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research article

Revisioning social work with older people living in a care home: promoting rights and reducing social control

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Care home residents are exposed to high levels of social control. Despite this, and regardless of their disempowered and vulnerable status, they receive limited attention from social workers. The social work role is primarily transactional, relating to admission, reviews of placements, Deprivation of Liberty Safeguards assessments and investigations of abuse. Evidence suggests that higher levels of engagement with residents are likely to reduce risks of abuse and contribute to reduced levels of social control. There are three routes of impact: a formal ongoing link with care homes; greater involvement with the four existing roles, shifting the focus from procedure to process; and the adoption of a new, more critical role that is informed by political ethics, enhancing rights and social justice. This revisioned role will offer residents access to the knowledge and skills of a social worker and to higher levels of protection from systems and practices that are harmful and controlling.

Keywords older people • care homes • social work with older people • social control

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Introduction

This article aims to make visible a population who are very marginal to social work discourse: older people who live in care homes. It will consider the ways in which social work may, unwittingly, be complicit in the social control of residents[1] and explore how social work could be both strengthened and revisioned in order to contribute to reducing social controls and abuse and to promote rights and social justice. It is important to recognise that there is very little research on social work with older people in the UK and almost none focused on the role of social work with care homes. Given the largely

disempowered, disadvantaged and vulnerable status of many care home residents, this deficit is noteworthy, particularly when situated alongside social work's claims relating to the promotion of rights for groups of people who share this profile.

In this article, we use the following definition of social control to underpin discussion: the purpose of social control is to regulate the behaviour, including freedom of movement, of individuals and groups in their social environment; at a societal level, it is also about maintaining social stability and the status quo (Chriss, 2022). The article is informed by a number of theoretical constructs and concepts that illuminate issues relating to social work, social control and/or care homes. These are woven through the text where they are best situated to strengthen a point or support an argument.

We offer some context regarding care homes for older people, before exploring the ways that social work currently engages with residents and care homes and how it may be complicit in issues of social control. The discussion outlines our vision and ambition for a future social work role.

Care homes and care home residents: context and background

There are a range of policy imperatives that encourage older people, including those with support needs, to remain in their own homes, for example, 'ageing in place' policies (Luker et al, 2019). Nevertheless, a small but significant proportion of older people do live in a care home (see Box 1). In 2022, this figure was estimated to be 408,371 in the UK, which represents approximately 3 per cent of the total older population.

Box 1: Definition of a care home

'Care home' refers to all types of settings that offer 24-hour accommodation and care to older people, including nursing homes, residential care homes and specialist dementia care homes.

Care home residents have become markedly more dependent over time: they are admitted at a later stage in their life course than they were in the past (Forder and Caiels, 2011). The majority the majority are women aged 85 years or over; 80 per cent have complex co-morbid conditions, dementia and/or a hearing impairment; and a significant proportion have depression and are frail, in pain and/or incontinent (Dening and Milne, 2021). Most people do not choose to be in a care home; many are admitted in a crisis situation, such as following hospital discharge or the death of their family carer (Harrison et al, 2017; Samsi et al, 2022). Publicly funded residents often have a very limited choice about the home they are admitted to and are more likely than a self-funder to be placed a long way from their community (Schlepper and Dodsworth, 2023).

The care home sector has also changed significantly over the last 20 years. It has become increasingly privatised and fragmented, with 90 per cent (n = 17,079) of care homes being run by the private sector and an increasing proportion being owned by big companies. Care homes are also larger (CQC, 2023a), and there is now greater reliance on residents paying their own fees; in 2023, over a third of residents in England were self-funders (Office of National Statistics, 2023).

Care homes are situated geographically and metaphorically 'off the public radar' and, increasingly, outside the purview of the state. Moving to a care home is widely viewed as a failure to maintain community-based living; it tends to be regarded as the place of 'last resort'. This almost wholly negative discourse 'is largely portrayed as fact, rather than critiqued as oppressive, ageist' and damaging to the well-being of older people and their families (Higgs and Hafford-Letchfield, 2018: 230).

Older people living in care homes are subjected to a range of social controls that compromise their human rights, autonomy and freedoms. Some residents, particularly those with dementia, are routinely deprived of their liberty, that is, they are unable to leave the care home unaccompanied, albeit (often) through the legal framework of the Mental Capacity Act (see later). Day-to-day decisions about what to eat, when to go to bed and/or when to see relatives are constrained by care home routines (Mikelyte and Milne, 2016). An increasing number of residents are also the subject of surveillance, including in their own bedrooms (Anand et al, 2022). The extent to which social work is complicit with these and related dimensions of social control is discussed later in the article. First, we briefly review the shifting nature of the welfare context within which social work is situated and the amplification of risks relating to social control.

Social work and social control

There is a long-standing tension in social work between 'care' and 'control'. Although social workers tend to place greater emphasis on the care dimensions of their role, the control dimensions have become more prominent over the last 20 years, particularly since 'austerity' (Humphries, 2022). The impact of neoliberalism and the enduring climate of budgetary constraints have played an ever greater role in reducing access to public services, reserving them for those in 'greatest need', in crisis or 'at risk' of abuse (Carey, 2022).

One of the consequences of this shift is that social work has become increasingly aligned with the performance of relatively narrow statutory functions, such as 'assessments of mental capacity' or 'safeguarding' (Rogowski, 2020). These roles are situated theoretically inside the 'social order' model of social work and are intrinsically bound up with issues of social control (Payne, 2005). A focus on safety, reducing risk and protecting people with care and support needs from harm tend to demand 'interventions' that lean towards control: a reduction of a person's liberty, (closer) monitoring of decision making and/or engagement with professionals who can themselves exert some form of control, for example, increasing the dose of psychotropic medication. That there is very limited time or space in these interventions to accommodate the counterbalancing influences of 'softer', more care-oriented dimensions of social work, such as developing a trust relationship, is noteworthy (Trevithick, 2012). This is particularly discomforting when considered alongside evidence that having a meaningful relationship with the (same) social worker is a key feature of both risk reduction and the promotion of legal and human rights (Lloyd, 2005; Ward and Barnes, 2016). It has also been consistently identified as 'very important' to older people (Tanner et al, 2023). Its erosion is a primary challenge to social work's claim to practice person- or relationship-centred care (Banks, 2014). The fact that there is almost no room to address socio-structural inequalities, such as

poverty or ageism, is also antithetical to the promotion of social justice, a core social work value (Social Work England, 2019).

Care homes represent arenas where welfare constraints intersect with issues of 'risk', 'the market' and dependency, dementia and frailty. One of the products of this intersection is a greater emphasis on social control. The care home is a setting where social control can take root; it can powerfully shape the nature of care. That this process happens gradually, opaquely and with the endorsement, even collusion, of the state makes it especially interesting to explore. It is in the uncomfortable space where the care home 'meets' social work that this article is located.

Social work with care home residents and social control

In England, social work's relationship to care home residents and their families is primarily transactional: social workers tend to be involved at the time of admission, in placement reviews, in assessments relating to Deprivation of Liberty Safeguards (DoLS) and during safeguarding investigations.

Admission to a care home

Social workers are routinely involved in the process of care home admission for older people who rely on public funding (from the local authority) to pay their fees (Harrison et al, 2017). Self-funders often find a care home with the help of their family and rarely have contact with a social worker.

Despite research showing that moving to a care home at a time of crisis is far from optimal (NICE, 2016; Samsi et al, 2022), one of the main routes of admission is from hospital. The current Discharge to Assess (D2A) model (see Box 2) increases the likelihood of this happening. This model aims to reduce the risk of people remaining in hospital longer than necessary; it also helps free up hospital beds. Those who need a lot of support are admitted, ostensibly temporarily, to a care home to await a needs assessment to decide whether they should remain in the care home or return to their own home with care and support. This assessment is expected to be undertaken by a social worker, usually based in a community team, within six weeks.

Box 2: D2A

The D2A model was introduced as best practice in 2016 by NHS England. It aims to discharge older patients as soon as they are 'clinically optimised'. Those with the highest level of need are transferred to a care home for 'assessment of their longer term needs' (see: www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance).

There are a number of issues with D2A. First, it is a prominent example of a model that is driven by organisational – in this case, the health service's – priorities, with all of the attendant risks of marginalising the older person's wishes and rights

(Heenan and Birrell, 2019). Despite assurances of reassessment to 'return home', people who are admitted to a care home under D2A are often not reassessed within the six-week window, as they are not a priority for the community team; they are considered to be 'safe'. They are also vulnerable to an emerging trend whereby local authorities are placing older people with high support needs in a care home because the fees are less expensive than funding a community-based care package (Horton and Wood, 2022). This is in direct conflict with the ageing-in-place policy emphasis we noted earlier.

These twin pressures combine to amplify the risk of the older person becoming a permanent care home resident by default. This 'default decision' could be viewed as a form of social control. It is also a human rights issue. Older people in this situation are exposed to undue restrictions and their right to have 'private or family life respected', that is, to go back to their own home, is not being upheld (Section 1, Articles 5 and 8 of the European Convention of Human Rights).

Social workers appear powerless to stop this default admission process, or even to (at least visibly) challenge it as a dimension of social control; nor do they challenge the prioritisation of the health service's needs above the needs of the older person (Local Government Association, 2024). One of the mechanisms at play here is the narrow conceptualisation of 'transition' that permeates the care system and, by extension, the social work role. Tanner et al (2015) argue that supporting older people experiencing a transition should be 'fertile ground' for social workers, but because it is viewed predominantly as a physical move from one setting to another rather than a psychological process that involves significant adjustment over time, there is limited room for social work engagement (Lloyd, 2005).

That these risks almost exclusively affect older people who require publicly funded care marks this out as an issue of social justice. It reflects the profoundly marginalised and disadvantaged status of this particular population and speaks to the need for social workers to advocate for older people's rights – for example, to choose which care home to be admitted to – which are threatened by the systemic drive to 'empty beds' (Heenan, 2023). Engaging with social work's therapeutic potential to support the transition process is a related role, one that is evidenced as facilitating more positive outcomes for older people and their relatives in other countries (Milne et al, 2024). The fact that most of this group are older women is an additional, though little-recognised, dimension of the social justice agenda; they have been described as the 'invisible majority' in care home settings (Barnes, 2012).

DoLS

DoLS (see Box 3) warrants specific attention due to its importance as a mechanism of (potential) social control. That social workers make up the vast majority of Best Interests Assessors (BIAs) and that many more older people are subject to DoLS than younger adults are also relevant. The local authority (acting as the supervisory body) is responsible for overseeing the DoLS process and granting authorisations. In 2022/23, 300,765k applications for DoLS were made: four fifths of those granted were for care home residents (NHS Digital, 2022).[2]

Box 3: DoLS and BIAs

- DoLS is a legal framework introduced to protect the rights of people under the Mental Capacity Act 2005. It applies to people who lack the capacity to consent to their care arrangements in a care home when those arrangements amount to a 'deprivation of their liberty'.
- A BIA is usually a social worker with additional qualifications and training. BIAs carry out an assessment to ensure that any restrictions in place are necessary to prevent harm, proportionate to the risk of harm and in the person's best interests.

Generally, social workers regard the BIA role positively. Evidence suggests that when social workers are given the time to do a thorough assessment – as was intended by the Mental Capacity Act 2005 – they report that it can offer a practice-related opportunity to 'do real social work' (Buckton, 2023: 304). 'Proper' BIA practice has the potential to reinforce key social work values, including promoting older people's rights (British Association of Social Workers, 2017), and to reduce social control (Hubbard, 2018). Examples include establishing that the older person does have mental capacity, so no DoLS is needed, and that they are being over- or covertly medicated by the care home. It can also trigger an application to the Court of Protection (known as a challenge under Section 21A of the Mental Capacity Act) if an older person consistently objects to being in the care home; this may result in the person going back to their own home.

However, there is growing evidence that the BIA role is less robust than it once was, with the consequent loss of rights for older people. The 2014 'Cheshire West' judgment (see Box 4) has diluted DoLS by lowering the threshold for deciding if someone is deprived of their liberty. Buckton (2023: 302) argues that this judgment 'supplanted carefully calibrated professional judgement with a simple definition that can be applied in every case', leading to much more 'routinised practice' that is less likely to be individualised to the needs of the older person. Buckton (2023) notes that ten times as many DoLS applications have been made since 2014, with the vast majority relating to care homes. This and linked evidence suggests that DoLS assessments are being conducted because an older person is not 'free to leave' the care home, not because restrictions on their freedom to leave may need to be put in place. In other words, it is about employing a legal mechanism after the restrictions have been imposed, not as part of a potential future plan. Inadvertently, BIAs have been recruited into supporting a process that prioritises protecting the care home and the local authority, not the rights of the older person.

Box 4: The 'Cheshire West' judgment

The 'Cheshire West' judgment by the Supreme Court in 2014 (Cheshire West and Chester Council v P [2014] UKSC 19) defined the 'acid test' for a deprivation of liberty as someone being 'under continuous supervision and control; and not free to leave'. Since this judgment, most people who lack the capacity to consent to their care arrangements in a care home are considered to be 'deprived of their liberty'.

It is noteworthy that local authorities are increasingly setting up dedicated teams of BIAs. This shift reflects two intersecting processes: an organisational response to a significant increase in the number of DoLS applications; and an uncoupling of social work with older people from the work of BIAs. Best interest assessments were intended to be an embedded but independent element of social work (Hubbard, 2018). One of the main contributors to the dilution of DoLS as a legal mechanism and best interest assessments as a process is a reduction in welfare resources. If time is needed to do a thorough assessment and time is in short supply, the assessment process will be reduced in size and shape to fit the tick box that it is constrained by.

These changes make visible the erosion of professional autonomy and the loss of social work skills and knowledge in the BIA role, including, importantly, the loss of criticality, advocacy and rights-based practice (Rogowski, 2023). Given that their intended role was to protect older people from harm, it is ironic that one of the main outcomes of recent BIA practice is an increase in the number of older people being deprived of their liberty, which – if not thoroughly justified as being in the person's best interests – are more likely to lead to the imposition of social controls and the kinds of human rights abuses experienced by residents during the pandemic (see later).

Reviews of care home placements

The Care Act 2014 requires local authorities to conduct reviews, at least annually, for people with care and support needs who receive public funding; this includes people living in care homes. Reviews are often done by social workers. Although there is very limited research on reviews, the evidence we do have suggests that they tend to be largely administrative and subject to similar systemic constraints as the admissions process (Scourfield, 2015). Care home residents are also not a priority for local authorities because, as noted earlier, they are considered to be 'safe'. Local authorities are under enormous pressure. In their 2023 spring survey, the Association of Directors of Adult Social Services (ADASS) identified that 430,000 people were waiting for an assessment of their needs. One in four people had been waiting at least six months (ADASS, 2023).

Pathways of responsibility are also disjointed. A social worker may make a recommendation as a result of a review, for example, to refer the older person for an audiology assessment, but in a system that uncouples the social worker from the older person once the review is completed, there is limited capacity to make sure it happens.

Paradoxically, evidence suggests that older people tend not to play a significant role in their own reviews (Scourfield, 2015). It is difficult not to regard this as, at the very least, poor practice and, at the most, a feature of social control. It is important to remind ourselves of the dependent status of most care home residents and the particular vulnerabilities of publicly funded residents. This group of residents need a strong advocate in attendance who has spent time getting to know them before the review and has an in-depth appreciation of their needs and wishes, as well as a commitment to engaging with a rights-based discourse (Tanner et al, 2015). Making the case for the older person to have higher levels of funding from the local authority to meet their more complex levels of need is a key example (Milne et al, 2024).

These changes are accompanied by, or may be a consequence of, a subtle shift of power away from the older person and their family towards the care home. Not only

does the local authority depend on the care home for placement provision, but it is also unlikely to welcome the extra work incurred by a move to another home, particularly in a climate of shortages of care home places. Although the review process is ostensibly about the older person's care and well-being, since it has been eclipsed by organisational imperatives not to spend any extra money, it has become narrowed to a procedure rather than a process. The use of discretion has been substantially reduced by the twin assaults of sustained managerialism and austerity (Evans, 2010; Pascoe et al, 2023). Concerns about poor practice may not be visible if social workers are reliant on care home staff to give them access to key information, for example, case records, and/or they do not have the time to build relationships with residents and staff. Valuable opportunities to engage with the concerns of the older person and their family, provide proactive advice about legal rights and funding issues, and monitor the quality of care provided may be lost (Scourfield, 2015).

Safeguarding issues

In all four UK jurisdictions, local authorities have a statutory duty to investigate instances of abuse or neglect, including self-neglect, of 'adults with care and support needs' (see Box 5). This includes instances arising in care homes.

Box 5: Safeguarding duty

Under Section 42 of the Care Act 2014, the local authority has a duty to make safeguarding enquiries to decide what action is needed where a person:

- appears to have needs for care and support;
- is experiencing or is at risk of abuse or neglect; and
- as a result of those needs, is unable to protect themselves from the abuse or neglect or the risk of it.

The Care Act 2014 guidance defines institutional (or organisational) abuse as 'neglect and poor care practice within a specific care setting'. It may be physical, verbal or psychological, an act of neglect, or an act of omission, for example, not giving an older person their medication (Department of Health, 2014: §14.17). Organisational abuse can range from one-off incidents to ongoing ill-treatment and can apply to one or many residents (Age UK, 2020). In one sense 'institutional abuse' simply refers to the setting in which it occurs; in another, it is a recognition of the fact that the very nature of 'institutions' can place residents at risk (discussed later). Abuse in care homes tends to be complex in both nature and resolution (Phelan, 2015). Many local authorities automatically consider it to be 'high risk' and to warrant specialist expertise in safeguarding work (Graham et al, 2017). This is most often social work expertise.

Despite policy actions to regulate care homes, establish care quality standards and improve the training of care workers, abuse is a persistent feature of long-term care (Smith et al, 2023). National data suggest that in 2021/22, around a third of all safeguarding enquiries were related to care homes (NHS Digital, 2022). Although

prevalence data vary widely, a recent systematic review suggests that 64 per cent of care home staff reported that they had 'perpetrated abusive acts against residents over the past year' (Yon et al, 2019). Prevalence estimates for abuse subtypes, reported by residents themselves, were highest for psychological abuse (33 per cent), followed by physical (14 per cent) and financial (14 per cent) abuse, neglect (12 per cent), and sexual abuse (2 per cent). The most frequently reported types of neglect were 'ignoring a resident when they called for assistance' and 'not responding when they asked to be taken to the toilet' (NICE, 2021; CQC, 2023b).

There are two ways that abuse intersects with issues of social control. The first is that all abuse, though institutional abuse in particular, is about 'regulating the behaviour' of both individuals and residents as a group 'in their social environment'. The second relates to the shift of power referred to earlier and the limited access residents have to the services of a social worker. While this is relevant to all the social work roles that we are reviewing here, its most profoundly stark and damaging consequences relate to abuse (Flynn, 2015).

Risks of abuse and social control were significantly amplified during the COVID-19 pandemic in 2020 (Anand et al, 2022). Care homes became far more 'closed'. Under the umbrella of 'increasing safety', they (re)acquired (some of) the features of a total institution (Goffman, 1961): families were, effectively, banned from visiting; some residents were locked in their rooms 24/7; access to communal areas, such as lounges, was severely restricted; and many residents were unable to gain access to medical care, including hospital admission for life-saving treatment (Milne, 2020a).

Despite the adult safeguarding duty remaining in place during the pandemic, it is clear that local authorities – and social workers – did not (often) intervene to save lives or conduct investigations (Milne, 2020a). The lack of external scrutiny provided by social workers and other professionals, such as general practitioners (GPs), also contributed to instances of abuse going unchallenged (Amnesty International, 2020). This underscores the importance of social workers engaging with care homes to a greater degree and extending the reach of their current proscribed role.

Abuse in care homes

It is important to recognise that abuse in care homes is most often the product of an institutionalised culture rather than a rogue care worker; poor practice can develop into restrictive practice and then into abuse insidiously over time. For example, not taking an older person into the garden regularly may gradually become placing their walking frame out of their reach and then into actively restraining them from getting out of their chair. The role played by 'depersonalisation' is especially damaging (Kitwood, 1997). This refers to a self-reinforcing process in which people with dementia are (mainly) ignored, dismissed, marginalised, misunderstood and (often) mistreated. Although Kitwood's (1997) work on realigning services away from a focus on 'the dementia' and towards a focus on 'the person' had a profoundly positive influence on services, evidence suggests that depersonalisation retains institutional potency. In her recent study of care home life, Johnson observes that older people are routinely 'stripped of "personhood, care, dignity and respect"' (Ryan, 2020, quoted in Johnson, 2023: 693).

The corrosive role played by the care home market is also relevant. Low staffing levels, inadequate pay, high staff turnover and limited time spent with residents are some

of the consequences of 'efficiency' (Lloyd, 2012). These undermine the development of person-centred care and the positive role that relationships can play in bolstering resident well-being. The fact that care is treated 'as a commodity' is a related issue. Task-focused models of care prioritise time and tasks over relationships and communication. The more the older person is regarded as a 'set of tasks', the greater the risk of poor or abusive care. That publicly funded residents are more likely to live in care homes with a lower Care Quality Commission (CQC) rating than self-funders underscores the role that the market plays in creating a division between the 'haves' and the 'have nots' (CQC, 2023a; Office of National Statistics, 2023).

Strengthening social work with care home residents

Discussion in this section will explore two issues: how social workers could offer a more effective service to care home residents; and how greater levels of engagement may reduce levels of social control. We structure our arguments around the existing roles outlined earlier. It is important to acknowledge that the evidence base is uneven and limited. In the subsequent section, we explore a revisioning of the social work role that takes us beyond the confines of the current paradigm.

Assessments and reviews

There is some evidence that more nuanced, time-rich social work assessments before care home admission, mainly relating to hospital discharge, increase the likelihood of an appropriate placement. They may also promote greater involvement of the older person in the decision-making process, reduce the risk of psychological harm and support a more positive transition (Milne et al, 2024).

Inappropriate placements from hospital are on the rise; more older people are having to move from one care home to another within weeks of discharge. This appears to be linked to two processes: the development of discharge models like D2A; and the fact that an increasing number of placement decisions are being made exclusively by health professionals (Zhang et al, forthcoming). In this context, the older person is denied access to a holistic social work assessment, including exploring alternative options to a care home. It also risks marginalising the voices and perspectives of the older person and their family. Multiple moves are also known to be very damaging to older people's health and well-being.

Reviews of residents by social workers is another assessment role that has been highlighted. Work by Manthorpe and Martineau (2017) identifies reviews, or the lack of them, as one of the 'missing links' in a number of serious case reviews (see Box 6 later). Their work reinforces existing evidence that annual reviews can often resolve emerging problems early on before they become embedded.

It is noteworthy that, despite funding pressures, a number of local authorities have protected the social work role in the review process. They have 'care home reviews teams' made up entirely of social workers or 'community social work teams' that have key responsibilities for care homes in their area, including conducting reviews (Bauld et al, 2000). Social workers have (more) legal powers than their unqualified social care colleagues, including those relating to safeguarding, and are more likely to take account of changed needs and the older person's perspective.

Information and advice

There is recent evidence that the (traditional) social work role of providing information and giving advice is highly valued by older people and their families, especially in contexts of transition (Ray et al, 2015; Tanner et al, 2023). Specifically, this involves helping people navigate the opaque and confusing care system, providing clear guidance regarding care home funding, and ensuring that older people and their carers understand their legal rights and the local authority's duties (Baxter et, 2008). Unless they are visiting for a specific reason, for example, to conduct a review, social workers do not offer this service to care home residents.

Other information-related roles for social workers have been suggested. For example, keeping care staff up to date with safeguarding issues and legislative and policy changes (Manthorpe and Martineau, 2017). The fact that care staff have very limited knowledge about practices that place older people at risk of harm is a widely noted concern in reviews of serious harm or deaths in care home settings (Rees et al, 2021).

Safeguarding

Despite the growing body of work relating to safeguarding models and practices, there is almost no work on the specific role of social workers (Graham et al, 2017; Local Government Association, 2020). As social workers are, uniquely, situated at the nexus of the local authority's safeguarding duties, the needs of the victim(s) and the care home context, this is a curious deficit.

Work done by Manthorpe and Martineau (2017), who carried out a documentary analysis of 38 serious case reviews involving care home residents, is an exception (see Box 6). The authors make a strong case for social workers to be more involved in care homes and argue that this may reduce risks of abuse, including risks of serious harm or death. They propose 'active engagement' by social workers on an ongoing basis. As professionals with crafted engagement and communication skills and a critical capacity, Manthorpe and Martineau (2017) consider that social workers are well placed to identify 'failing homes' at an early stage, challenge poor practice and act to prevent abuse.

Box 6: Safeguarding adult reviews

Under the Care Act 2014, safeguarding adult reviews (SARs) – previously called 'serious case reviews' – are held when an adult with care and support needs has died or has suffered significant harm as a result of abuse or neglect and there is concern that agencies could have worked better together to protect them. SARs are about past events and learning lessons for the future.

One of the issues that characterises care homes where older people have died or been seriously harmed is the lack of attention paid to them by externally employed professionals, including social workers (Higgs and Hafford-Letchfield, 2018). 'Endemic mistreatment and neglect, but also individual poor care, can reflect … gaps in attention

from a multiplicity of professionals who *cannot see the whole picture*' (Manthorpe and Martineau, 2017: 2094, emphasis added). The current model – where social workers infrequently visit a single resident for a specific statutory reason – means that they are not in a position to notice a deterioration in the quality of care across the home, an increase in the number of complaints or changes to the well-being of residents beyond the individual they are seeing (Brown, 2011).

A second reason why social work involvement with care homes reduces instances of abuse is that their professional registration engages staff with a set of accountabilities that are both external and alternative to those that are part of the home's regime (Mikelyte and Milne, 2016). These offer a challenge to 'taken-for-granted' practices and provide staff with a rationale for resisting collusion with poor-quality care (Lloyd, 2012; Marsland et al, 2015).

Social workers being available for consultation would also help because staff, residents and families are often reluctant to raise concerns about abuse directly with the home (Welch et al, 2017). Barriers include the fear of reprisals (that is, [further] mistreatment of the older person), concerns about where the older person would go if a new home had to be found and, for staff, worries about retaining their jobs and not knowing who to contact about abuse issues (Rees et al, 2021).

Manthorpe and Martineau (2017) conclude that post-admission social work is 'largely marginal' to older people's lives. They regard this as a loss and make a plea for social work skills to be on offer to this 'group of older citizens' to a much greater extent than is the case at present (Scourfield, 2007). Before discussing a revisioning of the social work role, we briefly review the nature of social work support for care homes in other countries.

Social work and care homes: other models

In a number of European countries and larger homes in North America, it is mandatory for care homes to employ a social worker. A review of the international literature summarises the social work role in the care home as: helping the older person and their family make a decision about placement; providing bio-psychosocial assessments; offering holistic person-centred care to residents; reviewing the placement; advocating for residents; and supporting care home staff (Hardy et al, 2020). A recent Canadian study identified the key roles as advocating for residents, 'humanising care', balancing autonomy with safety and facilitating collaboration (Wong, 2021).

Social work, social control and care home residents: a revisioned role

Although there is limited evidence that social work has a direct relationship with reducing social control, it is clear that greater levels of engagement with residents, their families and staff are likely to reduce risks of abuse and harm and contribute to a reduction in practices and regimes that are socially controlling. Recognition of care home residents as profoundly disadvantaged and 'at risk' of social control by the care system, care homes and social workers themselves is a related issue. Here, we outline three key ingredients of a revisioned social work role.

First, having some level of formal ongoing involvement with a care home appears to be an effective way to prevent problems from developing and resolving issues at an

early stage. Knowledge of the care home – of its staff, culture and patterns – alongside knowledge of individual residents and their families seem to offer a protective 'early warning system'. The regular presence of a familiar social worker is also likely to lead to the development of trust relationships and training opportunities with staff. It is also associated with lower instances of abuse (as noted earlier).

Reframing the current transactional roles as processes is a second ingredient. A transaction inhibits the development of relationships and emotional connectivity; it offers limited opportunity to get to know the older person, understand their needs or accompany them on the care journey (Tanner, 2020). This 'relational austerity' – which Hingley-Jones and Ruch (2016) suggest is a response to social work's alignment with its statutory functions – makes it more likely that the voice and rights of the older person will be marginalised and that care-related decisions will be risk averse. Managerialist procedures also act as obstacles, for example, pressure to close cases quickly (Tanner, 2020). Research on social work with community-based older people suggests that in contexts where trust relationships are prioritised and the older person's perspective is foregrounded, improved well-being and sustainable care are much more likely outcomes (Moriarty et al, 2015; Ray et al, 2015; Tanner et al, 2023). There is no reason to think that this finding would not apply to care home residents. The fact that 'counselling and other types of social work' is specified as 'an intervention' in Section 8 of the Care Act 2014 reinforces this point.

There is a third more critical role too, which has a number of dimensions. Reconceptualising all 'residents' (including self-funders) as 'older people with care and support needs' would immediately recalibrate their status and their legal right to ongoing support from the local authority, including social work. In any other setting, bar a hospital, this would be the case. Challenging the narrative of 'care homes as safe places' is a second issue. This is not difficult, as residents are routinely exposed to '…inhuman treatment, everyday indignities, persistent abuse and devaluation' (Johnson, 2023: 693). There is a strong case for social workers to engage in addressing the structural, cultural and practice-related deficits that create or contribute to these outcomes and to advocate for the human and legal rights of residents to be treated with dignity and to be free from risks of abuse. Given that this is territory that social workers recognise in practice with other groups of adults with care and support needs, its absence with care home residents is notable.

This is no small undertaking; it demands that social workers challenge the existing paradigm. This would include: reframing the 'causes' of abuse as linked to the market drivers of efficiency, such as low staffing levels; identifying institutional risk factors for the development of depersonalising cultures; challenging normative practices that engage with social control; and advocating for residents' rights (Kartupelis, 2021). The role played by the increasingly polarised nature of the care home sector in amplifying inequality is another issue. Barnes et al (2015) refer to this more radical practice as a form of 'political ethics', drawing on an ethic-of-care approach. It is a way of working that operationalises the value of social justice through awareness of the ways that systems, cultures and 'accepted' norms and practices contribute to harm, abuse and risks of social control. A fundamental issue of control – particularly for people with dementia – relates to the risk of silence, that is, the erosion of the right to be heard and to have any meaningful influence over care-related decisions (Bartlett and O'Connor, 2010).

One of the main barriers to action is ageism (Milne, 2020b). Addressing ageism and age discrimination is a primary social work responsibility. These influence, directly and

indirectly, the micro domain of practice, the meso arena of the care system and the macro context of social policy and care funding models. The limited access residents have to a social worker is a form of systemic ageism. Except in state-defined situations of 'need' or 'risk', they simply do not warrant the services of a social worker, nor are their needs considered sufficiently important to justify their attention. In addition to a rights-related argument, the case for extending social work engagement is its positive potential to offer a more rounded, multidimensional service. As Lymbery (2019: 43) states, it is 'the totality of what a social worker can contribute rather than in its individual elements' that makes the difference to an older person's well-being and quality of life.

This article has a number of limitations. We have not heard from older people who live in care homes, and we know (almost) nothing about their or their families' experience of social work services. We know very little about the views of social workers either. The second author of this paper will be addressing this deficit soon, drawing on work from her PhD. Although this article is, in essence, a case study focused on social work, social control and care homes in England, many of the issues raised will have resonance with (at least) other European countries. They share not only demographic and policy contexts but also a number of the socio-political challenges relating to care homes and social work.

While we have offered (some of) the ingredients of a revisioned role, we appreciate that in the current climate of welfare retrenchment, any suggested 'extension' of social work services is unlikely. We also recognise that there is a fundamental paradox in the UK social work role: social workers are expected to challenge inequality created by social structures while, at the same time, representing those structures by (predominantly) being employed as agents of the state (Parker and Doel, 2014). There remains an inherent tension between the care and control dimensions of the role.

Conclusion

In this article, we have made the case for an expanded role and greater levels of involvement of social workers with care home residents. We have argued that more social work is likely to lead to reduced risks of abuse, neglect and poor practice and lower levels of social control. In part, this is about attending to ways in which the current truncated roles are at odds with the principles of person-centred practice, advocacy and promoting older people's well-being, and in part, it is about engagement with a broader set of issues, including enhancing rights and social justice, adopting a critical lens on residents' status and treatment, addressing ageism in all its forms, and challenging the structural features of a care system that, if not checked, disadvantages and damages residents, particularly those who are publicly funded (Duffy, 2017). For this to be achieved, work with care homes needs to be conceptualised as a core part of the social work role and a key responsibility of the local authority. It is time that one of the most marginalised and vulnerable populations in England is incorporated under the full purview of social work and that residents are offered the chance to benefit from the skills, knowledge, values and protection of a social worker.

Notes

[1] In the UK, it is customary to refer to older people who live in care homes as 'residents'.

[2] Once the DoLS authorisation is in place, the person has the right to request a review of it and to have a 'relevant person's representative' (RPR) who maintains contact and

represents the person. The RPR can challenge or request a review of the authorisation on behalf of the person.

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Conflict of interest

The authors declare that there is no conflict of interest.

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