

Negotiating safety and vulnerability in everyday life: perspectives of UK older people from participative research

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Abstract

This article reports on a participative study that began to explore what safety and vulnerability mean to older people and the resources they draw on to keep themselves safe. The methodology was designed in collaboration with an independent advocacy organisation and ten of its older members, who were also research participants. It involved focus groups and repeated visits to five participants to discuss their daily lives. The findings indicate that “safety” and “vulnerability” have subjective, experiential dimensions, which are situated in particular relationships, environments and experiences over time. Participants reported drawing on their own strengths and the strengths of others in their families, communities and local services to achieve an acceptable level of felt safety for themselves. However, this sense of safety could not be disentangled from, nor always prioritised over, wider aspects of living well including maintaining reciprocal relationships, preserving self-identity, and contributing to the well-being of families and other social groups of which they felt themselves a part. Implications are considered in light of UK and wider European policy aspirations to support both autonomy and safety: specifically, the need to foster supportive communities, to offer low-level support and to pay attention to what safety means to each individual.

Introduction

This article reports on a participative study that began to explore what safety and vulnerability mean to older people and the resources they draw on to keep themselves safe. The study was conducted by researchers at Stirling University in collaboration with Ceartas, an independent advocacy project in central Scotland, and some of its older members. It arose in the context of an increasing policy and legislative focus on protection or safeguarding in UK adult services (Stewart & MacIntyre, 2018), and related attention to elder abuse, vulnerability and their implications for support at European and international levels (Lindert et al., 2013; Montgomery et al., 2016)¹. Nevertheless, there are gaps in our knowledge of service users' perspectives on safety, vulnerability and protection, particularly older people's, and particularly with a focus on individuals' own strengths, priorities and meanings (Sherwood-Johnson & Mackay, 2020; Wallcraft, 2012).

This paper focuses on three of the study's research questions:

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

These questions were explored on a small scale, with one aim to develop and pilot our methodology ahead of a prospective larger project. Nevertheless, our substantive findings already have potential to inform theory, practice and the interpretation of policy, across the UK and internationally. The following three sections explore some aspects of the project's policy, theoretical and empirical contexts with respect to risk; vulnerability and autonomy; and experiential knowledge.

Old age, risk and professional care

Risk and responses to risk have been core tenets of the professional and academic literature about older people's social care and health for many years (Mitchell & Glendinning, 2008). This is reflective of a wider contemporary preoccupation with

¹ The project ran from 2017 to 2019 and this paper was first drafted prior to the current COVID-19 pandemic.

risk in Western societies (Powell et al., 2007; Webb, 2006). Nevertheless, it is reflective too of societies' perspectives on older age, including some ageist assumptions about the delivery of care and support in later life (Weicht, 2013).

Working with risk is complex. For instance, Taylor's (2006) focus group study demonstrated how older people's health and social care staff operate between competing paradigms, reflective of conflictual policy, organisational and social drivers: including pressure to work collaboratively whilst reserving the right to intervene based on a professional duty of care; and pressure to maximise older people's choices whilst protecting organisations from potential litigation. This is quite aside from the significant differences that have been shown to exist between conceptualisations of risk by professionals, older people and family carers respectively (Ballinger and Payne, 2002). An early UK example was provided by Clarke's (2000) study of risk and dementia, which highlighted how some professionals drew on medical knowledge to manage the problems of dementia, whilst family carers drew on personal and biographical knowledge to manage the challenges that dementia posed to particular identities and family relationships. Similarly, Mitchell and Glendinning's (2008) literature review, still pertinent today, found an ongoing focus on physical risks in the context of older people's services, and an under-representation of older people's voices in comparison with practitioners' and carers'. They argue that these imbalances evidence a technico-scientific understanding of practitioners' roles and tasks in respect of risk, rather than a socio-cultural one, notwithstanding increasing acknowledgement of the value of lay knowledge to improving practice.

Outside the sphere of social care and health, older people's own risk-taking behaviours have been more extensively researched. For instance, psychological studies in the US and UK have challenged common assumptions about increasing risk aversion with advancing age. Instead, a more nuanced picture has begun to emerge, in which the type of risk concerned makes a significant difference to older people's risk decisions, as do a range of other, intersecting factors including gender, motivation and experience over time (Bonem et al. 2015; Rolison et al., 2013). Similarly, Bornat and Bytheway's (2010) interview and diary-based research in the UK evidenced older people's competences in managing everyday risks, developed over lifetimes. They argue that health and social care practitioners engage disproportionately with older people who are isolated and/or in crisis, and might therefore come to assume a higher than warranted association between older age, vulnerability and the negative sides of risk.

Vulnerability and autonomy

Vulnerability is itself a core component in the contemporary construction of older people's health and social care. Despite its common usage, it is widely agreed to be an under-theorised concept (Rogers et al.2012; Dodds, 2012). It is linked with discussions of obligations to protect, for instance in relation to the development of UK adult safeguarding policies and systems. However, it has met with contention because of its association with paternalism and stigma, particularly when applied in a blanket fashion, for instance to all older people (Stewart & MacIntyre, 2018). In Europe and North America, theories of active ageing have arguably deferred rather than addressed these problematic associations, with older people coming to be viewed as either independent and self-reliant citizens striving to stay healthy (the "third age") or dependent, frail and a drain on resources (the "fourth age"), with little regard for how social inequalities impact later life (Centre for Ageing Better 2020; Grenier et.al., 2017). Arbitrary boundaries underline these problems: for instance the requirement for all people over the age of 70 to self-isolate as part of the initial UK response to the Covid-19 pandemic, regardless of their health status (Crowther, 2020). Similarly, Christie (2020) observes how a diagnosis of dementia sanctions the view of someone as inherently risky and vulnerable, and how this can often be unrelated to the skills and insights the person still retains. Grenier et al. (2017) extend these arguments, proposing that the concept of a fourth and final stage of life allows governments to classify someone as a lesser priority for the extensive support that younger people might expect, robbing them of wider citizenship rights.

A construction of vulnerability as inherent to the human condition (Fineman, 2008) can counteract these "othering" approaches (Crowther, 2020). Rogers et al. (2012) build on this perspective to map out a taxonomy of specific kinds and sources of vulnerability, which they divide into the inherent, the situational and the pathogenic. Inherent vulnerability affects all of us to varying degrees depending for instance on our age, gender, health status and abilities/disabilities. Situational vulnerability is context-specific, for instance relating to the care services available where we live. Pathogenic vulnerability describes population-wide or individual responses to address the initial perceived vulnerability, which actually increase the risk of harm. For example, older people's vulnerability increases when they are in hospital because they are at greater risk of professionals making decisions for them, purely on medical grounds (Donnelly et al., 2019). This raises the issue of the connections between professional and moral obligations to protect people experiencing

vulnerability, on the one hand, and obligations to respect autonomy and self-determination, on the other. These connections are the subject of international debate across legal, philosophical and ethical domains (Carney, 2015; Fallon-Kund, et al., 2017; Mackay, 2017).

Increasing individuals' choice and control over their own health and social care has been a common policy and legislative goal across many countries in recent decades. The promotion of autonomy in this context has often been linked with market principles and control over resources for the purchase of services. For instance, both the Care Act 2014 in England and the Social Care (Self-Directed Support) (Scotland) Act 2013 aspire to place individuals' own perspectives at the centre of support planning; with the option for them to manage the public funds allocated to their care.

There are various problems, however, with attempts to improve care quality by envisioning service users as autonomous actors in a market place (Lloyd, 2010). One is that the specific constellation of a given person's inherent, situational and pathogenic vulnerabilities can be overlooked. Indeed, there is UK evidence to suggest that the relationship of self-directed support to safeguarding had not been thought through in advance, at policy and planning levels at least, despite their broadly contemporaneous development (Hunter et al., 2012; Manthorpe et al., 2010). There is also the tendency for respect for autonomy to be allied with non-intervention (Stewart, 2012). In contrast the care ethicists argue that autonomy is both supported and limited by professional relationships and the time and resources they offer. This links back in turn to Rogers et al's (2012) ideas about pathogenic vulnerability: the need to consider how social and health care practitioners, and the state, in their practices and policies (including non-intervention) increase rather than reduce the harms they are trying to avoid. Additionally responses to vulnerability need to engage the agency and participation of the individuals or groups affected; otherwise the focus will remain on an externally imposed views of vulnerability based upon a medically orientated deficit model (Spiers 2000)

Experiential knowledge

Engagement or non-engagement with older people's lived realities is one important criterion against which contemporary health and social care policies have been critiqued. For instance, Taylor (2011) and Barnes et al. (2013) show how the popular policy concept of "well-being" and its purported links with other concepts like

“independence”, “choice” and “control” are drawn upon as “discursive tools” (Barnes et al., 2013, p.481) in support of UK personalisation and related policies for older people, but fail to connect with empirical evidence about people’s lives.

“Independence” emerges as a relative and multi-faceted concept, where older people and others have been asked their views, whilst the links between “independence” and “choice” emerge as much more subtle than policy assumes (Hillcoat-Nalletamby, 2014; Rabiee, 2013). Taylor (2011) argues that “well-being” is best viewed as something constantly under generation in social and relational contexts, in contrast with more static and individualistic policy constructions. His view is supported by the findings from Barnes et al.’s (2013) qualitative, participative research that also underline the emotional and organisational labour involved in “being well enough” in older age.

There are similar complexities inherent in some core concepts of adult safeguarding policies. In particular, professionals have taken the lead in defining abuse, with a focus on individual and family characteristics. One Irish study found that older people’s own definitions placed much more emphasis on cultural and structural harms: for instance, isolation, ageism, enforced retirement and inadequate provision or withdrawal of resources (Anand et al. 2013). Overly-individualistic conceptions of vulnerability have also been contested, as outlined above, and there is a strong argument for engaging more fully with subjective experiences of vulnerability, which may not coincide with top-down and externally imposed definitions (Spiers, 2000). Meanwhile the meaning of safety has been largely unexplored. Inspired by studies like that of Barnes et al. (2013) and by learning from our previous safeguarding research (Sherwood-Johnson & Mackay, 2020), this study set out to examine older people’s own understandings and experiences of safety and vulnerability, using a participative and strengths-based approach.

Methodology

This qualitative study sought to gain the insights of a small group of older people, over a sustained period of time, on safety and vulnerability in their everyday lives. It used a participative approach to develop methods, analyse data and disseminate findings in ways that were meaningful for those involved (Fleming et al. 2014). Table 1 sets out some basic details about participants in both Stage One and Stage Two of the study. Full details about ethnicity cannot be included because we did not ask participants for this information; however all participants were white.

Table 1: Details of participants

	<i>Pseudonym</i>	<i>Sex</i>	<i>Key additional details (Stage 2 only)</i>
<i>Stage 1 only</i>	Bob	M	
	Dave	M	
	Julie	F	
	May	F	
	Sue	F	
<i>Stages 1&2</i>	Carol	F	Lived alone in supported housing. Experience of disability as both an older and a younger adult.
	Harry	M	Lived with wife and carer, Jane, who also participated. Received home care daily. Participation in project concluded early.
	Jack	M	Lived alone and used some aids to daily living.
	Jane	F	Lived with and cared for husband, Harry, who also participated. Jane also received support and had significant health concerns.
	Jean	F	Lived with husband. Experience of disability as both an older and a younger adult.

In Stage One, we held two focus groups to explore the concepts of safety and vulnerability, and to discuss the methods we might use in the individual work at Stage Two. Ten older people attended one or both focus groups; one attended with a befriender and another with a carer. We used images to prompt discussion about potential research methods, including interviews, observation and use of diaries and photographs (University of Stirling, 2019).

In Stage Two we worked with five older people, recruited from the focus groups, to explore safety and vulnerability in their lives on a one-to-one basis. Each participant was paired with a researcher who met with them on a series of occasions over a period of up to three months. Participants selected which methods they wanted to use. Informal interviews were most common, followed by walking tours of participants' local areas and daily activities. The chosen methods enabled narratives to unfold in quite naturalistic ways (Clandinin and Connelly 2000). For example, visual methods to map out key life events were thought, by the focus group, to be a good idea, but in Stage Two this option was avoided and one participant felt it was a potentially intrusive approach. Instead memories were triggered and elaborated within more general conversations. At the end of Stage Two, the data collected were summarized by the researcher who had not been paired with the participant; and then both researchers met with each participant. This three-way review identified key points arising from their data, checked the researchers' understanding and confirmed which points could be carried forward for discussion in the collaborative analysis workshops at Stage Three. This allowed participants to remove information which on reflection they did not wish to share, but also to see the value of their contribution.

In Stage Three we began an initial sorting exercise, drawing meaning inductively from the data, informed by the principles of thematic analysis (Miles and Huberman, 1994). We recorded our ideas using Nvivo software. Participants were then involved in two collaborative data analysis workshops. The first asked participants to read and discuss direct quotations from the data, and to place them on pieces of paper, one for each suggested theme. The discussion that ensued helped interrogate the validity of the themes and refine their meanings. The visual representation produced then guided the full data analysis. The second workshop similarly used quotations under a revised thematic framework to validate and refine the findings.

We found our participatory approach enhanced both the process and the outcomes of the study. Participants' involvement in the design of Stage Two ensured that the methods we began with were broadly suitable and could evolve over time as we trialed them together. This process helped us to build trusting relationships, which in

turn facilitated conversations that felt more respectful and authentic than would otherwise have been the case. This fitted well with our ethical commitments and also our commitment to valuing experiential knowing (Banks et al., 2013). The involvement of multiple perspectives in the data analysis stage, in particular, challenged all of us to review our ideas and to try out new ways of interpreting them (Ritchie and Spencer, 1994), rather than settling too early on one fixed set of conclusions. This is similar to experiences reported by Fleming et al (2014).

Ethics

We gained approval from the University of Stirling General University Ethics Panel to carry out the Stage One work, and again once the methodology for Stage Two had been refined through the focus groups. Participants were recruited by our colleague in Ceartas. Informed consents were confirmed at each stage of the project and on an ongoing basis; a judgement about loss of capacity to consent to involvement led to the loss of one Stage Two participant before the analysis stage. Names and identifying details have been changed in this and other outputs.

The methodological approach brought up ethical questions around information-sharing and the potential blurring of boundaries between researcher and supporter (Carter et al., 2013). Additionally we were sensitive to avoiding unrealistic demands on participants who already had busy lives; some managing significant health conditions and/or care for others. So whilst participants were fully informed at the start of each stage about the aims and methods verbally and in writing, we continued to have conversations about the implications of involvement for them throughout. In this way we avoided potentially patronising assumptions about the participants' capabilities and resilience (Iphofen, 2011). Instead, participants shaped their own ways of contributing, and reported that involvement has offered them insight and satisfaction. Methodological and ethical learning from the study was significant and will be the subject of further publications.

Findings

We discuss aspects of our findings from Stages One and Two here, in relation to three intersecting themes. First, we consider what safety and vulnerability meant to participants. Second, we summarise the types of resources participants were

drawing on to keep themselves safe, and how they negotiated the opportunities and pitfalls of these. Third we discuss how safety was prioritised or de-prioritised in relation to other aspects of the older people's lives.

Meanings

A primary point of note was the differences in understandings and experiences of "safety" and "vulnerability", even amongst this small group of participants. Key public and policy perceptions of risks to older people, for instance rogue traders and financial scams, were of more concern to some people than others. Meanings and principal concerns appeared to be strongly influenced by participants' relationships, environments and experiences over time. For instance, Jane was one of seven participants who reported past experience of close communities and families, and feelings of vulnerability associated with their loss:

...they're not neighbours like you had in the old days. ...you know, I used to make soup, and casseroles, and take it to the old woman across the road, and the same with *[name]* that died, and that wee lady on the corner.

Jane

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... You don't get that now, not to the same extent.

Jane

Jane's understandings of safety and vulnerability were also shaped by her current close relationships. Specifically, she had been married to Harry for many years and was now his carer; the risks she focused on throughout Stage Two 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 and did not want to see him hurt. Similarly, Jane's close relationship with her son affected her take on vulnerability:

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 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.

Experience of past difficulties shaped people's meanings too. 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. Jean also linked her current experiences of vulnerability with changes in her health and lifestyle. Here she is reflecting on her feelings about 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

Conversely, Jean was keen to emphasise the importance of maintaining key abilities:

When I was younger, I didn't mind so much asking for help, but as you get older there was something about sometimes you might feel more vulnerable and you kind of want to be able to do it yourself more.

Jean

Indeed, it is the risk of being judged to fit the stereotype of age and dependency which is presented as one source of vulnerability here. Participants often resisted the imposition of such a stereotype, because it was experienced as a threat to their sense of themselves.

People's perspectives on safety were also connected to their interactions with their environments. For instance Carol used an electric wheelchair and 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.

Jean highlighted several vulnerabilities specific to people using mobility scooters, particularly when combined with restricted upper body mobility, for instance the positioning of buttons and green men and the lack of turning space at some crossing places. Jean also spoke about her avoidance of a local area re-designed as a "shared space", in which traffic lights, road markings and usual rules of priority had been removed, with the aim of encouraging all users to co-operate and proceed with caution. Here Jean feels more vulnerable because there is no defined edge to the kerb and the textures of the paving are confusing, particularly for people with conditions affecting their vision. Meanwhile, Jack was wary of broken pavements and certain passageways in his neighbourhood at night. Like Jean and Carol, he regularly changed his behaviour to avoid the environments that made him feel unsafe.

Resources and Negotiation

Adaptations made at a personal level were key amongst the resources that older people reported that they drew on to keep safe. 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

Jack had amassed considerable expertise in different types of call-blocking technology, whilst Jean had significant experience of adapting mobility scooters to meet her particular needs. Both used their knowledge to give advice to others.

Other resources that participants drew on often resided in people too: for instance, committed carers and family members, supportive communities and professionals they trusted. For instance, when Jean experienced some incidents of not understanding what a person was telling her in social situations, she gained the support of a psychologist. Together they devised a card that can be handed to the person Jean 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 anywhere that she wasn't known.

In families too, even well-meaning interventions could feel more or less enabling from the person's point of view. Approaches to risk varied, with some relatives perceived as more risk-averse than the person wished to be themselves. Participants also varied in their attitudes towards accepting support. For example, there was acute tension for Harry between what he felt able to do for himself and what his family and professionals felt that he could do, whilst 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. Both Dave and Harry talked about changing their behaviours or taking safety measures to ease the concerns of others, for instance limiting where they went out, or always carrying a mobile phone. Negotiating a course through this terrain took hard work and could be emotionally draining:

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

This was notwithstanding the adaptability, assertiveness and emotional resilience that participants displayed in their accounts of their ongoing roles as mothers, fathers, husbands, wives, aunts, cousins and grandparents.

There was a sense of reciprocity in participants' accounts of their community connections too. 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, two participants' accounts demonstrated particularly clearly the sense of purpose and connectedness associated with activities focused largely on supporting others: specifically, 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.

Priorities and Trade-offs

People differed, then, in the types of things that made them feel safe or unsafe, whilst the resources they drew on and/or negotiated their way through were also situated in particular social and environmental contexts. A third important, and related, point is that people's strategies for keeping safe were often not clearly separable from their wider strategies for living well: they often didn't talk in terms of "risks" at all. Moreover, minimising certain risks could be de-prioritised, even where they were perceived:

Researcher: ...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

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

As demonstrated here, a certain sense of home and a certain sense of control were two of the things that participants might prioritise over the physical conditions and tasks that might be thought preferable to lessen common risks.

Other types of risks were actively pursued. For instance, Jean continues to travel by train, despite having been advised never to hold on to anything except her walker, and despite needing to discount this advice when she moves up and down the carriage on a longer journey. If she didn't take longer journeys, she couldn't visit her grandchildren any more. Bob too had reasons for resisting certain advice aimed at older people, and these reasons seemed important to his sense of himself:

I think, a lot of older people, because of their age, maybe just accept what, likes of the doctor says. Oh this is a doctor, I'll accept I'll not be able to go a bike. Whereas I'm different, what, not go a bike! I used to be out on my bike, I was very, very active years ago, as I said, all day, out on my bike.

Bob, Focus Group 2

There were also examples of participants accepting risks to themselves, because of their concern about competing risks to others. For instance, Jane was well aware of the practical arguments for needing respite as a carer, and had the offer of a holiday that she would have liked to accept. However, no substitute 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.

Discussion

This study had a small number of participants. It was not an ethnically diverse group and it was based in a single, reasonably affluent area of Scotland. The data were enriched by repeated contacts with participants over time, and by their contributions to methods development and analysis. However the specific experiences shared cannot be assumed to represent any wider population. Nevertheless, what is eminently transferable is the finding that “safety” and “vulnerability” have subjective, experiential dimensions, which were situated in participants’ particular relationships, environments and experiences over time. The older people reported drawing on their own strengths, both of resourcefulness and emotional resilience, and on the strengths of others in their families, communities and local services to achieve an acceptable level of felt safety for themselves. However, this sense of safety could not be disentangled from, nor always prioritised over, wider aspects of living well including maintaining reciprocal relationships, preserving key markers of self-identity, and contributing to the well-being of families and other social groups of which they felt themselves a part. These findings are in line with wider empirical and theoretical work about the situated and experiential aspects of risk (Clarke, 2000) and vulnerability (Spiers, 2000), the contextual and relational nature of “being well enough” in older age (Barnes et al., 2013; Taylor, 2011) and indeed the interdependence of the human condition (Fineman, 2008; Lloyd, 2010; Ward & Barnes, 2016).

The findings have several implications for policy aspirations to support and safeguard older people in ways guided by their own wishes and values. First, it is important to observe that keeping people safe, by their own definitions, emerges as not wholly or even mostly the reserve of UK safeguarding services. Participants felt safe when they had access to low-level support that respected and interfaced with their own strengths and priorities and the emotional weight of managing risk and change in older age. People felt safe, too, when they felt connected with valued other people. Services alone cannot deliver these dimensions of felt safety. Nevertheless, it is worth reflecting on the characteristics and conditions of families and communities who are able to support, include and value their older members, and the role of policies and services in fostering these conditions. In this context, it is also worth raising critical questions about the genesis of particularly marked divergences between local and national policies, on the one hand, and some of the needs and meanings of older people, on the other. These issues point to deficiencies in engagement with older people, not only within the confines of pre-defined policy areas, but more importantly on the boundaries at which several policy agendas inter-

relate and overlap (Sherwood-Johnson & Mackay, 2020). Ideas about structural sources of vulnerability and about pathogenic vulnerability (Rogers et al., 2012) are supported by these findings and offer some potentially useful ways for policy-makers to think about and address these gaps around the edges of different policy agendas.

As far as older people's interactions with health and social care practitioners are concerned, the findings underline 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 feel safe and supported. Practitioners need to be mindful that their interventions may not be perceived as central to older people's own work to keep safe and well, or they may even be experienced as counter to it. Our participants offered examples of practitioners' approaches producing pathogenic vulnerability, on the one hand, and examples of vulnerability responded to in ways that also support autonomy, on the other. Reflection on these examples might be instructive for professional development and social work education.

Finally, as far as safeguarding interventions are concerned, we note with Spiers (2000) that experiential and externally defined models of vulnerability and safety need to complement each other. We acknowledge that circumstances can sometimes arise where a person feels safe enough, but professionals might legitimately disagree. However, we contend that safeguarding interventions imposed without appreciation of a person's view of themselves, their circumstances and their strengths, are far less likely to be workable and/or to increase the person's quality of life. These ends need to be pursued in collaborative and relationship-based ways (Lloyd, 2010; Mackay, 2017). This means hearing and accommodating the values and aspirations that older people articulate for themselves, but not losing sight of the personal, social and situational factors that might limit a person's autonomy, particularly when subject to abuse or harm (Braye et al. 2017; Keywood, 2017). It means systems and structures that afford practitioners flexibility, resources and support as they negotiate these complexities in partnership with older people over time.

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