept them connected to their core sense of who they were, in the context of their important relationships. One result of this is that the study has echoed findings of other studies into topics much broader than views about risk: for instance older people's perspectives on wellbeing and their definitions of helpful services in more general terms. In particular, Ward et al. (2012) and Barnes et al. (2013) have also demonstrated the importance of relationships to older people's well-being, whilst a range of studies have underlined the importance of time-keeping, trustworthiness and consistency of professional health and social care support to older and disabled people, again to allow trusting relationships to develop (Altrum, 2011; Manthorpe et al., 2008; Rabiee, 2013).

The inseparability of people's sense of safety or vulnerability from their wider perspectives on how they wish to live their lives, their reciprocal commitments within relationships, their histories and environments and the deep sense of their own identities which is also intertwined with each of these, has important implications for health and social care professionals. Specifically, this underlines the time and care that needs to be taken to understand each individual's situation and perspectives, in order to be able to co-produce services that help them to feel supported and safe. Some older people, in some situations, may wish to prioritise other considerations than their own physical safety. Professionals and carers may need to revise their priorities, and these findings might aid understanding of the other types of factors that may be at stake where conflicting priorities arise.

Participants' accounts of their everyday lives in this study were largely reflective of the majority of circumstances, in which choices about these priorities lie with the older person. It is worth noting, however, that the relationship of autonomy to keeping people safe has been a subject of some particular consideration in instances where the capacity of older people and/or other adults to make decisions is in question (Fyson, 2009) and in instances where there appears to be a risk of considerable harm (Bergeron, 2006; Braye et al, 2017). Whatever the outcome of such practice dilemmas in respect of the actions taken, this research offers important lessons to professionals and carers about the emotional weight of this terrain for older people. Losses of abilities and independence can be very deeply grieved, and some measures that might be deemed necessary to support safety might nonetheless shake a person's core sense of their own identity. Resistance to particular types of action and also to particular conversations can be an older person's way to protect themselves emotionally, as well as to preserve their sense of who they are. Far from being confined to practical tasks then (Carey, 2016), significant skill and sensitivity is required on the behalf of professionals and carers, in order to help navigate an acceptable way through this terrain.

### *Summary of implications for older people and carers*

Older people in this study reported keeping themselves safe in a range of ways. A leaflet has been produced which summarises these: this has already begun to form the basis of dissemination to other older people and carers, will be drawn upon in future events and is available on the project website (<https://feelingsafe.feelingvulnerable.stir.ac.uk/>) for others to view and use. At a micro-level, we hope that some of these ideas may prove useful to other older people and carers too. Taken together, we hope that disseminating these findings will assist those facing similar negotiations to recognise the nature and complexity of the issues at stake, to validate their feelings and to help counterbalance more negative stereotypes by giving older people's strengths and resilience their due. Similarly, we think the findings could help support family carers and others who are close to older people to make greater sense of the struggles that can arise over risk decisions, in ways that empathise with the older person's own perspectives, respect their personal priorities and preferences and draw upon their strengths.

### *Summary of implications for health and social care practice and policy*

This study is an important supplement to existing research about keeping people safe, which may focus on professional assessments and practice, and may not focus so fully on people's own definitions of safety, their strategies for keeping safe, and the emotional and relational dimensions of these (Mitchell & Glendinning, 2008). In health and social care practice with older people, the study has outlined the importance of:

- Building a relationship of trust with older people. This means practitioners need sufficient time to get to know an individual and work at their pace;
- Exploring and respecting older people's own meanings and priorities with respect to safety;
- Acknowledging and appropriately accommodating older people's own strategies for keeping safe and living well;
- Understanding and being sensitive to the emotional significance of these issues and the implications for an older person's sense of their own identity;
- Appreciating that, whilst some people like to reflect on their everyday lives and the challenges and risks they have faced, for others these may be intensely private, and talk about them may actually threaten a person's sense of safety.

At a service level there are the following additional implications:

- Health and social care, home care and support work: Older people value consistency and good-timekeeping. Meticulousness in observing confidentiality is essential if older people are to feel secure using services. Some interactions with professionals take place in the context of considerable imbalances of power, so informal or formal advocacy may need to be facilitated to allow a person's voice to be heard. Low-level support helps older people to feel safer: not just crisis support.
- Targeted services like Care & Repair and My Bus: issues can arise with the accessibility and flexibility of these. Regular feedback should be sought to maximise usefulness to older people.
- Planning of the urban environment: Older people have a range of specific needs when it comes to negotiating the urban environment safely. They should be fully consulted at every opportunity, particularly when changes are planned.

- **Businesses:** Many older people value alternatives to conducting their business online. Some older people value the opportunity to conduct bank transactions in person, in a private, accessible space. Some older people value an in-store cashback facility for safety reasons, even if there is an external cash machine. Older people whose needs are not catered for may take their business elsewhere.

### *Next steps*

As detailed on pp.7-8 above, our plans to produce and disseminate materials for older people, carers, practitioners and policy-makers are now well underway. Additionally, we have developed relationships with our partner agency and participants and have piloted a process for developing research in a collaborative way. Indeed, we have three participants keen to continue contributing to the dissemination work. We have explored the aspects of ethnographic methods best suited to approaching this topic and the aspects most accessible to our participant group. We have piloted these and refined them, not least through experience and reflection on the practical and ethical challenges.

These positive experiences, and this practical learning will support us to develop the planned follow-on project. They will also be disseminated to the wider research community via journal articles and conferences. The approaches and tools we have developed will also be of use to health and social care practitioners when discussing risk with older people. We are continuing to work with Ceartas and our older participants to ensure that the materials and tools we produce in collaboration with them are as accessible and useful as possible to practice in the field.



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Appendix One: Images used to discuss potential research tools in focus  
group two



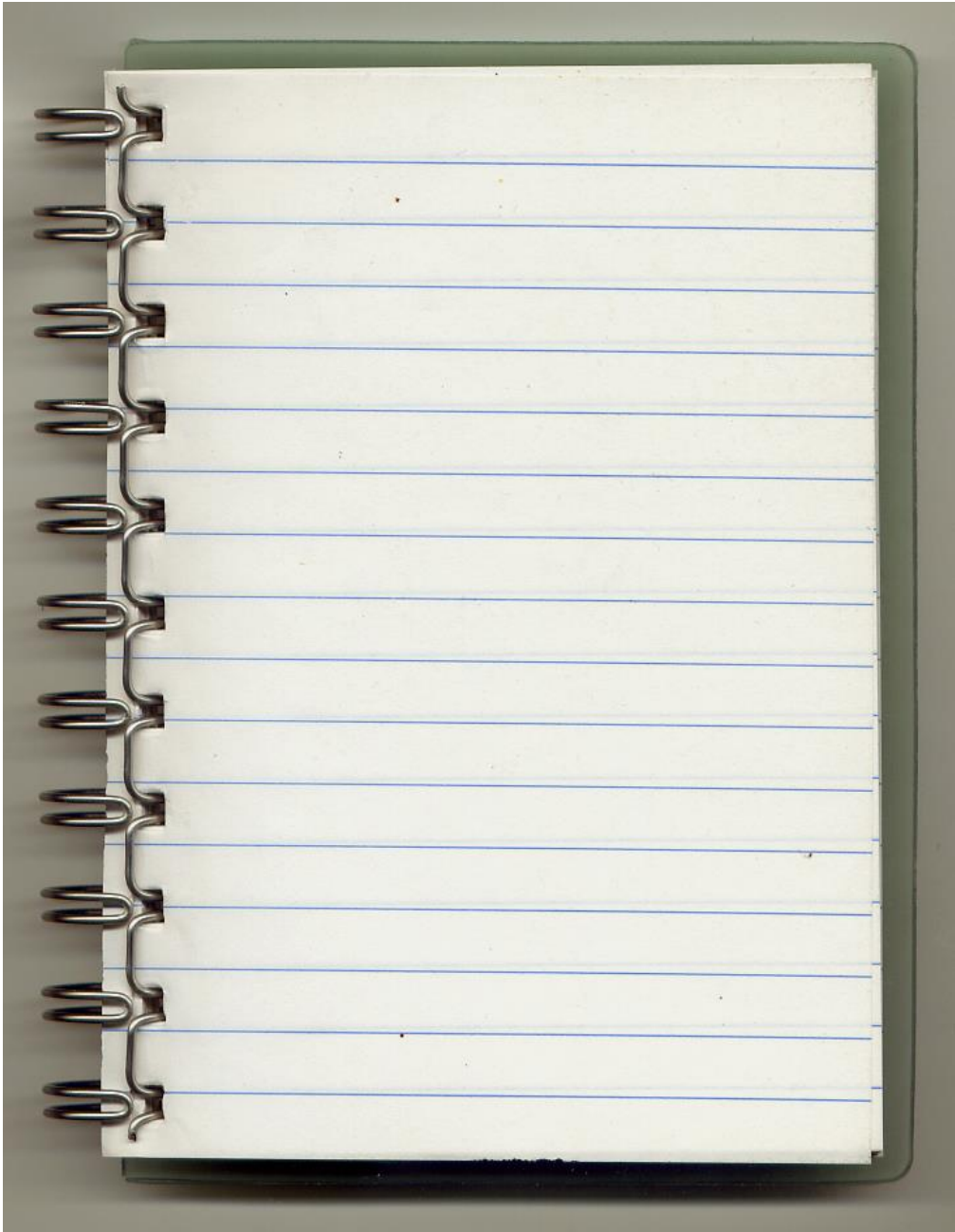
# One-to-one interviews



# Three-way interviews



# Visiting & seeing daily life



# Keeping a notebook

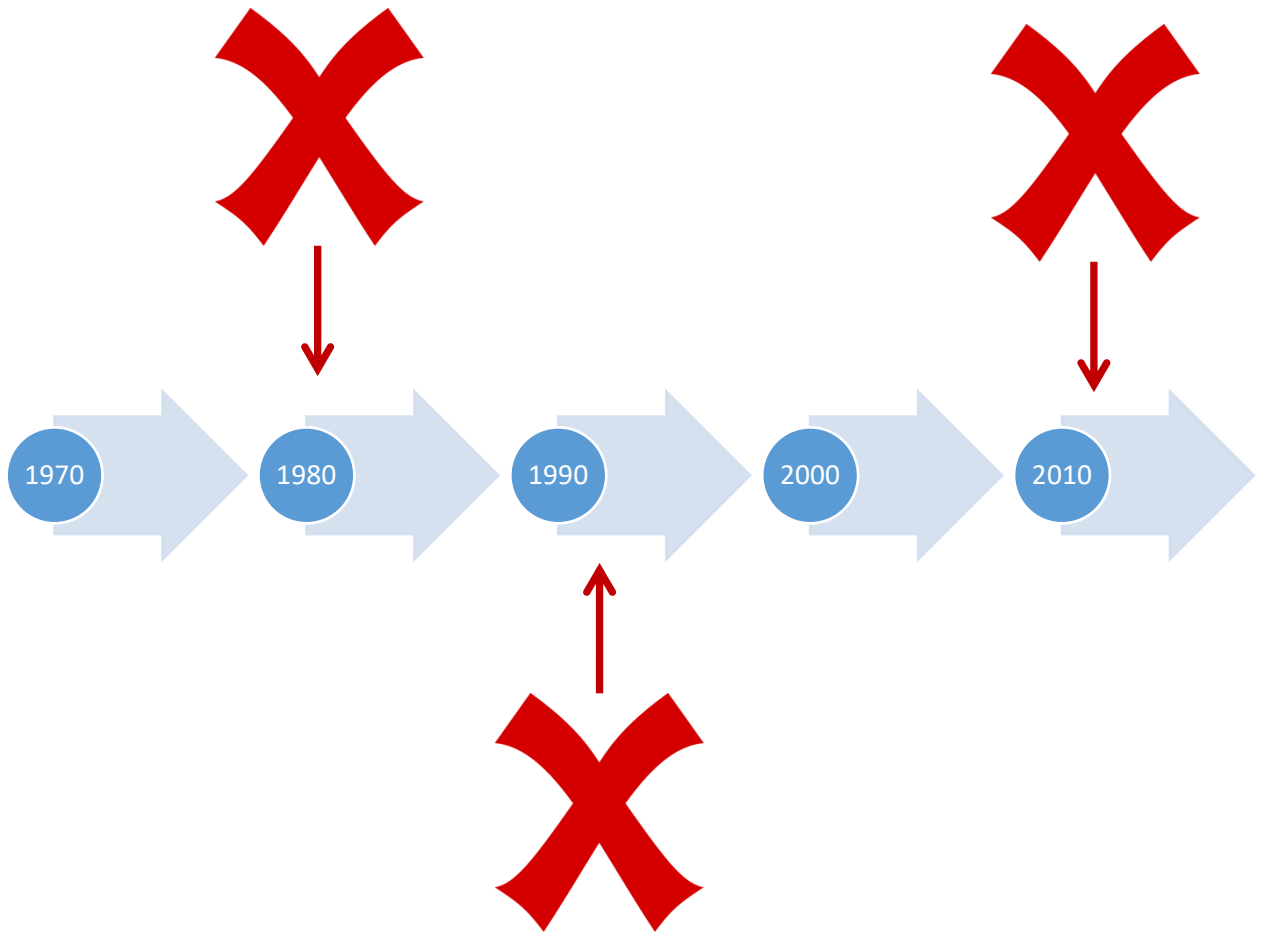


# Using video



# Making pictures





## Mapping key events