What makes older people vulnerable? What sort of events trigger requests or need for services and support?

**Background**
One of the difficulties in trying to understand the background to what leads to demand for services is ambiguity in language. The word ‘vulnerable’ is used about people not having adequate safeguards, or being at risk. Thus certain categories of older people may be defined as vulnerable. For example, those who are in a vulnerable group are judged more likely to succumb to a particular illness. Preventive measures, such as a flu jab, can be taken to aid protection of those who are vulnerable.

Similarly some older people are said to be vulnerable to abuse: this has to be interpreted as meaning that something about their own state of health (learning disability, mental health state, physical state), their individual circumstances or the environment in which they live means that they are less likely than others to be able to protect themselves from abuse from others.

‘Vulnerability’ is often used interchangeably with ‘risk’: people are said to be ‘vulnerable to … ’ or ‘at risk from … ’. Yet too often there is no clarity about what it is that people are vulnerable to, that is what is the nature of what might happen. ‘Vulnerability’ or ‘risk’ become loose cannons and, left on their own, serve only to alarm or unhelpfully label someone. It is more use to state that there is risk of a fall arising from … or that social isolation, resulting in the person going out less, might lead to depression and less activity, which in turn could result in other health problems. Statements that someone is at risk of abuse, or at risk of losing their independence are of little value for action without further definition. Even worse is a description of someone as ‘ a vulnerable older person’, a label without any clarity.

In relation to social care one risk is that of being unable to manage on one’s own in the same way as one is at the moment – that is, that something may happen so that the person cannot manage without external intervention. This is sometimes defined as ‘being at risk of losing one’s independence’. However, there are problems with this use of language in that it assumes independence as an absolute: you have it or you don’t. The reality is that at times any of us may do some things for ourselves and have people to do other things for us, whether cleaning, decorating or gardening. The balance of what we do ourselves and what others do for us may shift, in particular if in later life we find ourselves less physically able. There will be a stage when, if they have sufficient money, people may choose between doing something themselves, perhaps taking a long time and with considerable difficulty, or having someone else to help. A later stage comes when someone can no longer perform the task.

To add to the confusion in terminology, many will see themselves as being independent if they continue to be able to direct the way that something is done even though they may not be able to do it themselves.
The interests of social care commissioners are likely to focus on what tips a situation from being one where a person is managing without state support to one where they need such help. It is at this time that there may be a search for the triggers, that is the events that tip a situation that had been contained to one that no longer can be. However, even when defined as precisely as this there remain difficulties in specifying what is being examined: someone may be surviving in a situation but finding much of what is happening in their lives to be problematic or out of control. An event such as a fall, a stroke or the death of a partner occurs and the situation collapses. The assumption is that the event has changed the capacity of the person to manage their daily life: prevent the fall and the person will continue to cope. In part that is correct. Yet what is seen as a trigger event may have performed a different function: it may have alerted someone to aspects of their lives that they find intolerable and made them unwilling to accept these in the future.

It has to be recognised also that some people who may not ask for support might be eligible for such support. Unfortunately a commissioner is not in the position of, say, a welfare rights campaigner who sets out to maximise the amount of benefits that an eligible person receives. The commissioner is in the business of rationing: So the topic turns on both what prevents someone from asking for help because they are managing well enough, and what sorts of services or support reduce a demand for intensive support.

‘Vulnerability’ may be used about a) a category of people who are thought to be at risk, b) a situation or event or c) an environment. The first of these is clear cut: for example, people with ill health, disabilities, limited resources or those from particular ethnic group may be more at risk of some events than the population at large. The second refers to the sorts of activities that people undertake: standing on a chair to reach into a cupboard is more risky than using a step ladder. Thirdly, the environment (loose rugs, awkward steps, dark passageways) will have an impact on people’s ability to manage.

There has been much focus over the last 20 years throughout British life on reducing risks, to the extent that ‘risk averseness’ is now in itself seen as a problem. People should not be discouraged from taking reasonable risks, the argument runs, because their quality of life reduces and the avoidance of risk may create other problems. For example, a fear of falling may lead to someone becoming inactive, with all the subsequent problems to health and fitness.

Vulnerability is a broad term and has different meanings in different settings. There are some general features to most definitions, but also significant variations.

Social vulnerability ‘refers to the inability of people, organizations, and societies to withstand adverse impacts from multiple stressors to which they are exposed. … (It) is created through the interaction of social forces and multiple stressors, and resolved through social (as opposed to individual) means. While individuals within a socially vulnerable context may break through the “vicious cycle,” social vulnerability itself can persist because of structural—i.e. social and political— influences that reinforce vulnerability. As with any analysis that asserts the dominance of external structures on people’s lives, there is a danger that people are portrayed as passive victims and the capacity of the individual is underplayed.

Psycho-social vulnerability refers to the personal attributes of the person and the social/environmental conditions which predispose the person to the particular risk.

---

1 Wikipedia – Social vulnerability
One way of looking at vulnerability is known as the risk/hazard model. Vulnerability can be assessed by looking at, first, the risk and the degree of exposure to the risk and, secondly, the extent to which individuals or communities are susceptible to that risk.

Table 1 Risk/Hazard model

An alternative approach is the Pressure and release model. This looks at root causes and then considers the factors that lead to greater degrees of vulnerability.

Table 2 Pressure and release model

Each of these two approaches has been developed to examine major events such as climate change or natural disasters. Therefore there has to be consideration of the extent to which they are relevant to understanding the vulnerability of older people.²

Those assessing and working with older people who appear to be in some ways ‘at risk’ face particular responsibilities to unpick generalities such as ‘vulnerability’ and to ensure that they move to specifics: what are the capacity and resources of this person? what are the particular problems that he or she faces? In this sort of analysis it is imperative that the older person contributes wherever possible to all stages of analysis and resolution.

In terms of vulnerability of older people in the domain of social care there are numerous factors that could be listed. Some examples are:

² Wikipedia – Social vulnerability
Capacity of the individual to communicate either how they are or what they want; people may be limited in capacity because of physical factors (deaf/blind, suffering from stroke, dementia, poor English skills).

Psychological state – people who are depressed are less likely to promote their problems.

Physical capacity to manage daily living and household tasks – there is a relationship between ability to perform such tasks and feelings of self-worth, and subsequently between feelings of self-worth and a willingness to assert one’s concerns.

Limited physical capacity may present physical risks.

The environment of the house – warmth, suitability for management by the older person.

The external environment – the extent to which someone feels that it is safe and enjoyable to go out.

Social contacts – meeting family and friends both provides potential for support and enhances people’s experiences of their worlds.

This is by no means an exhaustive list.

Thus far the central focus of studies of vulnerability has been on the identification of the parameters of vulnerability: which people? what situations? what environments? A more recent development has been consideration of resilience, the capacity to withstand challenges:

A comparative European study of how vulnerability may be generated in older people noted the interaction between reserve capacity and environmental challenge. Reserve capacity refers to the resources available to the person through tangible facilities, inner resilience or social networks, while environmental challenge relates to the difficulties presented by the environment in which older people live. This can refer to social spaces and provisions such as public transport or, equally, to individuals’ own domestic surroundings. By considering the ways in which differences between reserve capacity and environmental challenge are managed by older people, it is possible to identify whether appropriate support is best delivered informally or, as is usually the case in a crisis situation, through a professional route. Either route can increase the reserve capacity and thereby enable individuals to meet their own personal ‘environmental challenges’. … Enabling people to reduce the environmental challenge through comparatively minor interventions such as changes to lighting or furniture layout, for example, demonstrates this. Combining this with interventions to reduce isolation and thereby maximise reserve capacity has the potential to make a substantial impact in maintaining independence. 

In similar vein there are attempts to look at capacity a) to react to risk and adversity and b) proactively, to ‘create options and anticipate responses to health risks and adversities’. The value of the approach is that it shifts the focus from managing risk to building resilience.

Another approach has been to look at the ways that staff go about their work. Taylor studied the frameworks used by health and social services staff to consider risk. He identified six models that were adopted:

3 Social Care Institute for Excellence Research briefing 21: Identification of deafblind dual sensory impairment in older people, London: SCIE
Identifying and meeting needs: people come with needs, and the professional task is to assess these in relation to circumstances and meet them where possible.

Minimising situational hazards: helping service users and staff (particularly home care workers) to avoid domestic hazards, with an emphasis upon avoiding risk rather than taking risk.

Protecting this individual and others: in situations where individuals may harm others or themselves, their wishes may have to be challenged and a decision imposed without consent.

Balancing benefits and harms: risk-taking (as opposed to only risk avoidance) is seen as an intrinsic part of the job and sometimes necessary to encourage rehabilitation.

Accounting for resources and priorities: resource shortage results in the establishment of "panels" to ensure justifiable resource allocation that is prioritised by conceptually labelling levels of risk that relate to the urgency of the response required.

Wariness of lurking conflicts: staff concerns of being at risk themselves, such as concern at being sued or becoming the focus of unwanted media attention - a "sixth sense" of professional danger.  

From the perspective of commissioners and providers it is important to consider what enhances resilience. Some policy implications cited in the Wikipedia article are:

1. Involve local communities and stakeholders in vulnerability studies.
2. Strengthen people's ability to help themselves, including an (audible) voice in resource allocation decisions.
3. Create partnerships that allow stakeholders from local, national, and international levels to contribute their knowledge.
4. Generate individual and local trust and ownership of vulnerability reduction efforts.

The Linking Communities project being undertaken by Age Concern Lancashire attempts to involve local people in just such ways. Other ways to look at the building of resilience are to look at what people want and what enhances their well-being. In work commissioned by Hampshire county council service users and carers identified the types of support or care services that they would choose to use:

- Being treated with respect and dignity and this includes good two way communication at the right pace at every stage.
- Feeling safe.
- Information and advice and knowing what is going on as it relates directly to the individual situation. This increases control and choice.
- Personal care being right for the individual at the right time and place as well as being with the right person.
- Social interaction. Getting out and maintaining friends as well as developing new ones.

The survey went on to identify messages for providers:

---


6 Hampshire Model Personalisation Programme Market Development Workstream: a survey of Self-Directed Support (SDS) users and carers
Personal care and daily living support at home

Nearly three quarters of respondents were seeking these services. However the wider quality of life needs are often hidden behind the necessary practical care issues and their importance to service users and carers is highlighted in this survey. No service is only about practical support.

Consistency - avoid changing staff - relationships built between service users and carers and the care workers are critical to the long term success of the service.

Communication Personalised written information on what can be expected and when and whom to contact. Inform the service user in advance when staff have to be changed or are delayed.

Confidence - The relationship with the agency is key to the expressed need for feeling safe. It builds trust and security which in turn allows greater benefit, i.e. psychological as well as practical, from the service provided.

Flexibility Provision of personal support is seen by many as a route to also access the wider community and therefore maintain a better continuing life.

Studies of well-being highlight what are seen to be the components that lead people to feel better about their lives. A sense of ‘involvement’ appears central to well being; the nature of involvement will differ for different individuals and may be found in work, daily living, decisions, family, wider community, connections/connectedness, active citizenship. Other critical factors are:

- sustaining and maintaining good physical and mental health;
- ability to perform tasks of daily living;
- a match between external and internal expectations;
- ‘sufficient’ resources;
- a feeling of self-worth which may be defined as valuing self and seeing one’s life as meaningful.

Others produce different lists.

Research has shown that older people tend to closely associate four things with well-being: their health and functioning; the existence of relationships and social support; their material circumstances; and their opportunities for personal growth and development. Add source

Hughes looked at the constituent elements of quality of life. She produced a list which is relevant for building resilience. Her components are:

- the individual characteristics of the older person;
- physical environmental factors;
- social environmental factors; personal autonomy factors;
- subjective satisfaction; and
- personality factors.

With similar relevance to building resilience, Bowling, Grundy and Farquhar conclude that three components are most important:

- perceived well being (life satisfaction; perceived control);
- health and activity; and
- environment (fears in particular about safety; whether people like the area where they live; being warm enough).
Overall the factors most associated with quality of life are related to survival:

- the ability to carry out tasks for daily living; this can be described as the maintenance of functional ability;
- one’s physical and mental health;
- level of income.

Another study that has a long list of attributes of well-being includes:

- **Community participation** – important in promoting well being and a sense of value. Older people report their biggest neighbourhood fear as problems with traffic, while they are surprisingly less worried about teenagers, crime and drugs.
- **Exercise** – protects against mental health problems including depression giving a positive sense of wellbeing. Most health promotion campaigns are directed at children and those of working age.
- **Volunteering** – is associated with increased satisfaction, a sense of purpose and larger social networks.

Allen recommends a joined up service providing support and care for older people during and after depression 'trigger points' such as retirement, moving home, caring for a sick or elderly relative or following the death of a spouse or partner.

Finally, a list of factors that promote dignity, all of which contribute to the person's sense of self respect.

- **Choice and control.** Enabling people to make choices about the way they live and the care they receive.
- **Communication.** Speaking to people respectfully and listening to what they say; ensuring clear dialogue between workers and services.
- **Pain management.** Ensuring that people living with pain have the right help and medication to reduce suffering and improve their quality of life.
- **Personal hygiene.** Enabling people to maintain their usual standards of personal hygiene.
- **Eating and nutritional care.** Providing a choice of nutritious, appetising meals that meet the needs and choices of individuals, and support with eating where needed.
- **Practical assistance.** Enabling people to maintain their independence by providing "that little bit of help".
- **Privacy.** Respecting people's personal space, privacy in personal care and confidentiality of personal information.
- **Social inclusion.** Supporting people to keep in contact with family and friends, and to participate in social activities.

It is likely that all of these will contribute to an individual's capacity to maintain resilience at times of stress.

Dartington argues that there are significant ways that the world has got tougher for the most vulnerable in our society.

---

A culture of enterprise and opportunity, put to good use by the disabled people's movement, does have a downside - a wide-ranging lack of respect for dependency, even where this is necessary and appropriate, in human relationships. The culture of targets and audit in the delivery of public services - a distortion of organizational theory developed in other sectors - has made the effective delivery of humane and responsive care more difficult to achieve and maintain.9

This background paper does not answer the question of what triggers a demand for social care services. Rather it argues for careful analysis of phrases such as 'vulnerability' or 'demand for social care' to avoid the dangers inherent in blanket interpretations and solutions.

Roger Clough  
Research Director, Linking Communities, Age Concern Lancashire  
October 2010

---