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Abstract

National policy to safeguard older people from abuse in England and Wales gives social services the lead role in coordinating local multi-agency adult safeguarding procedures. With the exception of Lipsky's (1980) work on street-level bureaucracy, relatively little research attention has considered the day-to-day reality of social workers charged with implementing public policy. This article reports findings of multi-method research carried out in a social services department in Wales to identify the constraints and realities social workers faced when implementing policy to protect older people from abuse. Data sources were 33 social workers and managers and local adult safeguarding documentation and statistics. Methods included semi-structured interviews, focus groups, observed meetings, and documentary and statistical analysis of adult protection activity. The research found the dilemmas social workers grappled with were inherent in the structure of their work, as Lipsky had proposed. Dilemmas included known poor practice and quality in some care services; resource shortfalls; and delays in investigating alleged elder abuse. The paper concludes by developing the metaphor of a 'cognitive mask' to describe how social workers manage the dissonance arising from dilemmas inherent in the context of their work to safeguard elders, and it suggests how this 'mask' can be removed.

Key words

Elder abuse; street level bureaucracy; challenge of poor practice; quality of care.

Introduction

Reading UK accounts of policy failure in social care is a peculiarly pleasure-less pursuit. 'Opportunities missed' and 'critical incidents' pervade these narratives of failure. The action plans and intensified regulatory interest that follow will hold professional practice to account. In child protection particularly, familiar rituals follow: tabloid press hysteria is visited upon the social workers (seldom doctors) involved, who are subsequently disciplined, dismissed and reported to the regulator. Procedures are reviewed, revised and rewritten; cadres of front-line staff are re-trained. 'Lessons' are once more 'learned'.

Public opprobrium and professional disgrace may be more muted in cases of policy failure to protect adults at risk. Members of the public would be hard-pressed to recall the name of Margaret Panting (a woman of 78 who died of substantial injuries caused by abuse by persons unknown, about five weeks after returning to live with members of her extended family in Sheffield) (Vickers and Lucas, 2004). 'Baby Peter', known to Haringey social services, the police and health services, and whose death in 2007 aged 17 months was caused or allowed by his mother, her boyfriend and his brother is, however, a name seared in UK public consciousness.

Serious case reviews and reports of circumstances where a child or adult at risk and known to social services has come to harm seldom, however, pay heed to the wider political, cultural and social contexts in which social workers practise. In the US, research on social workers' decision-making about potential elder mistreatment found it influenced by the supply and demand of services for the abused elder (Clark-Daniels and Daniels 1995). Ellis (2011), in a review of social work assessment practice in England over 15 years, found distinct types of discretion were shaped by different micro-environments surrounding decision-making, eg, the relative influence of managerialism and professionalism. Generally

however, the impact of these environments on professional practice remain unexplored in inquiry reports, despite Brodkin's (2001:13) observation that "[i]n the end, social welfare practices may only be as good as the politics that produce them".

The research reported here arose out of a case review undertaken by the author for a local authority into the circumstances surrounding the abuse of a 77 year-old woman by her son. The woman and her son were known to social and health services professionals and the police. Despite the documented risk the son posed to his mother, professionals had not used the multi-agency adult protection procedures to manage the case. Following completion of the review (and its 'lessons learned'), larger questions still remained.

One concerned the threshold a social worker used to judge whether a situation might be abuse (physical, sexual, psychological, financial or neglect) under national adult protection guidance (DH 2000; NAfW 2000). Operationalising a concept like 'threshold' depends on the understanding staff have of what constitutes abuse; and many situations of potential abuse are not clear-cut. Is it abusive if an adult son regularly 'borrows' (without repaying) a chunk of his mother's pension? If the mother is dependent on that son for day-to-day help to stay in her home, does this routine appropriation of cash become less (*sic*) abusive? Might it be expedient for social workers to 'overlook' a domestic situation which, if it collapsed, would present social services with dilemmas about how best to support an elder with complex needs in a resource-starved service world? What factors do social workers weigh up when deciding whether to use adult protection procedures in cases of suspected abuse?

To explore these questions, Michael Lipsky's (1980) work, *Street-Level Bureaucracy,* appeared to offer analytical potential. Lipsky had argued that the devices and routines street level bureaucrats (who include social

workers) adopt to manage the dilemmas in their work, effectively become the public policy they implement. Street level bureaucrats "believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits imposed on them by the structure of their work" (Lipsky 1980: xiii). Using Lipsky's thesis of street level bureaucracy, the aim of the research carried out in Wales and reported here was to identify the constraints and realities social workers faced when implementing policy to protect older people from abuse, and the dilemmas they faced when dealing with potential abuse of an elder.

What follows is in five parts. Firstly, Lipsky's (1980) thesis of street level bureaucracy is considered, and his contention that policy is, in reality, made by front-line workers in public sector agencies. This section continues discussion of abuse thresholds, and considers how self-determination and choice are conceptualised by professionals. Secondly, the research design and methods are described. Thirdly, findings are reported; key amongst these was the relative absence of social work challenge of poor practice. These findings are, fourthly, discussed in light of Lipsky's thesis, in particular his analysis of how dissonance develops and is sustained in human service work. Conceptually, this section develops the metaphor of a 'cognitive mask' to understand how the policy, social and economic context to safeguarding older people from abuse bears on social work decision-making and practice. Finally, some implications of this conceptual development to policy and practice to safeguard older people from abuse are considered.

Lipsky's *Street Level Bureaucracy* and social work practice

Lipsky's (1980) 'street level bureaucracies' are public agencies employing significant numbers of 'street level bureaucrats' who have direct contact with members of the public and who include social workers, and the police. Lipsky held that, in important ways, public policy was made in the day-to-day decisions street level bureaucrats made to cope with work pressures. He suggested that to understand why policy was not always implemented as policy-makers intended, "we need to know how the rules are experienced by workers in the organization and to what other pressures they are subject" (Lipsky, 1980, p. xi). A oft-cited Lipskian quote summed up the process: "the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out" (Lipsky, 1980, p. xii, emphasis in original). Lipsky suggested street level bureaucrats made policy in two ways – through individual acts of discretion, and by the aggregation of those individual acts which became, *de facto,* policy operated at the street level. This discretion was shaped variously by how much freedom in decision-making the agency permitted and, conversely, the need to make decisions when agency policy was ambiguous or non-existent.

It is Lipsky's work on the origins and manifestation of dissonance in the work of the street level bureaucrat that speaks to contemporary social work practice. He suggested street level bureaucrats experienced dissonance in their day-to-day struggles with the dilemmas inherent in their work. These lay, Lipsky argued, in the structure of street level bureaucrats' work and "a corrupted world of service" (Lipsky, 1980, p. xiii). Any commitment to public service the new recruit brought to their

work was defeated as high caseloads, ambiguous policy and cash-starved services prevented "them from coming even close to the ideal conception of their jobs" (Lipsky, 1980, p. xii). Instead, a "myth of altruism" (Lipsky 1980, p. 71) was maintained, where agencies devoted energy "to concealing lack of service and generating appearances of responsiveness" (Lipsky, 1980, p.76). Lipsky (1980, p. 153) suggested street level bureaucrats adopted various strategies to cope with this dissonance, including protecting themselves with "cognitive shields" to defend themselves from responsibility to act, leading, for example, to their blaming clients for the circumstances they were in.

Lipsky's research was done in the US in the late twentieth century. His phenomenological approach to understanding the subjective world of the street level bureaucrat, and what Hudson (1997, p394) called his "Goffmanian eclecticism", have been criticised for a lack of attention to a theory of power (Brandon 2005). That said, Kosar (2011, p299) maintains *Street-Level Bureaucracy* is "a classic of public administration", although the regulated, marketised, externalised welfare landscape of social care provision in the UK half a century on, is not one Lipsky's street level bureaucrats inhabited.

In England and Wales, the policy context for social work took a distinct turn in the 1980s. Major structural changes in adult personal social services were introduced by the National Health Service and Community Care Act 1990. In broad terms, the social work role was restyled from provider to that of enabler, commissioner and service planner, and marketisation transformed social services departments from monopoly providers to service commissioners. Managerialism created the 'new public management' whose *leitmotifs* were accountability, efficiency and competition (Pollitt, Birchall and Putman, 1998).

This "ideology of management" (Pollitt, 1993, p.16), along with 'modernisation' became the means by which public services were to be matched to public expectations (DH, 1998*)*. Standards, performance indicators, monitoring, inspection and audit were intensified in an unprecedented expansion of regulatory activity (Downe and Martin, 2006). In social care, the Care Standards Act 2000 introduced workforce and service regulation. Whilst post-devolution government in Wales has not pursued the market-driven privatised model that characterises social care in England (WAG, 2011), the new public management *zeitgeist* had taken root prior to devolution in 1999.

Against this backdrop, national policy in England and Wales to protect vulnerable adults from abuse came relatively late (DH, 2000; NAfW, 2000). Early research on the way local policies were being used found implementation was erratic (Mathew *et al,* 2002; Sumner, 2004), and social workers reluctant to use safeguarding policy to protect older people (Preston-Shoot and Wigley, 2002). In any case, implementing – or not – safeguarding policy depends on the threshold a social worker uses to determine whether an act or omission is potential abuse, and the analytical construction they place upon it. Neither is unproblematic.

Thresholds and 'choice'

In 2000, governments in England and Wales defined abuse in their respective policy guidance as a violation of an individual's human and civil rights by any other person or persons (DH, 2000; NAfW, 2000). The Law Commission's concept of 'significant harm' as a minimum threshold for intervention, was described as:

> (i)ll treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development.

(NAfW 2000, p16)

In their work on implementation of adult protection procedures in two English counties, Brown and Stein (1998) reported workers operated their own 'adjustable thresholds' of intervention, with 'informal' responses involving, say, monitoring, but no use of adult protection procedures. Taylor and Dodd encountered similar subjectivity in their study of 150 staff (from health and social services, police and the independent sector) using regional adult protection procedures. They found respondents could not identify all categories of abuse, particularly neglect. Staff had different thresholds of what they considered abuse; one-third said they would not report abuse through multi-agency procedures but would deal with the allegation internally. The authors commented: "the decision to report seemed to be based on a more subjective perspective, such as if it was 'severe enough' or repeated" (Taylor and Dodd 2003, p31).

The number of times an abusive act or action occurs is not itself a test of significant harm. However, in its analysis of phone calls to its helpline, the charity Action on Elder Abuse (AEA) reported many cases of financial abuse failed what AEA described as 'threshold tests' used by statutory agencies, where initial amounts of money taken from older people appear 'small', that is about £20-£30 per week (about a quarter of the basic state pension in 2010). AEA found examples of elders not having enough food to eat and living in increasing squalor, while relatively small amounts stolen added up to thousands of pounds (AEA, 2007).

An adult's right to make decisions is a further practice consideration for social workers dealing with potential elder abuse. In their research of how adult protection procedures were used in cases where elder abuse was suspected in domestic settings, Preston-Shoot and Wigley (2002) found many staff privileged self-determination over protection. Considerable

weight might be given to a person's views, described by social workers as their 'choice' — even when this left the older person exposed to risk.

'Choice', of course, is not an absolute concept. It is nuanced, contradictory and shaped by social and cultural factors that find expression in social policy and care provision: as Brodkin (2001, p2) commented: "… the quality of choices about help depend upon the "helping resources" to which social workers … have access". In the US, Bergeron (2006) suggested the notion of 'self-determination' (as well as 'competency') were oversimplified in social work practice and in elder abuse literature. Bergeron found mental incapacity given as the only reason to intervene in cases of potential elder abuse in domestic settings; she suggested social workers needed to think critically about the complex and contradictory values surrounding the work they do. Although not referencing Lipsky, she asked whether the culture of a social services agency 'accepted' an elder's refusal for intervention, as a way of balancing high caseloads against resource inadequacy. Bergeron summed up the professional conundrum:

> (t)he dilemma then in elder protection work is the understanding professionals have of the principle of self-determination to judge how much intervention preserves individual choice while providing victim protection.
> *(Bergeron 2006, p85)*

Bergeron (2006) pointed out that the 'choices' facing older people who agree to safeguarding intervention may be stark. In any case, decision-making needs practice. If the elder has been isolated, abused and belittled by someone in a close relationship to them, how can they assert the will to leave? If they are immobilised by the internalised shame that can accompany long-term, low-level but systematic domestic abuse, if they are afraid of public humiliation and the social stigma of disclosing domestic violence, how readily will they reveal what has happened to them? For a person (typically a woman) who has never decided where

she will live, managed her own affairs, nor had a sense of personal control, so-called 'self determination' may be nothing more than the stuff of soap opera.

Research design and methods

The research reported here was a multi-method case study of implementation of adult safeguarding policy in a social services department ('the Authority') in Wales. The study's intentions were threefold: exploratory (to explore the relevance Lipsky's concept of street level bureaucracy to policy implementation and social work practice in Wales in the early 21st century; descriptive (to describe what happens and why it happens, and how street level bureaucrats and their managers understand what happens); and explanatory (aiming to explain factors that bore on social workers' decision-making when dealing with potential abuse of an older person). The primary research question asked what factors influenced social workers' implementation of policy to protect elders from abuse. Subsequent questions (findings on which are reported here) included: what dilemmas did social workers and their team managers face in their implementation of procedures; what understandings did they have of the procedures; and what impacts did those understandings have on how they understood an elder at risk's situation, and on the decisions they took to protect an elder from abuse.

The study used multiple qualitative data collection methods, including one-to-one semi-structured interviews with each social worker and team manager working with older people (*N*=9); middle and senior managers in adult services (*N*=4); focus groups with two community care teams (comprising social workers, social work assistants and team managers); direct observation of one area adult protection committee (AAPC) meeting and two practice discussion sessions. In all, 33 social workers

and managers (team, middle and senior levels) took part in an interview, focus group or meeting. In addition, adult protection statistics and documentation covering a two-year period were reviewed. Documentation included: AAPC terms of reference, minutes and annual reports; adult protection monitoring; adult protection procedures and the Authority's operational guidance. Ethical approval was granted by the university's research ethics committee; no other ethical permissions were required at the time the research was done. The Authority did not have its own research ethics governance protocol. A guarantee of confidentiality and anonymity of sources was given to the Authority. Hence some data reported here omit precise figures to avoid identification of the Authority.

Qualitative data from interview and focus group transcripts, observed meetings, documentary analysis and research memos were entered onto an Excel database, to provide structure and flexibility to the management and integration of different types of data (Niglas, 2007; Hahn, 2008; Bazeley, 2009). The research questions and conceptual framework had generated an initial start list of analytical codes, which were developed during qualitative data analysis. Examples of codes included: social worker (SW) awareness of elder abuse; SW awareness of domestic violence; SW awareness of poor care; SW dilemma – hospitals; manager (M) or SW dilemma resources – shortfall; M or SW dilemma resources – quality. Secondary analysis of available Authority adult protection data, using the same Excel database, was carried out to identify trends and patterns in adult protection activity over a two year period. This was limited as data were not robust: practitioner recording practices were inconsistent; and national adult protection data collection systems in Wales changed at the time this research was done (CSSIW n.d).

The coded qualitative data were reduced iteratively using a constant comparative approach (Glaser and Strauss 1967) through four

successive data reduction rounds, aiming for corroboration (Rossman and Wilson 1985), or evidence of convergence or divergence in the data. This resulted in five analytic themes, three of which are reported here: 'awareness and professional experience of abuse'; 'dilemmas of resources'; and 'dilemmas of care'. Each theme was appraised in light of the research questions, the conceptual framework, and the coded data from whence it derived. This systematic grounding of theory development (Glaser and Strauss 1967) derived from the analytic process, which was driven by the research questions. Triangulation of the qualitative themes permitted the search for convergence and divergence in the multiple sources of information gathered, in order to develop , confirm (or disconfirm) the analytic themes (Creswell, 2003).

Findings

Safeguarding older people in the Authority

Authority safeguarding referrals concerning older people were lower than those for adults with learning disabilities in the year prior to the research. In the year before, referral rates were identical. This contrasted with the national picture where safeguarding referrals concerning older people ran at the highest rate in Wales, followed by people with learning disabilities (CSSIW, 2009). Adult protection referrals of all groups of vulnerable adults in the Authority came mainly from non-social services contracted providers, health and hospital settings. These comprised over half of all referrers in the year prior to the research, This contrasted with a much smaller rate of adult protection referrals from social workers in the Authority; these ran at one-quarter the national referral rate from social services care managers (CSSIW, n.d.)

Adult protection referrals in the Authority concerning older women exceeded those of men by two to three times. Women were more likely to suffer every type of abuse. The most common victim of alleged elder abuse in the Authority was an older woman, a finding consistent with national data in Wales (CSSIW n.d); or an older person living in a care home (more likely to be a woman because of higher male mortality rates). This contrasted with the national picture where the largest proportion of abuse victims were older people living in their own home (CSSIW, 2009).

In the Authority, social workers said they dealt with safeguarding alerts concerning elders infrequently. 'Seeing' abuse – whether social workers had what one manager called a 'third eye', or a sense of something 'not-right' – was raised more as the research proceeded, coinciding with a large-scale abuse investigation instigated in a care home at the time the fieldwork started. This home had been described by a social worker in an early focus group as "the whole place was an abuse … it was awful". The large-scale investigation raised a level of guilt in some social workers and nurses who had been undertaking statutory reviews in the home, who had known the home was poor (but regulatorily compliant), yet had continued to place people there. Social workers had witnessed care staff swearing at and in front of older people, observed older people told to sit down and shut up when they tried to attract attention, and knew of older people not been given their dentures to wear. They had discussed with each other how bad the home was. Yet none of this had led to their raising a safeguarding alert, which was eventually done by the regulator. It seemed as though professionals tacitly turned 'a blind eye' to what they saw.

Domestic abuse in old age was seldom reported as such. There were no examples of using domestic abuse support services in cases of domestic

abuse involving older people. One team manager commented that "it tends to be much more domestic violence as being seen for younger people, perhaps older people tends to go down the POVA (protection of vulnerable adults) route". The visibility of domestic abuse in older age may have been masked by the significance placed on an older person's exercise of 'choice' (to remain in an abusive home situation): " we should be prepared to endorse the individual's right to make choices" as one team manager commented.

Informed choice hinged on whether the person had mental capacity to make that decision. Discussing the choices an older person made, or any exploration of the risks inherent in decisions, was not reported features of social work practice in the Authority. There were no reported examples of proactive work with an older person on understanding potential risks or identifying ways to mitigate these. Instead, 'people have the right to make unwise decisions' was a mantra often repeated. The professional guide posts of contemporary social work practice — choice, independence, autonomy — appeared age-blind to factors such as frailty or abuse. 'Domestic violence grown old' (Straka and Montminy, 2006, p 251) was rarely considered.

Dilemmas of family care were often located in family dynamics and family structures that pre-existed concerns about potential abuse or neglect. Where one older person was caring for another with significant health and social care needs, sheer exhaustion and, not infrequently, a pre-existing poor relationship, could lead to fragile care situations collapsing completely. One partner may want the other admitted to a care home, one may refuse to have the other return home after a hospital admission. Such dilemmas were frequently encountered in social work practice in the Authority.

Lipsky (1980) had suggested that street level bureaucrats resisted procedures as a limit on their discretionary power. Evans and Harris argued the debate in UK social work about whether the exercise of discretion by social workers had been curtailed or continued following the introduction of care management in the 1990s, was inappropriately polarised. Instead, they suggested discretion is "a series of gradations of freedom" (Evans and Harris, 2004, p, 871). In this research, social workers exercised discretion in their "coming in and coming out of POVA" as one described it, that is, case managing inside or outside the protection of vulnerable adults framework. Social workers and managers liked the Authority adult safeguarding procedures, viewing them neither as ambiguous, nor fettering professional discretion:

> I like the guidance. I'm like Mrs Process, I like a process to follow, I like that stage 1, 2, 3, 4 … I know what we've got to do and know there's backup so I feel very comfortable about the whole thing. I like the framework… There's some really good checklists in there.
> *Social worker*

An Authority manager commented that "it is a very, very good set of guidance. It's very straightforward. The decision-making is very, very clear".

The formalised process of the framework, with its explicit entry and exit points, appeared to provide professional 'protection' – a 'certainty of structure' to frame decision-making in highly uncertain situations, as McCreadie *et al* (2008) found in implementation of the adult safeguarding policy *No Secrets* in England. 'Cover', for managers and social workers in this Authority, emanated from the multi-agency nature of the procedures, even if the co-equal participation of NHS (National Health Service) partners was lacking, and police priorities privileged other police work over adult protection investigations. This provided protective cover in the shape of multi-agency decision-making, rather than one agency – social

services – carrying decision-making responsibility alone. To borrow a Lipskian term, this cover seemed to be a policy *shield*, that is, protection from single agency responsibility for action or inaction.

The silence of challenge

In the Authority, challenge to poor practice was infrequent. The large-scale investigation of one care home had, as noted, raised questions about why the care plan reviewing and regulatory systems had not picked up earlier on the poor quality of life for people living there and, more tellingly, why the known poor quality of this 'whole-place-is-an-abuse' home had not been questioned, challenged or confronted by social workers and other professionals going in there.

Minutes of AAPC meetings and other Authority documentation were dominated by concerns about the quality of care of older people in hospitals and care homes, and with the non-attendance of health Trust personnel at meetings. Social workers spoke of the delays and difficulties of getting a health check for an older person, of their concerns about the risk of developing hospital-acquired infection if an older person was admitted to hospital. The absence of basic care in some healthcare settings was commented on frequently. One social worker likened the culture of some care homes as having become "the extension of the long stay geriatric wards", while another spoke sardonically of waiting for the NHS to re-badge relatives as "partners in care" as relatives had to provide so much basic care:

> … just to ensure their loved ones get access to adequate hydration during the day. It's about glasses and water jugs being close enough (to the person). I had a manager of a home say to me last week 'we don't leave water jugs out because there can be an accident, they can always ask us if they want a drink'.
> *Social worker*

Poor practice, such as a paid carer speaking roughly to an older person, might escape challenge at the time, but be spoken about later with colleagues. Whilst managers in the Authority seemed satisfied that obvious abuse would be actioned under safeguarding procedures, it was less certain that bad practice would be challenged. One manager was uncertain staff would 'read' some situations as requiring challenge, for example: "if people are left just sitting in a chair for four or five hours a day without any interaction at all, would people confront that?" Similarly, there were few examples given of social workers or managers within and across agencies challenging each other, or other agencies; for example, in questioning the time it took other agencies to provide services, or their quality and effectiveness.

The infiltration of these unacceptable but nonetheless common occurrences into everyday decision-making was insidious. A social worker described the self-questioning involved in care planning for an older person:

> … should this person be here? Or should they be somewhere else? At some level you're factoring that in, but I am aware it's a dangerous thought process.
> *Social worker*

Trading off least-worst scenarios against each other punctuated decision-making, for example in the case of the poor care a man received in his own home. His social worker commented:

> The problem is that whatever criticisms you might want to make of his care, and there are criticisms, it's probably significantly higher than your average nursing home.
> *Social worker*

Thinking of one care home, the same worker recollected "

> …that atmosphere and that attitude…most people who've never been in a nursing home would just be completely shocked by it. The danger for us is that we (get used to it).

Social worker

A manager speculated on the process involved:

> I suspect what happens really … is that incrementally you know people adjust their standards … and you have to make sure their standards stay above what's acceptable.
>
> *Authority manager*

The wider systems that may themselves have contributed to poor care, eg, cursory reviewing processes, flaccid regulatory or commissioning functions paying only intermittent attention to the quality of life experience for older people living in places they regulated or paid for, were not overtly questioned or criticised by social workers. Paradoxically, the potential for collective professional challenge in the UK is, arguably, greater than at any time in the history of the social work profession. Since 2004, employers and registered social workers have been required to comply with the codes of practice for social care employers and social care workers. For social workers this has involved, *inter alia*, 'bringing to the attention of your employer or the appropriate Authority resource or operational difficulties that might get in the way of the delivery of safe care' (Care Council for Wales, 2002). Employers have a mirror responsibility to develop systems for such reporting. Whistleblowing policies have been in place in England and Wales since implementation of the Public Interest Disclosure Act 1998. Yet there were no examples of professional power being exercised to challenge the macro context of health and social care provision for older people, and the service systems that sprang from it. Dominant contemporary ideologies of managerialism, partnership, marketisation and the like, had secured compliance — in the *not*-questioning — by persuading social workers that the constraints and realities of their day-to-day work with older people were inevitable, that their power to effect change was limited.

Discussion

In this silence of challenge, and 'not seeing' elder abuse, a contemporary dissonance seemed apparent. Lipsky (1980) had identified dissonance as the result of street level bureaucrats struggling with dilemmas inherent in the structure of their work: large caseloads and inadequate resources that defeated any idealistic aspirations they may have brought into the work. Lipsky suggested street level bureaucrats developed 'cognitive shields' to manage this dissonance and survive in the workplace.

A cognitive mask?

In this research, the dilemmas of care (its quality and resilience) and dilemmas of resources (quantity and type) social workers grappled with daily were the warp and weft of work with older people, threads that were interwoven into their stories and accounts. Rather than a crude 'client blaming' cognitive shield (denial in other words), small, actions or inactions accreted not into a shield (with imagery of solidity and impermeability), but *masks* that occluded clear vision. As a fencing mask both protects and partially obscures, cognitive masks closed down taking a sharp, clear, wide-angle view to ask *why* those dilemmas existed. They masked the existence of domestic violence in older age and so ruled out, for example, exploring what support, sanctions and structure the older person might want to stay in or leave that situation.

This cognitive mask is unlike the 'mask of ageing' conceptualisation in social gerontology. In that, an inner, youthful self is caged behind an inflexible and immovable mask of ageing, which manifests as tension between the ageless self an older person feels they are, and the ageing body they inhabit (Featherstone and Hepworth, 1991). The difference between the cognitive mask and the mask of ageing is that assuming the latter alerts both the older person, and the audience, to something being

hidden (Woodward, 1991). The cognitive mask does not hide what is underneath; rather it obfuscates and obscures what is 'out there'. In this research, the cognitive mask foreclosed assertive, persistent questioning of *why* there was an absence of services and support to older people who are abused by partners or close family members. Cognitive masks rendered professionals limited in their capacity to see through, and beyond, the outputs of contracting and regulatory systems that *ipso facto* would not prevent abusive, institutionalised cultures and practices taking root in some care homes. In other words, the masks narrowed the vision of what was seen, excluding the wider social, political and cultural context that framed that view.

The texture of these masks derived both from structural features of social care (fragmentation of service commissioning, provision, care management, regulation and so on), and behaviours of actors working in these structures at this social and historical junction. As Layder (1993) noted, people create the world they see. 'Seeing' is shaped by levels of understanding of the links between three levels: a macro context (for example, the resourcing and quality of services to older people, and ideologies *de nos jours* of choice, independence, personalisation and their ilk); a meso context (organisations, professional cultures and practices in services), and a micro context (subjective meanings and values the individual brings to their work with older people).

Cognitive masks do not fall fully formed straight out of 'managerialism', 'care management' or any of the other 'bad guys' said to bedevil contemporary social work (see, for example, Dustin 2007). Rather they derive from the interplay of macro, meso and micro levels, within a context of time, place and history: specifically in this study, that of social work with older people in general, and elder abuse in particular, in the early 21st century. They masked a dissonance where, for example,

knowing some care homes and healthcare services were poor resulted in tacit acceptance by default — by not questioning *why* that was. *Why* are resources so limited, and services so frequently of marginal quality for older people? *Why* are some care homes still like the back wards of post-Poor Law geriatric hospitals?

These social problems are not 21st century creations, as poor services to older people have a dismal persistence. Means and Smith (1998) charted the embedding of ageism in welfare history and the historical failure to establish older people as a priority of health and social care; while Hugman (1994) noted that social work with older people has typically been designed as the volume allocation of public resources (such as day centre places, meals on wheels, home care), rather than intervention requiring high order professional skills. The contemporary contribution to this historical stasis, as far as services to older people are concerned, is a multi-agency adult protection infrastructure that illustrates the paradox of unintended consequences: in coordinating activity and intervention, the system has distanced professionals from the elder, and has instead focused their gaze on the safeguarding system and on the pressures their inter-agency colleagues are under operating the system. Challenge to other agencies – asking *why?, why not?,* is mitigated because each agency knows the other is under pressure, they too have little time, little cash. Partnership work that is not mandated has to rely on cutting partners a bit of slack.

The metaphorical 'cognitive mask', like a fencing mask, narrows vision and excludes a wide-angle view of social, political and cultural factors bearing on how older people are 'seen', supported and treated. Considered separately, the lack of NHS engagement in adult safeguarding structures, and a quality of some care homes described by a manager as "just about on the side of statutory compliance", have an air of

monotonous ubiquity for those working in contemporary social care services. They are *unremarkable*. *Everyday*. The place at which the commonplace meets pressure on resources is a pinch point where dissonance sets in, expectations are lowered, and cognitive masks are forged.

Conclusion

Unmasking the context

The enduring legacy of Lipsky's (1980) work on street level bureaucracies is the attention it focussed on the context of street level decision-making. The research described here has suggested how the cognitive mask obscures the context framing social work decision-making in safeguarding elders from abuse. Removing the 'cognitive mask' —that is, creating organisational cultures and practices that name and challenge contextual constraints which negatively impact on safeguarding decisions — would require systemic change. It calls for the creation of organisational cultures that both encourage and *expect* professional and public challenge to the quality, resourcing and processes of safeguarding work with elders. Features of such cultures would include embedded critical thinking and questioning of practice, resourcing and decision-making at all levels of organisations; managers who model reflexivity and develop it in staff; managers who require reports poor practice as well as exemplary work, as a matter of course, not in the breach (Ash, 2010). In these 'unmasked' cultures managers would ask, routinely, why they received few, if any, reports of poor practice, services or care. Staff would relish self-challenge and feel professionally confident to challenge each other and other professionals. (Ash, 2011).

Making these changes happen does not fall into a neat, tick-off list of linear, discrete recommendations – the end result of any bad news story

in social care. Rather, changing cultures of care of older people at risk of abuse requires change that engages with policy, organisational and cultural determinants of care of older people generally, as well as elder safeguarding systems specifically. The cognitive mask is not fixed, but its removal requires focusing critical attention on the professional, organisational and policy-making contexts, including the nature and quality of care-giving to older people, within which social workers implement policy to safeguard older people from abuse.

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