Myth Busting Frail Aged: Exploring Age-Related Vulnerability in Elderly Community Care Clients

Author: Pauline Marsh, Tasmanian Council of Social Service

Introduction

Home and Community Care (or HACC) policy is underpinned by an aim to decrease the vulnerability of people who live in the community, in particular, the vulnerability of 'frail aged' people. However, age-related vulnerability is a slippery concept, its causes are not always easy to identify and as a result are often simplified.

It could be argued that everyone is vulnerable to some degree, depending on the particular situation. So why does age deserve special attention? A safe and easy response would be that ageing brings with it some specific risks and challenges associated with biological changes, such as the decreased physical ability to respond to risky situations.[1] But this response is problematic, because biological ageing does not always correspond with an increase in a sense of vulnerability. Nor do other vulnerability indicators such as living alone, being a woman or having a disability. The reality is much more complex. Biology interplays with many other factors: age interacts with each person's life experiences and relationships, with social structures and networks, and with wider economic and political structures and each contribute to the exacerbation or mitigation of age-related vulnerability.[2]

Tasmania is neck and neck with South Australia leading the population ageing race. In this climate of demographic change there is a projected increase in the demand for community care services. The danger of community care policy adopting simplistic constructions of age-related vulnerability is the potential for equally simplistic service delivery responses, which will then fail to adequately meet the needs of vulnerable elderly people.

In this paper I will present a case study to illustrate some of the findings from a qualitative research project I conducted recently for the Tasmanian Council of Social Service, as part of our Home and Community Care consumer consultation project. The project asked people where and when they felt vulnerable, and in particular, where and when they felt vulnerable to being mistreated or taken advantage of.

A close look at this particular case study demonstrates the complexity of vulnerability, and it also highlights some broader implications for community care policy.

Context

Before I get to the case study however, I will just give you a bit of background to the project.

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[1] Grundy (2006) p106.
[2] See Schroeder-Butterfill and Marianti (2006).

As a framework for understanding vulnerability of elderly community care clients in Tasmania, I used a model published in a recent issue of *Ageing and Society* by Elisabeth Schroeder-Butterfill and Ruly Marianti[3]. Their model breaks down vulnerability into four domains: exposures, threats, coping capacities and outcomes. In short, they suggest that vulnerability is best understood by taking into account the relationships between these four categories, that is the interplay between risk factors and threats, (such as age, gender and isolation) and coping capacities (such as the resources that offer protection, and peoples capacity to access those resources). The outcomes domain refer to the combined impact of the other three area, or the answer to the question, vulnerable to what?

Applying this model, I conducted 37 semi-structured, in-depth interviews with clients who were referred to me by HACC service providers – including day centre coordinators, nursing staff and community care workers, social workers and advocates. Clients were identified as 'frail elderly', or vulnerable.

Workshops were also conducted in a number of HACC funded day centres around the state, chosen deliberately as the intentional gathering places of frail elderly people who live at home, and thus enabled the inclusion of hard-to-reach members of the HACC target population. In addition, three small focus groups were also held with unpaid carers of elderly people, mainly with dementia.

The project was informed by a literature review, *Vulnerability of Community Aged Care Clients,* conducted in conjunction with UTAS, which is available on the TasCOSS website.

Case Study
Jill Smith, not her real name, is a widow who lives in a smallish city in Tasmania. Mrs Smith has many conventional, stereotypical indicators of vulnerability. To start with, she's old, a woman and a widow. To add to this she lives alone, is a bilateral amputee and thus wheelchair dependent and she also has severe arthritis, which means she has difficulty doing things with her hands like preparing meals and handling her money. In case that's not enough, she has a low income from the aged pension and to top it off her son is fleecing her. By all rights she should look like this…

But she actually looks more like this…

And when we talked about where and when she felt vulnerable she stated: "There's nothing that worries me, I'm never scared about anything. I don't think anything fazes me too much".

What is it about Mrs Smith's situation that enables her to feel so secure?

[3] Schroeder-Butterfill and Marianti (2006b) pp 9-36

Certainly, her positive attitude is a factor that makes a difference to the way she feels. However there are also a range of structural factors that play a significant part. And I'd like to have a look at a few of these, to demonstrate how, in her case, the coping capacities she has access to offset a lot of her risks. I'm going to discuss Mrs Smith using 3 headings: physical factors, financial issues and social issues, and as I discuss each area, I'll also touch on the broader implications that arise from her situation.

Physical factors

Firstly, the main risks and threats associated with Mrs Smith' mobility problems are her inability to get herself in and out of bed without assistance, and her debilitating arthritis, which means she needs assistance with meal preparation and similar tasks.

However, to offset her mobility problems, Mrs Smith has access to a range of affordable, appropriate pieces of equipment that improve her independence, and lessen her sense of vulnerability. The community Occupational Therapist has been involved and she has used an equipment loan scheme which means she has, amongst other things, pick up sticks, a wheelchair, and a commode. She also has a Red Cross alarm, which many other participants also had and many stated they felt secure as a result. In addition, Mrs Smith had her bathroom modified to suit her needs. She was fortunate to be able to use her husband's superannuation payout, before he died, to pay for this.

Modifications and equipment play a vital part in decreasing vulnerability. Participants who did not have access to the same amount of equipment as Mrs Smith felt that their dependency extended beyond just being physical, to a sense of total dependency, and they were unable to exercise autonomy.

In addition to good equipment, Mrs Smith has access to a healthy combination of informal and formal support.

Although she has a poor relationship with one of her children, her other children share the tasks of helping her in and out of bed, preparing food and providing transport. Alongside this family support, a formal community care organisation provides personal assistants to also help her get in and out of bed, assist with shopping once a fortnight, and domestic assistance.

There are a couple of important points I would like to make about the success of this combination of care.

Firstly, it doesn't always work. HACC services are very often delivered as a complement, or adjunct, to the informal care provided by a spouse, family member or significant other[4]. In fact the presence of a spouse or family member may be a key factor when waiting lists for services mean clients must be prioritised. However, not all family members are appropriate care-givers. Unlike Mrs Smith some participants in this project received very poor care

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[4] HACC MDS 2004-05 states 47% of reported carers were either a male or female partner. ABS data *Carers in Australia* 2004 states 43% of carers nationally care for a spouse or partner.

from their informal carers, whether due to the stress of the caring role, the lack of appropriate formal supports, or as a continuation of a pre-existing abusive relationship. The point is, that while a combination of formal and informal support can work well, each situation must be assessed individually to determine the suitability of the informal care options.

The second point I'd like to make is that the success of formal care in decreasing vulnerability appears in some cases to be dependent on the willingness of carers to perform tasks outside of their job descriptions. Mrs Smith felt extremely comfortable with her carers, and said she trusted them implicitly. In fact, and this was the case for other participants also, Mrs Smith got on so well with her carers that they were more than happy to do extra bits and pieces for her, that were beyond the boundaries of their allocated tasks. For example, they write her cheques, handle her bank cards, and they give her their home phone numbers – all things they are not meant to do. Other participants said their carers changed light globes, moved furniture so they could vacuum properly, and sat and had a cup of tea. The deal was, however, that no one told anyone about it, not the client, nor the super carer.

One participant described the situation like this:
"the girls that come in, they are fantastic, but they have a lot of restrictions put on them. They know they can't do certain things, but because the restrictions are so tight and stupid they don't abide by them"[5]

The inconsistency between work place policies, and the reality of what happens in peoples homes raises a lot of interesting issues. Firstly, around accountability – for example, the risk of formal carers handling money in the absence of transparent processes is fairly evident.

It also raises questions about the flexibility of care that is currently on offer – if the type of service is not meeting people's needs, it is ineffective and inappropriate. It doesn't lessen vulnerability, in fact it may increase it because carers end up performing tasks that are unregulated. Strong accountability and monitoring practises in community care would enable flexible care that meets clients' needs to be legitimately delivered, whilst still ensuring clients and formal cares are protected from exploitation, breaches of care, or acts of mistreatment.

Back to Mrs Smith.

Financial issues
As I mentioned, Mrs Smith is on a low income, she has difficulty physically handling her money and writing cheques, and is being harassed by her son to speed up his inheritance. As a result, she has a significant degree of financial vulnerability.

A low income becomes a significant risk when it prevents people from affording equipment, or home modifications.

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[5] Marsh (2007) p37

The cost of home modifications and equipment purchases is not always covered by Government community care funding, and the costs can sometimes be very large, and financially debilitating – they can sometimes deplete people's savings, or their superannuation, or cause people to take loans or reverse mortgages on their homes. So, ironically, although equipment and modifications improve physical independence, they can create financial insecurities, and thus increase vulnerability.

Some participants also talked about going without home safety devices like sensor lights and alarms, and about not being able to afford preventative health care services, such as the physio or podiatrist. In addition, quite a few elderly people talked about having to curb their social life because they were unable to afford it.

Mrs Smith could offset some of the limitations of a low income by accessing her husband's super. Not everyone has super of course, and for some who did have, like Mrs Smith, they spent it on modifications. Others took out reverse mortgages.

In the case of the potential financial exploitation by her son, Mrs Smith was able to access a lawyer who had taken action to prevent it from going any further, and others had got some redress through using advocates and social workers. In these ways people could lessen the impact, and also prevent exploitation from continuing, or from happening again. But for other people, without access to the same supports, the impact of financial exploitation was great. Some had not been able to disclose their situation to people in order to get help, either through embarrassment or fear. Others were unable to afford lawyers and were not eligible for legal aid. Others were confused about their rights when family members held Power of Attorney, creating an additional sense of vulnerability. But the issues around Power of Attorney is a paper on its own.

That being said, one point I would like to make is that Home and Community Care workers are in a unique position to be able to detect various forms of mistreatment, including financial exploitation, and to assist clients with some sort of response, not only by virtue of their physical presence in people's homes but also through their capacity to form strong, trusting relationships with people. Currently, I think that community care workers are an under-utilised resource in this area, and there is scope, particularly in Tasmania, for community care to improve its capacity to deal with situations of mistreatment of elderly people.

Another important feature of Mrs Smith's coping capacity is also that she has her marbles: not only does this mean she can independently manage her finances, it also means that when the troubles with her son began she knew how and where to get legal advice and support. Not having your marbles opens up a whole range of additional risks.

For example, carers of people with dementia who participated in this research talked about the increased risks of financial exploitation associated with a decreased ability to manage money, and a decreased inclination to take care with their money. They also talked about people taking large amounts out of the bank, and spending big amounts of money on ride on mowers and table tennis tables. Also, the difficulty nature of caring constantly for a person with dementia was also raised, and the stresses that can bring. Carers acknowledged that they could get very angry and frustrated with the person they cared for, increasing the vulnerability of that person.

A particularly tricky area in dementia care, which also has broader applicability, is the difficulty of balancing the need to protect people with the shared aim of enabling their independence. What I mean is that many carers were unable to allow the person they cared for to do the things they wanted to - the things that meant they were still independent - because those activities placed them and others in too much physical danger. An extreme example is driving a car. However, other examples include having a bath or continuing to play bowls. One participant with early stage dementia described this situation as being 'over cared for'.

Independence was highly valued by participants in this project, and when independence was taken away, people felt vulnerable. So the difficulty is that protecting people from harm can lessen their sense of independence.

Now back to Mrs Smith.

Social issues

On the social side of things, Mrs Smith's vulnerability is increased because she lives alone. Participants stated a couple of reasons why living alone can increase vulnerability. Firstly because there is no one there – simple, but it means that if someone falls, or something happens, there is no one there to help. One participant who lived alone told a story of being physically abused by a visitor which left him feeling very nervous about living alone – but this is fortunately rare. Some participants said they were uneasy about being harassed by door-to-door sellers or telemarketers when they were on their own.

The second reason why being alone can increase vulnerability is because of its link with loneliness. Many people talked about feeling lonely in the context of vulnerability. As we know, it's a highly undesirable state, and if left unchecked can lead on to depression.

Mrs Smith's coping capacities demonstrate how these risks associated with living alone can be offset.

Firstly, she said she likes living alone, and she appreciated that her choice to do so was respected. Her family had offered to move in with her, and for her to move in with them, but she had declined. It is also true to say that some people who had not had their choice of living arrangement respected, who felt they had been forced out of their home into alternative arrangements, were

very unhappy. So having choice respected can counterbalance some of the negatives of living alone.

Secondly, as mentioned, she has a good combination of formal and informal supports and equipment.

Thirdly, importantly, she feels safe in her community: she leaves the keys in the meter box outside the door, like many people do, which I think is an indicator of feeling safe. The risk of loneliness for Mrs Smith was reduced by her willingness and ability to get out and have social contact in her community. Suitable, affordable transport played a big part in this, as did age-friendly street scapes, and also having affordable social options.

Some participants didn't feel safe in their community – a couple of people told some disturbing stories about nasty neighbours, others about dogs down the street, or groups of school kids that made them reluctant to leave their homes. Perceptions of safety and actual safety may not be the same, but both are real. Quite a few participants said they wouldn't use automatic teller machines because someone would come up behind you and hit you on the head with a bat – although I didn't meet anyone who had had this happen to them, or anyone who knew of someone either. But some people did know of bag snatchings, and some retold media stories about elderly people being attacked by strangers in the street. These stories generated fears and suspicions.

Conclusion

The case of Mrs Smith demonstrates how vulnerability is complex and multi faceted. Age-related vulnerability is not a natural, inevitable part of ageing, and although feeling vulnerable can be partly influenced by attitude or personality, it is also influenced by broader social structures and policies. In a period of population ageing, and in a climate where the policy emphasis is on healthy ageing, or positive ageing - policy positions which have associated connotations of an individual responsibility for ageing well - there is an increased need to address the existing structural problems associated with the vulnerability of elderly people, and to prevent the onset of further interconnected problems.

This research suggests that risk factors such as physical dependency, cognitive impairments or poverty can be in part offset by other factors such as access to appropriate formal supports, aids and equipment and to low cost community and health services. Similarly, threats that increase vulnerability such as the death of a spouse, or loneliness can be counterbalanced by safeguards such as good social networks, and access to contact with others.

Bearing in mind the complexity of vulnerability, the overarching factors that have a positive or negative impact on the vulnerability of elderly community care clients can be summarised as the presence or absence of:

- independence,
- social contact,

- poverty, and/or
- support in situations when mistreatment does occur.

To simplify vulnerability to a set of age-related indicators is to simplify what it is that people need from community care. There is not a one size-fits-all, fixed model of care that can be applied to all ‘frail aged’ community care clients. To understand the complexity of vulnerability, however, gives us some insight into possible effective points for intervention by formal care services to both lessen vulnerability and to respond effectively to the negative outcomes of vulnerability, including mistreatment. Such an understanding also points toward the need to structure our community care programs as flexible and holistic services which truly aim to enhance independence and improve quality of life.

Reading List

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