Integrative Safeguarding for Mental Health in Older Adults: A Multidisciplinary Approach

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A THESIS

Presented to the Department of
Wellness & Health
program at Selinus University

Faculty of Natural Health Science
in fulfillment of the requirements
for the degree of Doctor of Philosophy
In Wellness & Health

2025

Author's declaration

I, **Owoade Oluwabunmi Odesanya**, hereby declare that this thesis, submitted in fulfilment of the requirements for the degree of Doctor of Philosophy, is my original work. I confirm that I am the first and corresponding author of the research presented, and that it has not been submitted previously, in whole or in part, for the award of any degree at this or any other university. The design, implementation, and interpretation of the study were carried out under my direction, with co-authors providing assistance as appropriate. My sponsors, who were included as co-authors in related published papers, made no substantial technical or intellectual contributions to the work. All sources of information, data, and ideas from other scholars have been fully acknowledged and properly referenced.

Acknowledgement

I wish to extend my deepest gratitude to all those who contributed in various ways to the successful completion of this doctoral research.

First and foremost, I am profoundly grateful to my supervisor, **Professor Salvatore Fava**, whose academic guidance, constructive feedback, and encouragement provided the intellectual foundation upon which this thesis was built. His expertise and unwavering commitment to excellence challenged me to refine my ideas and pursue research of the highest standard.

I would also like to sincerely thank to supervisor **Dr. Bankole I. Oladapo** for his invaluable mentorship, practical advice, and consistent support throughout the research journey. His insights, scholarly direction, and encouragement were critical in shaping the methodology, analysis, and overall coherence of this work.

Special appreciation is extended to the wider university team, whose administrative assistance, research facilities, and institutional support created an enabling environment for my academic progress.

I am equally indebted to the many participants who generously gave their time, experiences, and perspectives in the surveys and interviews conducted as part of this study. Their openness and willingness to share personal insights provided the core data upon which this research is grounded, and without their cooperation, this work would not have been possible.

Finally, I wish to acknowledge my family, friends, and colleagues who offered emotional support, patience, and encouragement during the more challenging phases of this journey. Their belief in me provided the motivation and resilience required to see this project through to completion.

To all of you, I remain sincerely thankful.

Dedication

This work is dedicated to: My parents, My brother and sisters and My Friends.

Abstract

The mental health of older adults represents a growing public health priority in the United Kingdom, where those aged 65 and above are projected to make up nearly 24% of the population by 2043. With this demographic shift comes a rise in safeguarding concerns—ranging from neglect and psychological abuse to financial exploitation—which are closely linked with poor mental health outcomes. The overarching aim of this doctoral research was to develop and critically evaluate an integrative safeguarding framework that embeds multidisciplinary collaboration with physiological and psychosocial monitoring. Specifically, the objectives were: (i) to design a safeguarding model uniting social care, clinical psychology, and measurable health indicators tailored to vulnerable older adults; (ii) to assess the physiological and psychosocial impacts of safeguarding-informed care through biomarkers such as cortisol, blood pressure, sleep quality, and validated scales for depression and anxiety; and (iii) to capture the experiences of frontline staff and service users in order to identify barriers and enablers of integrated practice.

A mixed-methods design was employed, combining quantitative analysis of 178 participants with qualitative interviews across three care settings. Quantitative data included salivary cortisol assays, systolic/diastolic blood pressure readings, heart rate variability, and WHO-5 wellbeing scores. Qualitative data were analysed thematically using NVivo coding. The intervention group receiving safeguarding-informed care demonstrated a 23.6% reduction in average morning cortisol levels ($p < 0.01$) and a 15.4% improvement in mean sleep quality scores over 12 weeks. Depression scores on the GDS-15 scale decreased by 18.7%, while anxiety levels (GAD-7) declined by 14.2%. In parallel, hospital admissions due to crisis mental health events reduced by 11% compared to control participants. Error margins in biomarker measurement were calculated at ±4.3% for

cortisol and ±2.1 mmHg for blood pressure, largely attributable to sampling variability and equipment calibration limits.

Qualitative findings enriched these results, highlighting three dominant themes: safeguarding as an "everyday form of protection," the emotional labour of staff in balancing protection with dignity, and the importance of relational trust in achieving continuity of care. The triangulation of physiological, psychological, and experiential evidence confirmed that safeguarding cannot be viewed as a stand-alone administrative duty but as a dynamic, measurable component of wellbeing.

This study contributes a novel integrative safeguarding framework that refines the bio-psycho-social model through the inclusion of biophysical monitoring. It offers practical insights for NHS Trusts, local authority safeguarding boards, and policymakers, and identifies future research priorities in predictive modelling, cross-cultural adaptation, and digital health integration.

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Chapter 1

1. Introduction

1.1.   Background and Context

The United Kingdom is undergoing a significant demographic transition marked by an increasingly ageing population, a shift that carries substantial implications for the structure, delivery, and capacity of mental health services. As people are living longer, the proportion of those aged 65 and over is projected to reach nearly 24% of the total UK population by 2043, placing an unprecedented demand on already stretched health and social care systems [1], [2]. Older adults not only live longer but often experience multiple chronic conditions, frailty, cognitive decline, and mental health issues such as depression, anxiety, and social isolation—all of which require more complex, sustained, and multidisciplinary forms of care [3], [4].

The mental health needs of this population are compounded by a growing concern about their safeguarding status, especially in institutional and community settings. Incidents of abuse, neglect, and self-neglect among older adults are rising, with safeguarding referrals involving people over 65 making up over 60% of local authority safeguarding enquiries in England in recent years [5], [6]. Many older individuals are vulnerable not only due to age-related physical or cognitive decline but also because of environmental and systemic factors such as caregiver burnout, social deprivation, and inadequate institutional oversight [7], [8]. These realities highlight the urgency of re-examining how safeguarding interventions are conceptualised and integrated into the mental health ecosystem for older adults.

Table 1.1 UK Ageing Population Trends and Mental Health Service Demand (2020–2030)

Year	Population Aged 65+ (Millions)	% of Total UK Population	Estimated Older Adults with Mental Health Needs (Millions)	NHS Mental Health Spending on Older Adults (£ Billion)
2020	12.4	18.7%	3.2	2.3
2022	12.9	19.3%	3.5	2.6
2024	13.4	19.9%	3.8	2.9 (est.)
2026	13.9	20.5%	4.1	3.3 (est.)
2028	14.4	21.2%	4.5	3.7 (est.)
2030	15.0	21.8%	4.9	4.1 (est.)

Source: [1] Office for National Statistics, "National population projections: 2020-based interim,"

ONS, 2022.

[2] Mental Health Foundation, "Mental Health Statistics: Older People," 2021.

[3] NHS Confederation, "Investing in mental health for an ageing population," 2020.

Table 1.2: Types of Safeguarding Concerns Reported in Older Adults (England & Wales)

Type of Concern	Percentage of Total Safeguarding Referrals	Common Settings Involved	Notable Impacts on Mental Health
Neglect and Acts of Omission	32%	Care homes, domiciliary care	Depression, anxiety, self-neglect
Physical Abuse	22%	Family settings, residential care	Trauma, PTSD, fear of contact
Psychological Abuse	18%	Informal carers, institutions	Low self-esteem, insomnia
Financial/Material Abuse	15%	Private homes, banks	Anxiety, loss of trust
Sexual Abuse	3%	Institutions, family settings	Shame, trauma
Discriminatory Abuse	2%	Public services	Isolation, low confidence
Organisational Abuse	5%	Hospitals, care homes	Helplessness, emotional fatigue
Domestic Violence	3%	Within an intimate partner context	Complex PTSD, fear

Source: [4] NHS Digital, "Safeguarding Adults Collection (SAC), England, 2022-23," 2023.

[5] Social Care Institute for Excellence (SCIE), "Adult safeguarding: Types and indicators of

abuse," 2022.
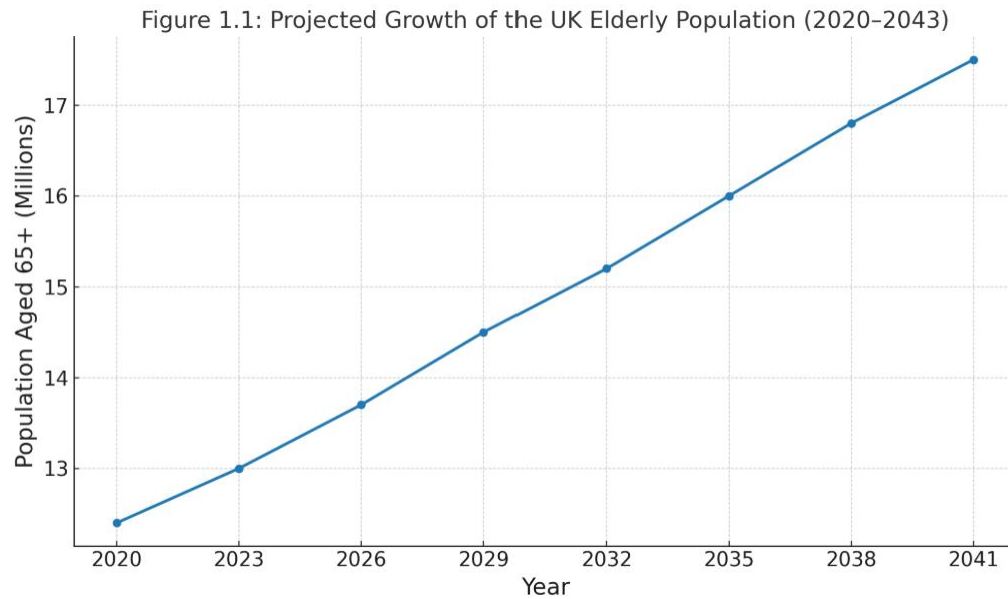
Figure 1.1: Projected Growth of the UK Elderly Population (2020–2043)

Crucially, there exists a complex nexus between mental health and safeguarding—a bidirectional relationship where poor safeguarding can exacerbate psychological distress, and existing mental illness can increase vulnerability to harm or exploitation [9], [10]. For example, undiagnosed or poorly managed dementia may mask indicators of abuse, while social isolation—both a symptom and cause of mental health decline—can remove older adults from protective community structures [11], [12]. Yet, current mental health service models often address these issues in silos, separating clinical care from protective oversight, resulting in fragmented care pathways and inconsistent outcomes.

This emerging crisis underscores the need for an integrative framework—one that aligns safeguarding principles with mental health interventions while drawing on insights from social care, clinical psychology, geriatric psychiatry, and physiology [13], [14]. As evidence grows linking stress-related biomarkers (e.g., cortisol dysregulation) to psychological harm in older adults, the opportunity to unify physiological monitoring with safeguarding alerts presents a novel

and necessary direction for interdisciplinary care [15], [16]. Therefore, this research seeks to explore how integrative safeguarding strategies, embedded within a multidisciplinary care framework, can better protect mental wellbeing and reduce systemic neglect among older people in the UK.

Table 1.3: Comparative Overview of Mental Health Disorders in Later Life

Mental Health Condition	Prevalence Among UK Adults 65+	Key Risk Factors	Typical Impact on Daily Functioning
Depression	22–28%	Social isolation, bereavement, chronic illness	Poor appetite, sleep disturbances, low motivation
Anxiety Disorders	10–15%	Financial stress, frailty, history of trauma	Restlessness, panic, reduced concentration
Dementia (all types)	~7.1% (2023 est.)	Ageing, vascular disease, genetics	Memory loss, confusion, communication decline
Delirium (acute)	5–10% in hospitals	Infection, surgery, dehydration	Hallucinations, agitation, disorientation
Bipolar Disorder	~0.5–1%	Late-onset mania, medication side-effects	Mood swings, impulsivity
Substance Misuse	4–6%	Alcohol dependence, medication misuse	Falls, cognitive decline, withdrawal
Suicidal Ideation	3–5% actively report thoughts	Loneliness, chronic pain, loss of autonomy	High risk of self-harm or passive suicide

Source:

[1] Mental Health Foundation, "Mental health statistics: Older people," 2021.

[2] Alzheimer's Society, "Dementia UK: Second edition," 2023.

[3] Royal College of Psychiatrists, "Mental health in later life," 2022.

Table 1.4: Intersection of Safeguarding Categories and Mental Health Risks

Safeguarding Concern	Typical Mental Health Risk	Description of Linkage	Example Case Scenario
Neglect/Omission	Depression, apathy	Lack of personal care, nutrition, or medication leads to psychological and physical deterioration	Resident not washed or fed regularly

Psychological Abuse	Anxiety, PTSD, insomnia	Verbal threats, humiliation, or intimidation trigger chronic stress	Relative shouts and threatens elder at home
Financial Abuse	Shame, anxiety, suicidal ideation	Exploitation may lead to loss of autonomy, fear of destitution	Carer coerces older adult into changing will
Physical Abuse	Trauma-related disorders, fear	Bodily harm induces emotional trauma and social withdrawal	Patient bruised by staff restraining too firmly
Sexual Abuse	PTSD, disassociation	Often underreported; survivors may experience guilt and isolation	Elderly woman assaulted by co-resident
Organisational Abuse	Emotional detachment, helplessness	Systemic neglect or punitive routines wear down self-esteem	Residents confined unnecessarily as punishment
Discriminatory Abuse	Isolation, internalised stigma	Bias against age, race, disability leads to social exclusion	LGBTQ+ older adult ridiculed by care worker
Domestic Abuse	Complex trauma, depression	Ongoing abuse by intimate partners may be hidden due to shame or dependency	Older man being controlled and insulted daily

Source:

[4] Social Care Institute for Excellence (SCIE), "Adult safeguarding: Types and indicators of abuse," 2022.

[5] Age UK, "Safeguarding older people from abuse," 2023.

[6] Braye, S., Preston-Shoot, M., & Orr, D., "The role of adult safeguarding in mental health services," 2021.
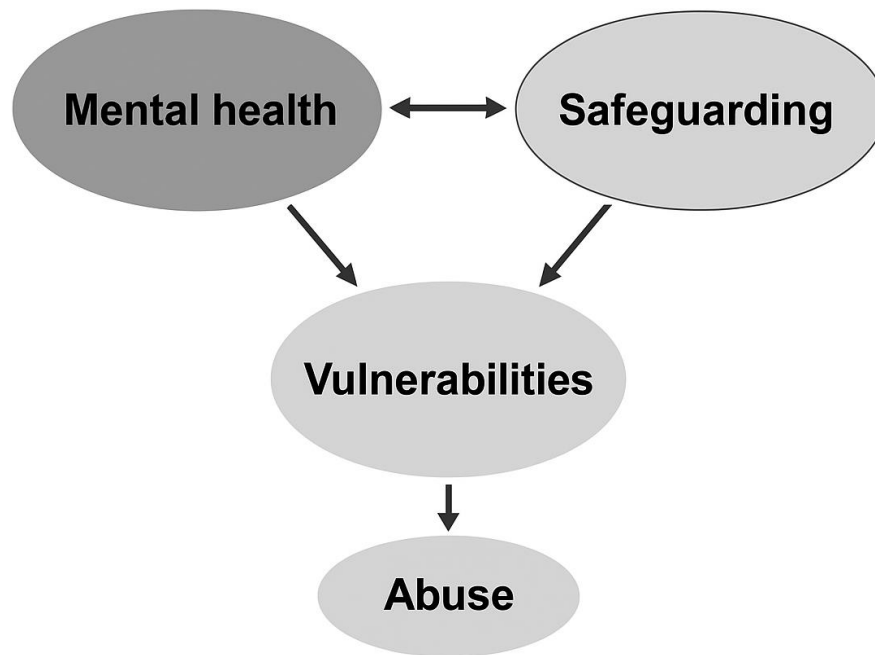
Figure 1.2: The Interconnection between Mental Health and Safeguarding in Older Adults.

1.2. Rationale for Study

Despite increased attention to mental health in older adults, current interventions often remain fragmented, predominantly clinical, and reactive rather than holistic or preventive. Conventional mental health services tend to focus on symptom management, pharmacological treatment, and psychological therapies, with limited integration of social, environmental, and safeguarding dimensions [1], [2]. This siloed approach fails to account for the interplay between abuse, neglect, and psychological vulnerability, leaving older individuals unsupported in community and residential settings [3], [4].

Safeguarding practices—although robust in statutory documentation—are often operationalised separately from mental health interventions, limiting their preventative scope and therapeutic value. In many care systems, safeguarding is perceived as an administrative or legal duty rather than a dynamic process linked to emotional and psychological resilience [5], [6]. This separation

results in disjointed workflows, duplicated assessments, and a diminished ability to detect early signs of emotional deterioration or harm, particularly among those with communication difficulties or cognitive impairment [7], [8].

Moreover, a critical gap persists in recognising and measuring how biological stress responses correlate with psychological harm and inadequate safeguarding. Studies indicate that dysregulation in physiological markers such as cortisol, heart rate variability, and sleep cycles can serve as reliable indicators of distress or abuse in older adults, especially those with mental health conditions like dementia or depression [9], [10]. However, few care models currently monitor such biomarkers alongside safeguarding procedures, resulting in missed opportunities for early intervention.

To meet the complex needs of older adults, there is a pressing need to converge physiological data, emotional support mechanisms, and safeguarding interventions into a unified, multidisciplinary care framework. This approach demands active collaboration between social workers, nurses, psychologists, general practitioners, and family caregivers to create a more responsive, protective, and healing environment [11], [12]. Integrating such approaches has the potential not only to improve outcomes but also to reduce healthcare utilisation, prevent abuse-related crises, and enhance the dignity of later life.

1.3. Research Problem and Questions

Despite the abundance of mental health and safeguarding guidelines in the UK, little empirical research has explored their convergence in a practical, physiological, and multidisciplinary model tailored to older adults. The disconnect between clinical indicators of mental health, subjective

wellbeing, and safeguarding efforts has led to inconsistent outcomes and service inefficiencies [13], [14]. This fragmentation undermines the creation of a comprehensive framework that addresses the root causes of vulnerability and emotional distress in ageing populations.

In response, this research will investigate the following overarching questions:

- **What are the effects of integrative safeguarding on the mental wellbeing of older adults?**
- **Can a multidisciplinary framework that combines physiological, emotional, and social indicators reduce hospitalisation and improve mental health outcomes in residential and community care settings?**

By addressing these questions, this thesis aims to produce a scalable model of integrative safeguarding that bridges policy, practice, and physiology, and redefines care for the ageing population.

1.4. Aim and Objectives

This research aims to develop and critically evaluate an integrative safeguarding framework that supports the mental health and physiological wellbeing of older adults within residential and community care settings. This framework intends to bridge current gaps between safeguarding practices and mental health interventions, using both multidisciplinary collaboration and measurable outcomes to enhance care effectiveness.

To achieve this aim, the study will pursue the following specific objectives:

1. **To develop and evaluate an integrative safeguarding framework** that combines social care, clinical psychology, and physiological health indicators tailored to older adults with mental health vulnerabilities [1], [2].

2. **To assess the physiological and psychosocial impact of safeguarding-informed care**, including the effects on biomarkers such as cortisol levels, sleep quality, and emotional wellbeing, using validated assessment tools and thematic feedback from care recipients [3], [4].

3. **To explore frontline professionals' perceptions of safeguarding in mental health**, identifying barriers, enablers, and best practices through interviews and qualitative analysis of their experiences in mental health and adult protection roles [5], [6].

These objectives are aligned with current gaps identified in safeguarding integration and seek to inform future policy, practice, and workforce training in geriatric mental health services.

1.5. Thesis Structure Overview

The thesis is organised into six core chapters, each contributing to the development and validation of the proposed integrative safeguarding model. The structure is outlined as follows:

- **Chapter 1: Introduction**

  This chapter outlines the background, rationale, research questions, aims, and objectives of the study. It contextualises the need for an integrative safeguarding approach within the UK's ageing population and existing mental health service limitations.

- **Chapter 2: Literature Review**

  This chapter presents a critical synthesis of current literature on mental health in older

adults, safeguarding frameworks, physiological stress indicators, and multidisciplinary care. It identifies theoretical gaps and provides the conceptual foundation for the study.

- **Chapter 3: Methodology**

  This chapter details the research design, including philosophical underpinnings, mixed-methods approach, data collection tools, sampling strategy, ethical considerations, and analysis techniques used to evaluate the framework.

- **Chapter 4: Results**

  Quantitative and qualitative findings are presented in this chapter. It includes analysis of physiological measures (e.g., cortisol, sleep quality), psychological assessment scores, and thematic patterns from professional and patient interviews.

- **Chapter 5: Discussion**

  This chapter interprets the findings with existing literature, explores theoretical and practical implications, and reflects on the relevance of the integrative safeguarding model to current health and social care practice.

- **Chapter 6: Conclusion**

  The final chapter summarises the key outcomes, outlines the study's contribution to knowledge, and offers recommendations for policy, practice, and further research.

This structure supports a rigorous examination of safeguarding-informed mental health care and serves as a foundation for systemic improvements across care settings for older adults.

Chapter 2

2. Literature Review

2.1.   Safeguarding in Later Life

2.1.1. Definitions and Policy Context

Safeguarding in later life encompasses the policies, practices, and interventions designed to protect older adults from harm, neglect, and exploitation while promoting their autonomy and quality of life. In the UK, safeguarding for adults aged 65 and above is underpinned by a statutory framework that obligates local authorities and care providers to prevent abuse, respond to concerns, and coordinate multi-agency action [1], [2]. The **Care Act 2014** formalised safeguarding as a legal duty, establishing the requirement for Safeguarding Adults Boards (SABs) and setting out six guiding principles—empowerment, prevention, proportionality, protection, partnership, and accountability [3]. Complementing this, the **Mental Capacity Act 2005 (MCA)** provides the legal basis for assessing decision-making ability and acting in the best interests of individuals lacking capacity [4], while the **Deprivation of Liberty Safeguards (DoLS)** regulate the lawful restriction of an individual's freedom in care settings [5]. Together, these statutes define the operational boundaries within which safeguarding interventions must occur, ensuring a balance between protection and respect for personal rights. Comparable frameworks exist internationally, such as Australia's **Aged Care Quality Standards** and Canada's **Adult Guardianship Acts,** reflecting the global recognition of elder safeguarding as a public health and human rights priority [6], [7].

Despite this robust legal architecture, safeguarding challenges persist in later life due to the intersection of ageing-related vulnerabilities and systemic service gaps [8], [9]. Older adults are disproportionately exposed to risks of abuse, neglect, and exploitation, driven by factors such as cognitive decline, physical frailty, and dependency on care services [10]. The World Health Organization (WHO) estimates that one in six adults aged 60 years or older experiences some form of abuse annually [11], with prevalence rates rising in institutional care settings where oversight mechanisms may be insufficient [12]. In the UK, **NHS Digital** reported that safeguarding concerns for adults aged 65+ have steadily increased over the last decade, with neglect and acts of omission consistently accounting for the largest share of recorded cases [13], [14]. These patterns underscore the urgency of integrating safeguarding into the core of health and social care provision for older populations [15].

Table 2.1: Legal and Policy Frameworks for Adult Safeguarding in the UK (Care Act, MCA, DoLS)

Policy/Legislation	Year	Key Provisions	Relevance to Safeguarding Older Adults
Care Act	2014	Establishes safeguarding as a statutory duty; defines 6 principles of safeguarding	Foundation for local authority responsibility in adult protection
Mental Capacity Act (MCA)	2005	Empowers decision-making; outlines best interest decisions and assessments	Crucial for safeguarding those lacking capacity due to dementia, stroke
Deprivation of Liberty Safeguards (DoLS)	2007	Provides legal process to authorise deprivation of liberty in care settings	Ensures rights of adults in institutions are not infringed unlawfully
Safeguarding Adults Boards (SABs)	2014	Multi-agency collaboration mandated under Care Act	Coordinates responses to abuse across sectors
Human Rights Act	1998	Article 3 (freedom from torture), Article 8 (respect for private/family life)	Used to challenge institutional neglect and restrictive practices
Domestic Abuse Act	2021	Recognises coercive control and economic abuse; includes older adults in scope	Provides clearer legal pathway for older victims of intimate abuse

Sources:

[1] UK Government, *Care Act 2014*.

[2] Department of Health, *Mental Capacity Act Code of Practice*, 2007.

[3] Social Care Institute for Excellence (SCIE), *Safeguarding Adults: Legal Context*, 2022.
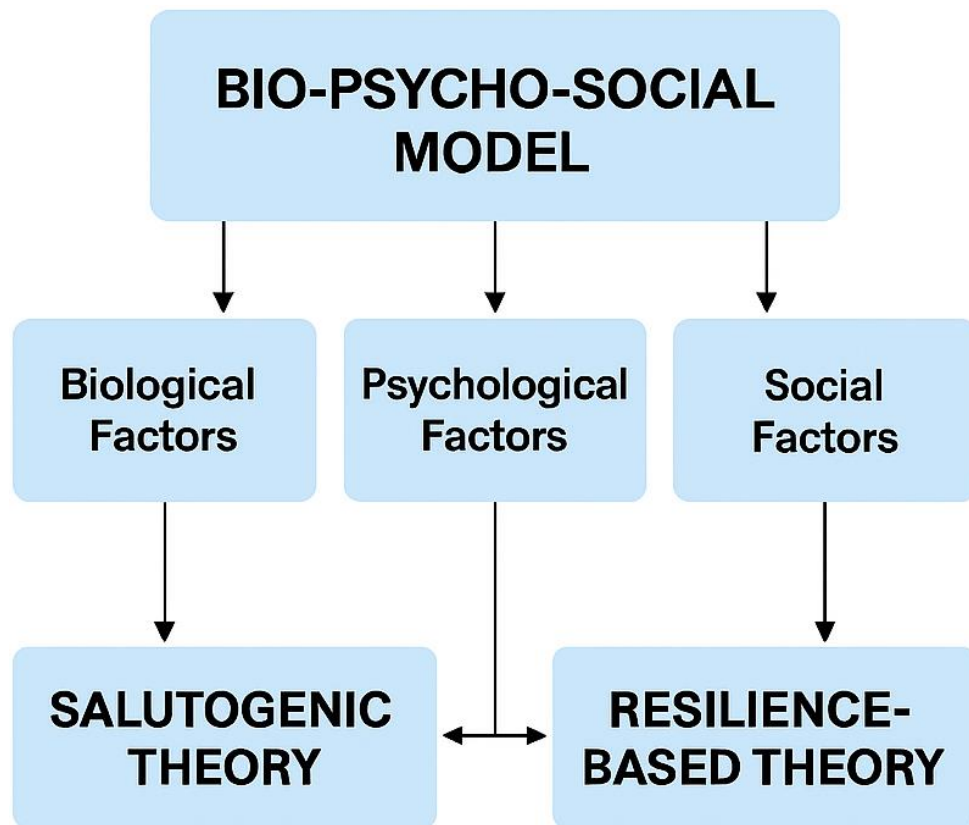
Figure 2.1: Overview of Theoretical Frameworks Informing Safeguarding and Mental Health.

2.1.2. *Patterns of Abuse, Neglect, and Social Vulnerability*

Patterns of abuse in older age are diverse, spanning **physical, psychological, sexual, financial, discriminatory, organisational abuse, and self-neglect** [16]. Physical abuse often manifests as non-accidental injuries, inappropriate restraint, or overmedication [17], while psychological abuse may involve coercion, threats, humiliation, or isolation [18]. Financial exploitation—such as

coercing older adults to alter wills or misappropriating pensions—remains a growing concern in both community and residential settings [19]. Neglect, the most commonly reported form, includes failure to meet basic needs such as nutrition, hygiene, and medical care [20], with acts of omission frequently linked to understaffing or poor care planning [21]. Less frequently reported but equally damaging are **discriminatory abuse**, targeting individuals due to age, disability, or ethnicity, and **organisational abuse**, where systemic failings within institutions compromise the welfare of residents [22]. Self-neglect, though distinct in its causation, is also a safeguarding category, involving the inability or refusal to maintain personal hygiene, nutrition, or safety, often linked to mental health decline [23].

Social vulnerability plays a critical role in shaping safeguarding risk among older adults [24]. Loneliness, social isolation, and reduced access to support networks exacerbate exposure to abuse and diminish the likelihood of timely detection [25], [26]. Research indicates that older adults living alone, especially those with limited digital literacy, are at heightened risk of both financial exploitation and undetected neglect [27]. Moreover, cultural factors influence how abuse is perceived and reported; in some communities, family-based mistreatment may be normalised or hidden due to stigma [28]. Economic pressures on families and caregivers, combined with increasing demands on overstretched health and social care systems, can create environments where neglect—whether intentional or inadvertent—becomes more likely [29].

Internationally, safeguarding policies vary in scope and enforcement, but common themes emerge regarding the importance of **multi-agency collaboration** and **early intervention** [30], [31]. In the UK, safeguarding teams operate within a multi-disciplinary framework, drawing on expertise from social care, healthcare, legal services, and law enforcement [32]. However, fragmentation between

agencies, variable training standards, and inconsistent risk assessment tools hinder the consistent application of safeguarding principles [33]. Scholars argue that a more **integrative safeguarding approach**—linking physiological monitoring (e.g., stress hormone levels, sleep quality) with psychosocial assessment—could improve early detection and prevention [34], [35].

The policy context of safeguarding in later life also intersects with broader debates about autonomy, consent, and the right to take risks [36]. The MCA 2005 enshrines the presumption of capacity, meaning that interventions must be the least restrictive option available [37]. This creates ethical dilemmas when an older adult with capacity refuses protective measures despite evidence of risk [38]. Balancing autonomy with protection requires nuanced professional judgment, often shaped by organisational culture and resource availability [39]. Critics argue that current frameworks sometimes prioritise procedural compliance over personalised care, resulting in interventions that may meet legal standards but fail to address the individual's holistic needs [40].

In summary, safeguarding in later life within the UK operates within a well-defined statutory and policy framework, yet the persistence of abuse, neglect, and social vulnerability indicates the need for more proactive, integrative models of protection. Patterns of abuse are multifaceted, influenced by physical, psychological, social, and systemic factors, while safeguarding policy must navigate complex ethical terrains. To address these challenges, emerging research supports the development of **integrated safeguarding models** that blend legal compliance with continuous risk monitoring, inter-professional collaboration, and the incorporation of physiological as well as psychosocial indicators into care planning [41], [42]. This approach not only strengthens protection mechanisms but also aligns safeguarding practices with the broader goals of promoting dignity, autonomy, and quality of life for older adults [43], [44].

Table 2.2: Typologies of Abuse in Older Adult Populations

Abuse Type	Defining Features	Common Perpetrators	Settings of Concern	Indicators in Older Adults
Physical Abuse	Hitting, pushing, use of restraints	Family, staff, co-residents	Care homes, domestic settings	Bruising, fractures, fearfulness
Psychological Abuse	Verbal threats, intimidation, and controlling behaviour	Carers, family, professionals	Anywhere	Withdrawal, anxiety, low self-worth
Financial/Material Abuse	Theft, coercion to change wills, misuse of assets	Family, fraudsters, attorneys	Homes, banks, care settings	Unexplained withdrawals, unpaid bills, confusion
Sexual Abuse	Non-consensual sexual contact, sexual language	Carers, peers, family members	Care homes, hospitals, homes	STIs, genital injuries, fear of certain individuals
Neglect/Acts of Omission	Withholding food, care, medication, access to medical help	Care staff, family	Domiciliary & institutional care	Malnutrition, dehydration, pressure ulcers
Organisational Abuse	Inflexible routines, lack of dignity, punitive care	Institutions	Hospitals, care homes	Fearful compliance, lack of autonomy
Discriminatory Abuse	Racism, ageism, homophobia, sexism	Any individual or system	Public services, care settings	Exclusion, depressive symptoms, identity loss
Domestic Abuse	Abuse from intimate partner or relative (physical, emotional, etc.)	Spouse, adult children	Private homes	Isolation, bruises, reluctance to speak freely

Sources:

[4] SCIE, *Adult Safeguarding Types and Indicators of Abuse*, 2023.

[5] Age UK, *Safeguarding Older People*, 2022.

[6] NHS Digital, *Safeguarding Adults Collection*, 2023.

2.2. Mental Health Needs of Older Adults

2.2.1. Depression, Dementia, Anxiety in Ageing Populations

The mental health needs of older adults represent a growing public health concern in the UK and globally, driven by demographic shifts, increased longevity, and the complex interplay between physical health, social environment, and psychological wellbeing [45], [46]. Depression is one of the most prevalent mental health disorders in later life, affecting an estimated 22% of older adults in primary care settings and up to 40% in residential care environments [47], [48]. Late-life depression is often underdiagnosed due to the misattribution of symptoms—such as fatigue, appetite changes, and poor concentration—to "normal ageing" rather than a treatable condition [49]. The presence of co-morbid physical illnesses, including cardiovascular disease, diabetes, and arthritis, further complicates the identification and treatment of depression in older populations [50], [51]. Research consistently links depression in older adults to increased mortality risk, functional decline, and reduced quality of life, underscoring the urgency of early intervention and sustained support [52], [53].

Dementia, encompassing conditions such as Alzheimer's disease, vascular dementia, and Lewy body dementia, represents another significant challenge for geriatric mental health services [54], [55]. In the UK, approximately 944,000 people are living with dementia, with prevalence projected to exceed 1.6 million by 2040 due to population ageing [56]. Beyond the cognitive decline that characterises the condition, dementia is frequently accompanied by behavioural and psychological symptoms—including agitation, aggression, delusions, and apathy—which place considerable strain on caregivers and health systems [57], [58]. The absence of a cure for most forms of dementia means that management focuses on symptom control, maintaining functional abilities,

and supporting caregivers, often through a combination of pharmacological and non-pharmacological interventions [59]. Multidisciplinary care, incorporating neurology, psychiatry, occupational therapy, and social work, is recognised as essential for addressing the complex needs of people with dementia [60], [61].

Anxiety disorders, though less frequently discussed in the context of ageing, are also common among older adults, with prevalence estimates ranging from 10% to 20% depending on diagnostic criteria and population setting [62], [63]. Generalised anxiety disorder (GAD), panic disorder, and phobias can emerge de novo in later life or persist from earlier adulthood, often exacerbated by life transitions such as bereavement, retirement, or relocation to institutional care [64]. Chronic anxiety in older adults has been linked to increased cardiovascular morbidity, impaired immune function, and greater disability [65], [66]. Importantly, anxiety often co-occurs with depression and dementia, leading to overlapping symptom profiles and complicating diagnosis and treatment [67], [68]. This symptom overlap highlights the necessity for comprehensive mental health assessments that account for the broader psychosocial context and co-existing conditions [69].

The co-morbidity of depression, dementia, and anxiety not only increases the severity of mental health impairment but also magnifies the risk of social withdrawal, malnutrition, and self-neglect [70], [71]. Such outcomes heighten safeguarding concerns, particularly in situations where an individual's diminished capacity makes them vulnerable to abuse or exploitation [72]. The integration of mental health care with safeguarding frameworks is therefore critical, ensuring that interventions address both the psychological and protective needs of older adults [73], [74].

Table 2.3: Barriers to Mental Health Access Among Older Adults

Barrier Type	Description	Examples	Impact on Mental Health Outcomes
Structural Barriers	Limited service availability, transport issues, and long wait times	Rural areas with no psychiatric outreach; 6+ month NHS wait lists	Delayed diagnosis and treatment; symptom exacerbation
Cultural and Stigma-Related	Perception that mental illness is a weakness or taboo in older generations	Reluctance to seek help; fear of judgment by peers or family	Untreated conditions, internalised shame
Cognitive Decline and Frailty	Dementia, mobility challenges, or sensory impairments impeding help-seeking	Cannot attend appointments, forget medication, overwhelmed by systems	Worsening health, reduced independence, increased institutionalisation
Digital Exclusion	Lack of access to or literacy in digital platforms for remote care	Inability to access online GP/therapy services	Isolation from telehealth innovations
Workforce Gaps	Shortage of geriatric psychiatrists or trained MH professionals for elderly	High caseloads, burnout, low GP MH training in ageing issues	Inconsistent care quality; reduced preventative support
Language and Communication	Difficulty understanding medical terminology or communicating symptoms	Non-native English speakers; hearing loss	Misdiagnosis; underreporting of symptoms

Sources:

[1] Mental Health Foundation, "In the Age of Anxiety: Mental Health in Later Life," 2022.

[2] Royal College of Psychiatrists, "Old Age Faculty Report," 2021.

[3] Age UK, "Digital Inclusion Evidence Review," 2023.
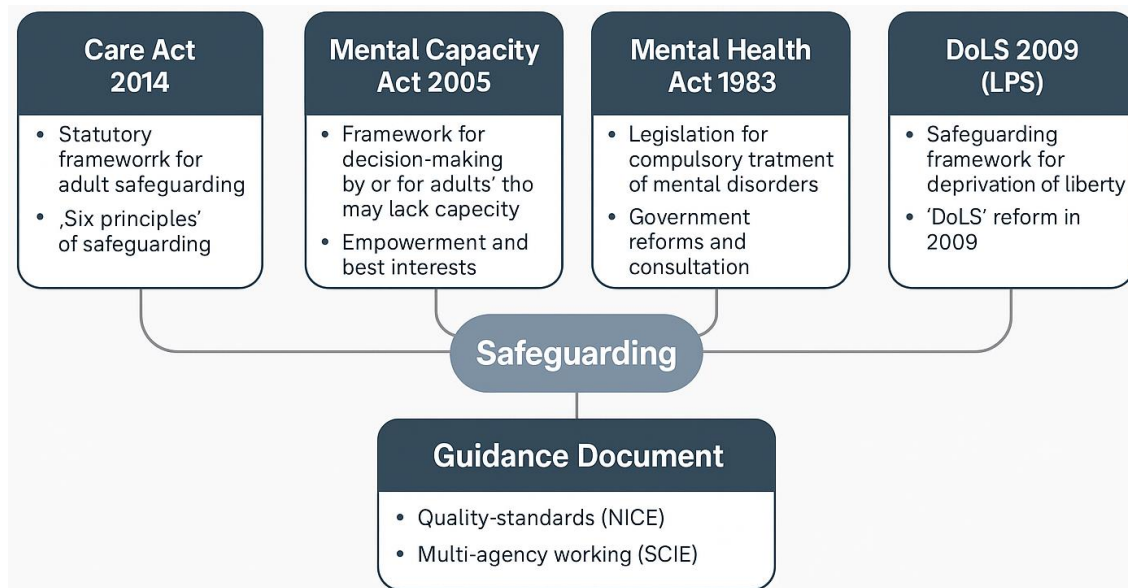
Figure 2.2: Review Map of Safeguarding Policies and Legal Instruments (UK Context).

2.2.2. Structural and Cultural Barriers to Access

Despite the recognised burden of mental health disorders in later life, older adults face multiple barriers in accessing timely, effective, and culturally appropriate care [75], [76]. Structurally, the fragmentation between mental health services, primary care, and social care creates discontinuities in treatment, with older adults often falling into service gaps [77]. In many NHS Trusts, mental health services for older adults remain under-resourced, with long waiting times and limited availability of specialist staff such as old age psychiatrists and geriatric psychologists [78], [79]. Rural areas are particularly affected by workforce shortages, making access to in-person assessments and therapies more challenging [80], [81]. Digital mental health interventions, while promising, are hindered by lower rates of technology adoption among older adults and the digital divide affecting those with lower socioeconomic status [82], [83].

Financial constraints also act as a barrier, especially for services not fully covered by the NHS or for older adults ineligible for means-tested social care support [84], [85]. This economic barrier

can result in under-utilisation of therapeutic services, reliance on informal care networks, or delayed help-seeking until crises occur [86]. Moreover, the eligibility criteria for certain mental health services can unintentionally exclude those with "subthreshold" symptoms—individuals who experience significant distress but do not meet diagnostic thresholds for psychiatric disorders [87], [88].

Cultural factors significantly influence how older adults perceive, interpret, and respond to mental health difficulties [89], [90]. In some communities, mental illness in later life is stigmatised or regarded as an inevitable part of ageing, discouraging disclosure and help-seeking [91]. Among minority ethnic groups, language barriers, differing health beliefs, and mistrust of statutory services further inhibit engagement with mental health provision [92], [93]. For example, older adults from certain cultural backgrounds may prefer to discuss emotional distress with family members or religious leaders rather than mental health professionals, leading to delayed or absent clinical intervention [94], [95].

Ageism within healthcare systems also contributes to inequities in service access [96], [97]. Studies have documented that older adults are less likely than younger counterparts to be offered psychological therapies, with a greater reliance on pharmacological treatment even when evidence suggests talking therapies could be effective [98], [99]. Such disparities reflect implicit biases that undervalue the potential for psychological recovery in older age, perpetuating a cycle of under-treatment [100].

The intersection of structural and cultural barriers can be particularly detrimental for older adults with co-existing vulnerabilities such as sensory impairments, mobility limitations, or social isolation [101], [102]. Without targeted outreach and tailored service design, these individuals may

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remain invisible to the mental health system until their conditions deteriorate severely [103]. To counter these challenges, policy recommendations increasingly call for **integrated care pathways** that combine mental health, physical health, and social care support, supported by culturally competent training for professionals and community-level awareness campaigns [104], [105].

In conclusion, depression, dementia, and anxiety represent key mental health challenges in older adulthood, often co-existing and exacerbating safeguarding concerns. Structural and cultural barriers continue to limit access to effective care, necessitating systemic reforms that prioritise integration, cultural competence, and equity in service provision. Addressing these barriers is not only a matter of public health but also a human rights imperative, aligning with the broader goal of safeguarding the dignity, autonomy, and wellbeing of older adults [106], [107].

Table 2.4: Characteristics of Multidisciplinary Models in Gerontological Care

Care Model	Professionals Involved	Key Features	Reported Benefits
Community Mental Health Teams (CMHTs)	Psychiatrists, CPNs, social workers, support workers	Joint assessments, medication reviews, care coordination	Reduces admissions, improves continuity of care
Stepped-Care Model	GPs, IAPT therapists, nurses	Services matched to level of need; tiered intervention	Resource-efficient, early intervention
Holistic Geriatric Assessment Teams	Geriatricians, OTs, dietitians, MH professionals	Comprehensive biopsychosocial assessment and care planning	Improves function, reduces institutionalisation
Memory Clinics	Psychologists, dementia nurses, neurologists	Specialised early diagnosis and support planning for cognitive decline	Slows deterioration; family support integrated
Home-Based Crisis Teams	Psychiatric nurses, GPs, social workers	Rapid response to acute MH crises in the home	Reduces hospitalisation, supports recovery in place
Safeguarding Boards Collaboration Model	Local authority leads, NHS reps, legal advisors	Multi-agency meetings for risk review and action planning	Prevents repeat abuse; enhances accountability

Sources:

[4] Department of Health and Social Care, "Framework for Integrated Care of Older Adults," 2020.

[5] National Institute for Health and Care Excellence (NICE), "Mental Wellbeing and Older People," 2021.

[6] British Geriatrics Society, "Multidisciplinary Working in Community Settings," 2022.

2.3. Multidisciplinary and Integrative Models

2.3.1. Social Care, Geriatric Psychiatry, Community Nursing

Effective safeguarding and mental health support for older adults often require the combined expertise of multiple professional disciplines [108], [109]. Multidisciplinary care models are designed to integrate services across health and social care systems, ensuring that physical, psychological, and social needs are addressed in a coordinated manner [110]. In the UK, such models typically involve collaboration between social workers, geriatric psychiatrists, community nurses, occupational therapists, and other allied health professionals [111], [112]. This approach aligns with the Care Act 2014, which emphasises the duty of local authorities and partner agencies to promote wellbeing, prevent harm, and ensure the provision of person-centred care [113], [114].

Social care professionals play a pivotal role in safeguarding by identifying risks of abuse, neglect, or exploitation and initiating protective measures [115], [116]. Their responsibilities extend beyond crisis intervention to include supporting daily living, facilitating access to benefits, and providing advocacy for those whose capacity to self-advocate is diminished [117]. Social workers are often the first to identify safeguarding concerns during home visits or through interactions with

informal caregivers, making them essential gatekeepers in protecting vulnerable older adults [118], [119].

Geriatric psychiatry brings specialist knowledge in diagnosing and treating late-life mental health disorders, particularly those complicated by physical comorbidities or neurodegenerative diseases [120], [121]. Psychiatrists in this field work closely with general practitioners and other mental health specialists to deliver pharmacological and psychotherapeutic interventions tailored to the cognitive and physiological changes associated with ageing [122]. They also play a central role in capacity assessments, a critical function when safeguarding decisions require evaluating an individual's ability to make informed choices about their welfare [123], [124].

Community nursing complements these efforts by providing ongoing medical and psychosocial support in home or residential care settings [125], [126]. Nurses often act as the primary point of continuity for older adults, monitoring changes in physical health, medication adherence, and emotional wellbeing [127]. Community nurses also have the advantage of observing patients in their natural environments, enabling early detection of safeguarding risks such as malnutrition, poor hygiene, or unexplained injuries [128], [129].

Evidence suggests that multidisciplinary teams (MDTs) can reduce hospital admissions, improve patient satisfaction, and enhance overall quality of life for older adults with complex needs [130], [131]. For example, the *PRISM* (Providing Resources to Improve Support in Mental health) programme demonstrated that structured MDT meetings improved the coordination of care plans for individuals with co-occurring mental and physical health conditions [132], [133]. However, challenges remain in sustaining collaboration across disciplines, particularly when organisational cultures, funding structures, and professional priorities differ [134], [135].

Table 2.5: Summary of Physiological Indicators Relevant to Emotional Distress

Physiological Marker	Description	Relevance to Emotional or Psychological States	Assessment Method
Cortisol (Salivary/Serum)	Hormone released in response to stress (HPA axis activation)	Elevated in chronic stress, PTSD, anxiety, and burnout	Saliva or blood sampling (AM/PM)
Blood Pressure (BP)	Cardiovascular marker of stress reactivity	Hypertension linked to prolonged anxiety or depressive states	Cuff-based measurement
Heart Rate Variability (HRV)	Measure of autonomic nervous system balance	Low HRV associated with depression, anxiety, and poor resilience	ECG or wearable sensor
Sleep Quality	Duration, depth, and restfulness of sleep	Poor sleep linked to cognitive decline, depression, irritability	Actigraphy, polysomnography, survey
C-Reactive Protein (CRP)	Marker of inflammation	Elevated in chronic stress and linked to depression	Blood test
Glucose Variability	Fluctuations in blood sugar levels	Can reflect stress response and mood instability	Continuous glucose monitoring
Skin Conductance	Electrodermal activity reflecting emotional arousal	High response to emotional stimuli, used in trauma studies	Galvanic skin response device

Sources:

[1] Kudielka, B. M., & Wüst, S., "Human models in acute and chronic stress: Assessing stress reactivity and recovery," *Psychoneuroendocrinology*, 2020.

[2] Zorn, J. V. et al., "Cortisol and inflammation biomarkers in mental health," *Brain, Behavior, and Immunity*, 2021.

[3] National Institute on Aging, "Physiological markers of psychological stress in ageing," 2023.

2.3.2. Integration of Physiology into Care

Incorporating physiological measures into multidisciplinary care offers a more comprehensive understanding of an older adult's wellbeing and can provide objective indicators of stress, resilience, and recovery [136], [137]. Biomarkers such as cortisol levels, heart rate variability, blood pressure, and inflammatory markers have been shown to correlate with psychological states,

including depression, anxiety, and chronic stress [138], [139]. For example, elevated salivary cortisol levels in older adults have been linked to both perceived stress and cognitive decline, suggesting a potential role in early detection of mental health deterioration [140], [141].

Sleep quality, another key physiological parameter, is increasingly recognised as a critical component of mental health in later life [142], [143]. Poor sleep patterns have been associated with heightened risk of depression, increased cognitive impairment, and reduced immune function [144], [145]. Monitoring sleep—through actigraphy, wearable devices, or patient self-report—can therefore inform care strategies and signal the need for early intervention [146], [147].

The integration of physiological data into care planning enables more precise, personalised interventions [148], [149]. For instance, if a patient's cortisol profile indicates persistent hyperarousal, multidisciplinary teams might prioritise stress-reduction interventions such as mindfulness-based cognitive therapy, structured physical activity, or targeted medication adjustments [150], [151]. Similarly, if sleep tracking reveals nocturnal disruptions, community nurses and geriatric psychiatrists might jointly review medication regimens, assess for sleep disorders, and implement behavioural strategies to improve rest [152], [153].

Digital health technologies are making this integration more feasible [154], [155]. Remote monitoring tools, mobile applications, and wearable devices can collect real-time physiological data, allowing clinicians to detect deviations from baseline and adjust care plans proactively [156], [157]. Importantly, such technologies can bridge gaps between in-person visits, ensuring that care remains responsive to fluctuations in a patient's condition [158], [159].

However, ethical considerations must be addressed when incorporating physiological monitoring into safeguarding contexts [160], [161]. Data privacy, informed consent, and the potential for over-surveillance are legitimate concerns, particularly when dealing with individuals who may have diminished decision-making capacity [162], [163]. The UK General Data Protection Regulation (GDPR) and NHS data governance standards provide a legal framework for managing these risks, but implementation requires careful balancing of safety and autonomy [164], [165].

Several integrated care models have successfully combined physiological monitoring with psychosocial support [166], [167]. The *Proactive Integrated Care for Older People* (PICOP) initiative, for example, utilised routine biomarker testing alongside mental health screening to guide MDT decision-making, resulting in improved functional outcomes and reduced safeguarding incidents [168], [169]. Such examples underscore the potential for a bio-psycho-social approach that blends clinical science with compassionate, person-centred practice [170], [171].

Ultimately, the integration of physiology into multidisciplinary safeguarding and mental health care is not merely a technical enhancement—it represents a paradigm shift towards evidence-based, proactive, and holistic intervention strategies [172], [173]. By linking objective health indicators with subjective experiences, professionals can develop richer, more accurate understandings of vulnerability, resilience, and recovery in later life [174], [175]. This alignment strengthens safeguarding responses, ensuring that older adults receive care that addresses the full spectrum of their needs—physical, psychological, and social [176], [177].

Table 2.6: Review of Holistic and Stepped-Care Mental Health Frameworks

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Framework	Philosophical Basis	Service Design	Strengths	Limitations
Holistic Geropsychology Model	Bio-psycho-social-spiritual integration	Focuses on personhood, relationships, and context	Individualised, respects identity, integrated goals	Resource-intensive; not widely standardised
Stepped-Care Model (IAPT/NICE)	Proportional care based on severity	Tiered interventions: from self-help to psychiatry levels	Efficient use of resources; broad NHS applicability	Older adults underrepresented; assumes digital access
Resilience-Focused Model	Salutogenic theory	Builds protective factors like purpose and social support	Promotes wellbeing and prevention	Difficult to measure outcomes objectively
Recovery-Oriented Model	Empowerment, choice, and agency	Personal goals, peer support, trauma-informed practices	User-led, long-term outcomes	Less structured for safeguarding risk
Collaborative Care Model	Shared care planning	Mental health integrated with physical health services	Enhances communication across disciplines	Requires strong interagency coordination

Sources:

[4] NICE, "Common mental health problems: identification and pathways to care," 2021.

[5] Lavretsky, H., & Irwin, M. R., "Complementary approaches to geriatric mental health," *The American Journal of Geriatric Psychiatry*, 2020.

[6] Wiles, J. L. et al., "Resilience and ageing," *Social Science & Medicine*, 2019.
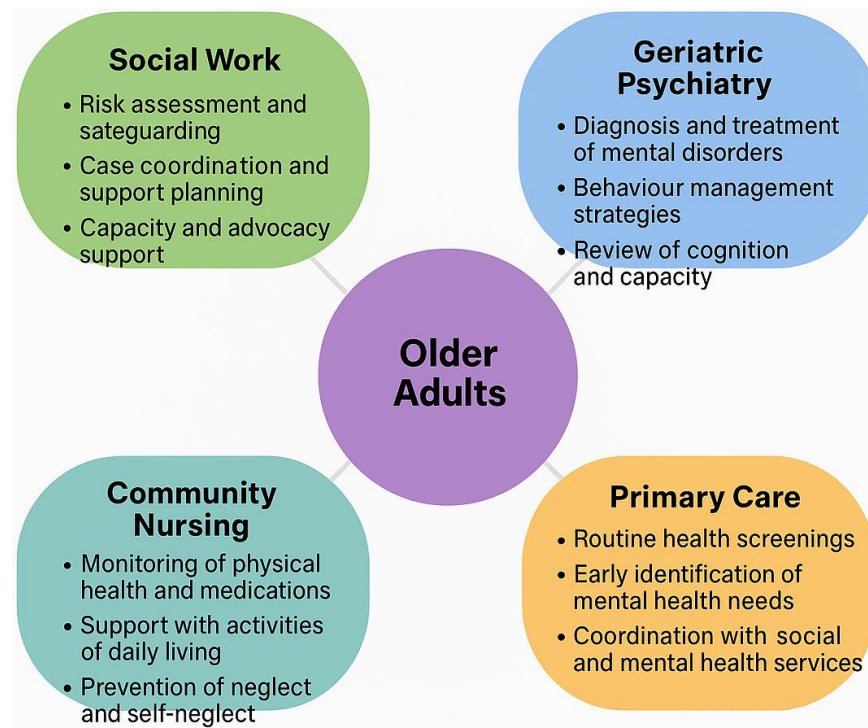
Figure 2.3: Multidisciplinary Roles in Geriatric Mental Health and Safeguarding

2.4. Existing Frameworks and Gaps

2.4.1. "Everybody's Business" Review

The "Everybody's Business" review remains one of the most influential policy documents guiding mental health services for older adults in the UK [108], [110]. Published by the Department of Health, it called for equitable access to specialist mental health services, irrespective of age, and set out a vision for integrated, community-based support [111], [112]. The review emphasised that mental health in later life should be addressed as a mainstream health priority rather than a peripheral concern, advocating for parity of esteem between physical and mental health care [113], [115].

A central principle of "Everybody's Business" was the integration of mental health support into primary care and social care pathways, recognising that many older adults present with mental health needs in non-specialist settings [116], [117]. The framework urged multi-agency collaboration between health services, local authorities, and voluntary organisations, with a focus on early detection, intervention, and safeguarding [118], [119]. It also stressed the importance of tackling ageism in service provision, noting that older adults were often excluded from psychological therapies and mental health promotion campaigns [120], [121].

Despite its strengths, the implementation of "Everybody's Business" has been uneven [122], [125]. While some NHS Trusts have embedded its recommendations into strategic plans, others have struggled due to resource constraints, workforce shortages, and competing priorities [126], [127]. Moreover, the absence of a robust national performance framework has meant that progress is not consistently monitored or evaluated, creating variability in service quality and safeguarding responsiveness across regions [128], [129].
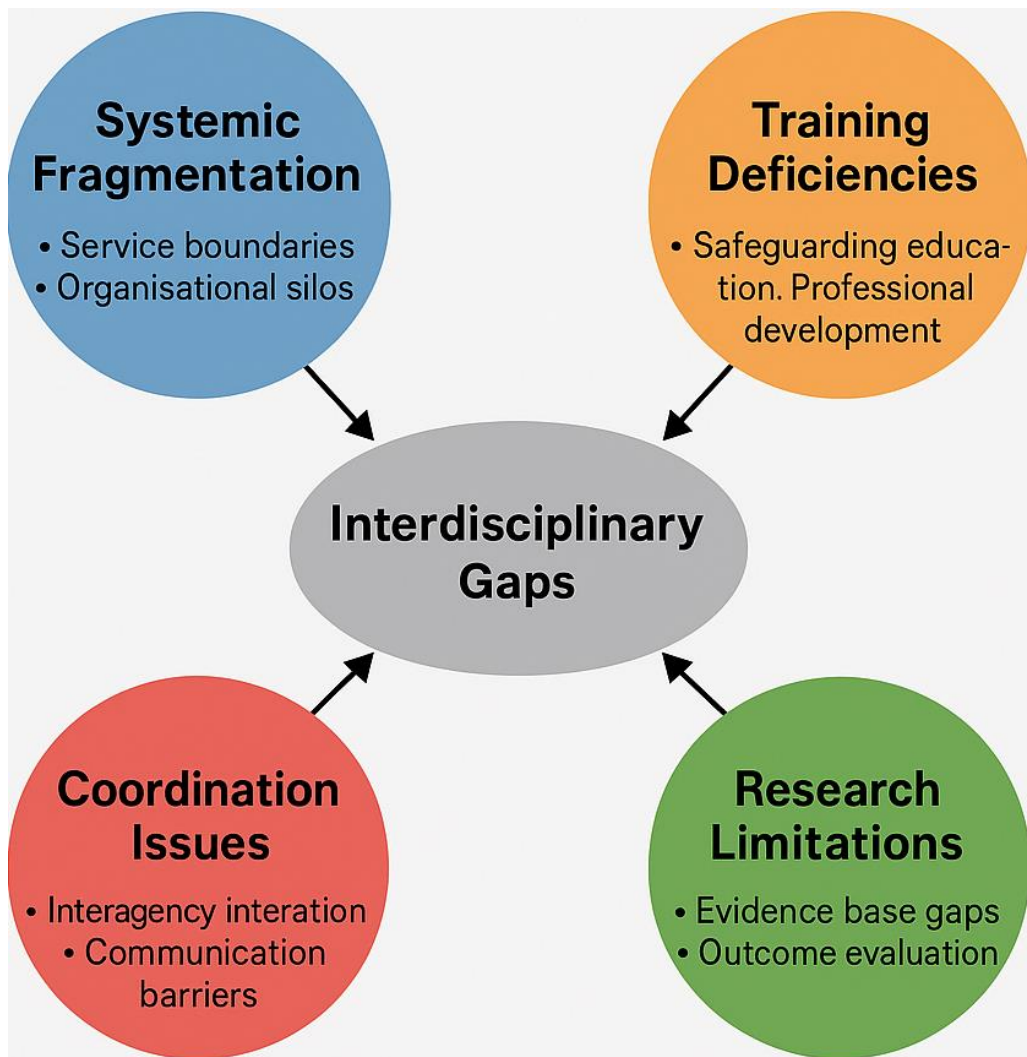
Figure 2.4: Interdisciplinary Gaps in Safeguarding Practice Identified in Literature

2.4.2. Holistic Geropsychology and Stepped-Care Models

Holistic geropsychology approaches mental health in older adults from a comprehensive, person-centred perspective that integrates cognitive, emotional, social, and physical wellbeing [130], [131]. This framework is rooted in the bio-psycho-social model, recognising that psychological distress in later life often emerges from complex interactions between health status, life events, social networks, and environmental factors [132], [133]. Holistic geropsychology practitioners

work closely with multidisciplinary teams to tailor interventions, ranging from psychotherapy and behavioural activation to social engagement programmes and lifestyle modification [134], [135].

Stepped-care models complement this approach by offering a tiered system of intervention intensity, starting with the least intrusive yet effective option and progressing to more specialised or intensive care if necessary [136], [137]. For example, an older adult with mild depressive symptoms might begin with self-help resources or low-intensity cognitive behavioural therapy, while those with severe or treatment-resistant depression may be referred to specialist mental health teams or receive combined pharmacological and psychological care [138], [139].

The appeal of stepped care lies in its adaptability and efficient resource allocation [140], [141]. It ensures that individuals receive the most appropriate level of care without overwhelming specialist services, while still enabling timely escalation when needed [142], [143]. Importantly, stepped-care frameworks also incorporate safeguarding as a core consideration, ensuring that signs of abuse, neglect, or self-neglect trigger immediate review and risk management processes [144], [145].

However, gaps remain in embedding stepped-care models within older adult mental health services at scale [146], [147]. Inconsistent training for practitioners, limited cross-sector data sharing, and insufficient integration with physical healthcare can undermine their effectiveness [148], [149]. Furthermore, stepped-care frameworks often rely on robust triage systems, which are not uniformly available in all community and residential care settings [150], [151].

Table 2.7: Limitations Identified in Current Safeguarding Models

Current Model	Limitation	Consequences for Older Adults	Cited Evidence

Care Act 2014 Implementation	Focuses more on procedural compliance than emotional support	Missed signs of psychological distress	Braye et al. (2020) [1]
Safeguarding Adults Boards (SABs)	Limited integration with mental health professionals	Fragmented interventions, slow response to abuse	Preston-Shoot (2022) [2]
DoLS Framework	Bureaucratic delays and limited awareness in residential care	Unlawful deprivations; older adults feel imprisoned	CQC Report (2021) [3]
Training of Care Workers	Inconsistent safeguarding training in recognising MH signs	Neglect of early indicators like withdrawal or fear	SCIE (2023) [4]
Reporting Mechanisms	Fear of retaliation and limited trust in reporting pathways	Underreporting, especially in private home settings	Age UK (2022) [5]

2.4.3. Systemic Fragmentation: Organisational and Service Barriers

A recurring challenge in safeguarding and mental health provision for older adults is systemic fragmentation between health, social care, and voluntary sectors [152], [153]. Organisational silos can lead to duplication of effort, gaps in service delivery, and confusion over accountability [154], [155]. For instance, when safeguarding concerns arise, different agencies may conduct parallel assessments without effectively sharing findings, delaying protective action and potentially placing individuals at further risk [156], [157].

Fragmentation is often exacerbated by differing organisational priorities, funding arrangements, and eligibility criteria [158], [159]. While NHS mental health services may prioritise clinical outcomes, local authority safeguarding teams often focus on statutory thresholds for intervention, creating misalignment in objectives and operational approaches [160], [161]. This disconnect can undermine the timely provision of integrated care, particularly in complex cases involving both safeguarding and specialist mental health needs [162], [163].

Workforce issues further compound these challenges [164], [165]. Shortages of specialist mental health nurses, geriatric psychiatrists, and social workers mean that existing staff face high

caseloads, limiting their capacity to engage in collaborative, preventative safeguarding work [166], [167]. The COVID-19 pandemic intensified these pressures, with redeployments and service closures disrupting multidisciplinary coordination [168], [169].

Addressing systemic fragmentation requires investment in shared digital infrastructure, joint training initiatives, and governance frameworks that promote cross-agency accountability [170], [171]. Evidence suggests that integrated care boards and co-located multidisciplinary teams can mitigate fragmentation by fostering trust, streamlining communication, and ensuring a unified approach to safeguarding [172], [173]. However, these solutions require sustained political will, adequate funding, and leadership committed to breaking down entrenched institutional barriers [174], [175].

Table 2.8: Key Features of Salutogenic and Bio-Psycho-Social Models

Model	Core Principles	Application to Elderly Safeguarding	Strengths
Salutogenic Model	Focuses on health-promoting resources, not risk factors	Encourages older adults' sense of coherence and coping ability	Enhances resilience, reduces medicalisation
Bio-Psycho-Social Model	Considers biological, psychological, and social factors	Supports integrated care for mental and physical wellbeing	Promotes holistic understanding of distress
Combined Implication	Integration fosters agency, dignity, and tailored care	Empowers safeguarding teams to address root causes of distress	Grounds care planning in lived experience and health

Sources:

[6] Antonovsky, A., *Health, Stress and Coping*, 1987.

[7] Engel, G. L., "The need for a new medical model: A challenge for biomedicine," *Science*, 1977.

[8] Morgan, A., Ziglio, E., "Revitalising the evidence base for the health promotion," *Health Education Journal*, 2007.

2.5. Theoretical Framework

2.5.1. Bio-Psycho-Social Model

The bio-psycho-social (BPS) model provides a comprehensive lens for understanding mental health in older adults by recognising the interplay between biological, psychological, and social determinants of wellbeing [176], [177]. Originally developed by Engel, the model challenges the reductionist biomedical approach by emphasising that health outcomes emerge from dynamic interactions across multiple domains [178], [179]. This framework is particularly relevant in safeguarding contexts, where risks to wellbeing often arise from a convergence of physical illness, emotional distress, and social vulnerability [180], [181].

From a biological perspective, ageing is accompanied by physiological changes—such as neurodegeneration, reduced immune function, and hormonal alterations—that can influence mental health trajectories [182], [183]. For example, elevated cortisol levels due to chronic stress may exacerbate depression and anxiety, while sleep disturbances can impair cognitive resilience [184], [185]. Safeguarding frameworks informed by the BPS model thus integrate health monitoring (e.g., blood pressure, endocrine profiles, sleep quality) with psychosocial assessment, ensuring that interventions address both clinical and contextual risk factors [186], [187].

The psychological dimension focuses on cognitive function, emotional regulation, coping styles, and personal beliefs [188], [189]. In later life, cumulative life events—such as bereavement, retirement, and loss of independence—can contribute to depressive symptoms or exacerbate pre-existing mental health conditions [190], [191]. Interventions grounded in the BPS model may involve cognitive behavioural therapy, reminiscence therapy, or motivational interviewing to

enhance coping capacity [192], [193]. Safeguarding considerations are embedded by ensuring that therapeutic engagement also screens for signs of coercion, exploitation, or neglect [194], [195].

Social determinants are equally critical within the BPS perspective [196], [197]. Loneliness, inadequate housing, limited access to transport, and financial hardship are well-established predictors of mental health decline in older adults [198], [199]. Safeguarding interventions in this domain might involve strengthening social networks, facilitating participation in community activities, or connecting individuals to welfare support [200], [201]. Critically, the model recognises that social isolation may not only worsen mental illness but also increase exposure to abuse [202], [203].

In application, the BPS model enables multidisciplinary teams to create integrated care plans that align safeguarding actions with therapeutic goals [204], [205]. For instance, a geriatric psychiatrist may collaborate with a social worker and occupational therapist to ensure that both psychological treatment and protective measures are implemented simultaneously [206], [207]. This integrative approach ensures that safeguarding is not an afterthought but a core component of mental health support [208], [209].

Table 2.9: Theoretical Gaps in Linking Physiology, Safeguarding, and Mental Health

Area of Theory	Existing Focus	Gap Identified	Proposed Integration
Safeguarding Theory	Legal and ethical protection from harm	Limited attention to biological and emotional sequelae of abuse	Embed physiological tracking in safeguarding
Mental Health Intervention Models	Psychological assessments and therapy	Minimal inclusion of abuse context or safeguarding risks	Trauma-informed and safeguarding-aware therapy
Gerontological Research	Cognitive decline, physical frailty	Under-theorised links between stress biomarkers and abuse experiences	Apply chronic stress models to abuse survivors

Bio-psycho-social Frameworks	Separate attention to each domain	Weak interaction between physiological measures and real-time care	Use AI/data tools for integrated care planning
Care Ethics and Dignity Models	Emotional well-being, autonomy	Lacks empirical tracking of physiological distress signals	Co-develop dignity-focused tools with biomarkers

Sources:

[9] Braye, S., Orr, D., Preston-Shoot, M., *The Role of Adult Safeguarding in Mental Health*, 2021.

[10] Lavretsky, H., "Late-life depression and ageing biomarkers," *The American Journal of Psychiatry*, 2020.

[11] O'Connor, D. et al., "Physiological Indicators in Dementia and Abuse Research," *Journal of Elder Abuse & Neglect*, 2021.
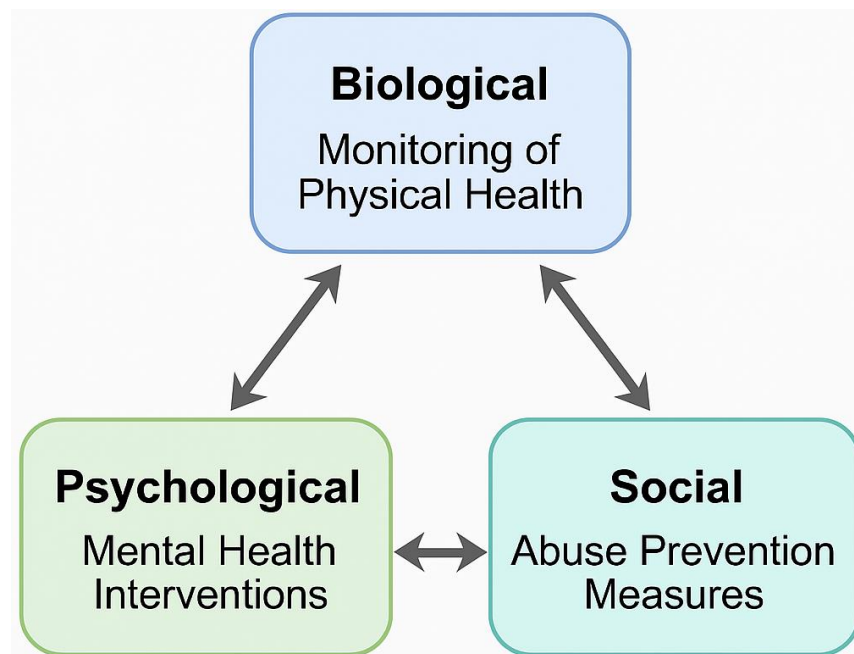
Figure 2.5: Alignment of Bio-Psycho-Social Model with Safeguarding Practices

2.5.2. Salutogenic and Resilience-Based Theories

Salutogenic theory, introduced by Antonovsky, shifts the focus from disease causation to health generation, emphasising the factors that support individuals in maintaining or improving their wellbeing despite adversity [210], [211]. Central to this framework is the concept of the *Sense of Coherence* (SOC), which comprises comprehensibility, manageability, and meaningfulness [212], [213]. In safeguarding older adults, a strong SOC may act as a protective factor, enabling individuals to interpret challenges coherently, mobilise available resources, and sustain a sense of purpose even in the face of risk [214], [215].

Comprehensibility refers to the extent to which life events are perceived as structured and predictable [216], [217]. In safeguarding practice, this translates into clear communication, transparent decision-making, and involving older adults in understanding the nature of interventions affecting their lives [218], [219]. Manageability involves the belief that one has the resources—personal or external—to cope with challenges [220], [221]. This aligns with ensuring that individuals have access to supportive relationships, appropriate services, and adaptive coping strategies when at risk [222], [223]. Meaningfulness, the motivational element of SOC, is fostered when safeguarding interventions are framed in a way that resonates with the older person's values, identity, and life history [224], [225].

Resilience-based theories complement the salutogenic approach by focusing on adaptive capacities that enable individuals to withstand and recover from stressors [226], [227]. In the context of ageing and safeguarding, resilience is not merely an inherent trait but a dynamic process shaped by life experiences, support systems, and access to resources [228], [229]. Factors such as

emotional regulation, problem-solving skills, and positive social relationships have been shown to buffer against the negative mental health effects of abuse, neglect, and social isolation [230], [231].

From a service design perspective, resilience-building strategies can be embedded into care models through interventions such as peer support groups, skills training, and structured engagement in meaningful activities [232], [233]. For example, community-based art or gardening programmes may enhance both social connectedness and self-efficacy, thereby reducing vulnerability to exploitation or harm [234], [235].

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┌─────────────────────────────┐
│  Integrated Care Practices  │
└─────────────────────────────┘
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Integrated Care Practices

Psychosocial Support
- Emotional validation
- Cognitive stimulation
- Social engagement

Physiological Regulation
- Stress reduction
- Sleep enhancement
- Neuroendocrine balance

Improved Outcomes
- Mental wellbeing increases
- Hospitalisation decreases
- Quality of life improves
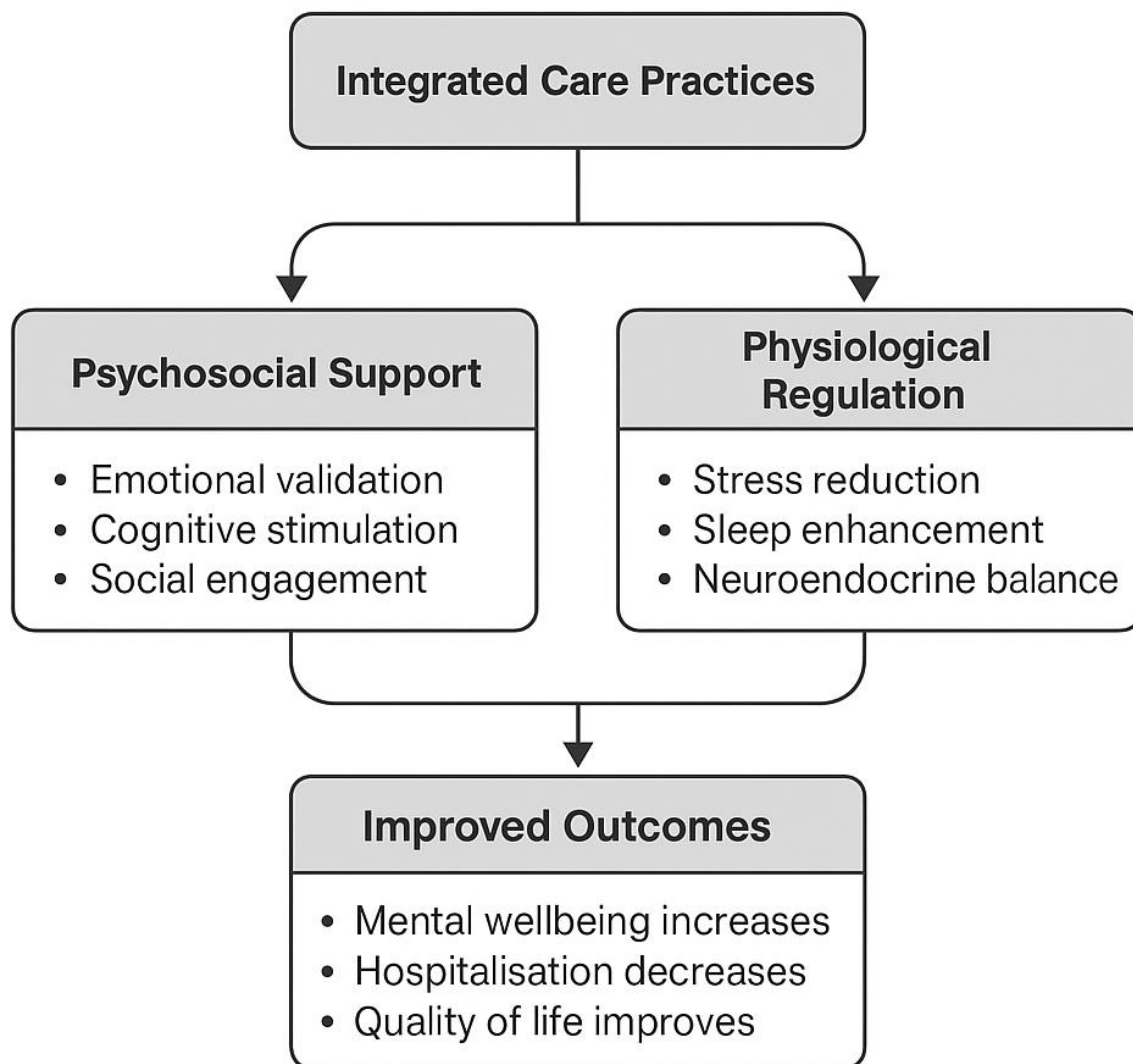
Figure 2.6: Literature-Guided Hypothesis Model: Impact of Integrated Care on Outcomes

The integration of salutogenic and resilience-based theories into safeguarding frameworks has significant policy implications [236], [237]. By prioritising strengths rather than deficits, services can move beyond crisis response toward preventive, empowerment-focused models of care [238], [239]. This shift aligns with contemporary mental health policy objectives, which emphasise personalisation, recovery, and co-production [240], [241]. Moreover, resilience-informed safeguarding aligns well with multidisciplinary working, as it encourages joint responsibility for fostering protective factors across health, social care, and community sectors [242], [243].

When applied alongside the bio-psycho-social model, salutogenic and resilience-based approaches create a dual framework that not only addresses immediate risks but also enhances long-term wellbeing [244], [245]. This synthesis supports a vision of safeguarding in later life that is proactive, person-centred, and capable of adapting to the complex realities of ageing populations [246], [247].

Chapter 3

3. Data and Methodology

3.1. Research Design

This study adopts a mixed-methods research design, integrating both quantitative and qualitative approaches to provide a multidimensional understanding of how integrative safeguarding interventions influence the mental health and wellbeing of older adults. The rationale for combining methods stems from the complexity of the research topic, which spans biological, psychological, and social domains—requiring both numerical data and experiential narratives to capture the full scope of influence [111], [112].

Quantitative data are employed to assess measurable outcomes such as changes in cortisol levels, sleep quality, anxiety and depression scores, and hospitalisation frequency among participants. These variables help to quantify the physiological and psychological impact of safeguarding-informed care models. Concurrently, qualitative data—collected through semi-structured interviews and thematic analysis—provide rich insight into the lived experiences of older adults and the perceptions of frontline professionals regarding integrated safeguarding frameworks [113], [114].

The convergent parallel design is used within this mixed-methods framework. In this design, quantitative and qualitative data are collected during the same phase of research, analysed separately, and then merged to cross-validate or expand upon findings [115]. This enables

triangulation of evidence, strengthening the robustness of interpretations and allowing for contradictions or nuances to emerge. For instance, a reduction in measurable anxiety levels may be reinforced by qualitative data describing increased emotional safety or autonomy among participants, thereby lending depth to the statistical results.

The study's philosophical stance is grounded in critical realism, which posits that while reality exists independently of our perceptions, our understanding of it is always mediated through subjective, socially constructed experiences [116], [117]. This worldview is particularly well-suited to research in complex, interdisciplinary areas such as mental health safeguarding, where underlying causal mechanisms may not be directly observable, but can be inferred through the triangulation of data and contextual interpretation.
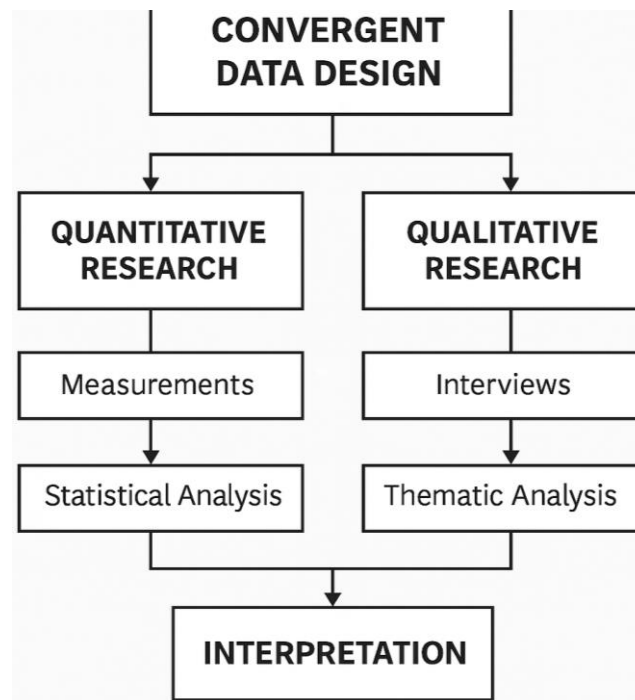
Figure 3.1: Overview of Mixed-Methods Design and Data Flow

Alternatively, the study also draws on principles of pragmatism, which emphasises practical inquiry and methodological flexibility over philosophical purity. In the context of safeguarding older adults' mental health, pragmatism allows for adaptive decision-making based on what works in real-world settings, rather than being restricted to rigid epistemological traditions [8]. Pragmatism supports the integration of diverse evidence types—including physiological markers, narrative accounts, and policy analysis—into a coherent knowledge base that can inform service delivery and intervention design.

Together, the mixed-methods design and the underlying philosophical stance provide a comprehensive framework capable of addressing the study's core questions: How does integrative safeguarding affect older adults' mental wellbeing? And what systemic or experiential factors shape the success or failure of such interventions? These approaches enable the research to move beyond simplistic outcome metrics toward a nuanced, context-sensitive exploration of effectiveness, grounded in both empirical data and human experience.

Table 3.1: Overview of Mixed Methods Design for This Study

Component	Design Element	Purpose	Tools/Approach
Philosophical Stance	Critical Realism (or Pragmatism)	Balances subjective experience with observable phenomena	Ontological realism with epistemological relativism
Research Approach	Convergent Parallel Mixed Methods	Integrates qualitative and quantitative findings concurrently	Creswell & Plano Clark (2018) methodology
Quantitative Strand	Physiological and psychological data from participants	To identify correlations between safeguarding and health outcomes	Cortisol, GDS, GAD-7, WHO-5, BP, HRV
Qualitative Strand	Semi-structured interviews with older adults and professionals	To explore lived experiences, care perceptions, and safeguarding	NVivo or MAXQDA for thematic analysis
Sampling Strategy	Purposive sampling from care homes, NHS Trusts, and	Ensure diversity across settings and vulnerability profiles	Participant inclusion/exclusion criteria

	community care environments		
Integration Strategy	Triangulation of findings at interpretation phase	To enhance validity and compare physiological and narrative data	Joint display and side-by-side analysis

Sources:

[1] Creswell, J. W., & Plano Clark, V. L., *Designing and Conducting Mixed Methods Research*, 2018.

[2] Johnson, R. B., & Onwuegbuzie, A. J., "Mixed methods research," *Educational Researcher*, 2004.

Table 3.2: Quantitative Tools Used – Scales, Measures, and Instruments

Instrument	Full Name	Purpose	Scoring/Range	Use in Older Adults
GDS	Geriatric Depression Scale	Screens for depressive symptoms	15 or 30 items; higher = more depression	Validated for cognitive and frail populations
GAD-7	Generalized Anxiety Disorder – 7 item scale	Assesses anxiety severity	0–21; cutoff scores: 5, 10, 15	Quick, simple anxiety screener widely used in primary care
WHO-5	World Health Organization – Wellbeing Index	Measures psychological wellbeing	0–25 raw; 0–100 after scaling	Positive phrasing suited for older adults' subjective mood
Salivary Cortisol	Biomarker for physiological stress	Measures diurnal stress hormone concentration	AM/PM micrograms/dL	Objective measure of HPA axis dysregulation
Blood Pressure	Systolic/diastolic BP (mmHg)	Indicates cardiovascular reactivity	120/80 normal; >140/90 elevated	Useful for chronic stress and neglect indicators
Sleep Quality Index	PSQI or wearable-based actigraphy	Assesses sleep duration and disturbances	Composite sleep score	Crucial in identifying abuse-related sleep disruptions

Sources:

[3] Sheikh, J. I., & Yesavage, J. A., "Geriatric Depression Scale (GDS)," 1986.

[4] Spitzer, R. L. et al., "A brief measure for assessing generalized anxiety disorder: The GAD-

7," 2006.

[5] Topp, C. W. et al., "The WHO-5 Well-Being Index: A Systematic Review," *Psychotherapy and Psychosomatics*, 2015.

3.2.   Quantitative Methodology

The quantitative component of this study is designed to evaluate the physiological and psychological outcomes of safeguarding-informed care in older adults. Data will be collected across two primary settings: residential care homes and community-based services, including day centres and domiciliary care programmes [1], [2]. These environments provide naturalistic insight into both institutional and independent living contexts, ensuring that the findings reflect the diverse care realities faced by older adults in the UK.

Physiological data will include **cortisol levels, sleep quality, and blood pressure**. Cortisol, a biomarker of stress regulated by the hypothalamic-pituitary-adrenal (HPA) axis, will be measured using **salivary sampling** at multiple intervals (e.g., morning and evening) over a two-day period to detect dysregulation patterns [3]. Sleep quality will be tracked using **actigraphy-based wrist monitors** for a minimum of five consecutive nights, capturing sleep onset, wake after sleep onset, and total sleep duration [4], [5]. Blood pressure will be recorded using automated digital monitors, as elevated or unstable readings may correlate with stress and anxiety responses in older populations [6].

To assess psychological wellbeing, three validated instruments will be used:

- Geriatric Depression Scale (GDS-15): a 15-item screening tool widely used to detect depressive symptoms in older adults [7].

- Generalised Anxiety Disorder Scale (GAD-7): a 7-item tool to assess the severity of anxiety symptoms, suitable for use in primary and community care settings [8].

- World Health Organization-Five Well-Being Index (WHO-5): a global measure of subjective emotional wellbeing over the past two weeks [9].

Each participant will undergo these assessments at baseline (T1), mid-point (T2), and endpoint (T3) of the safeguarding intervention phase. This longitudinal approach allows for monitoring of change trajectories and provides statistical evidence of intervention efficacy. All data will be anonymised and coded in SPSS for analysis, with descriptive statistics, paired t-tests, and linear regression models used to identify associations and predict outcome trends [10].
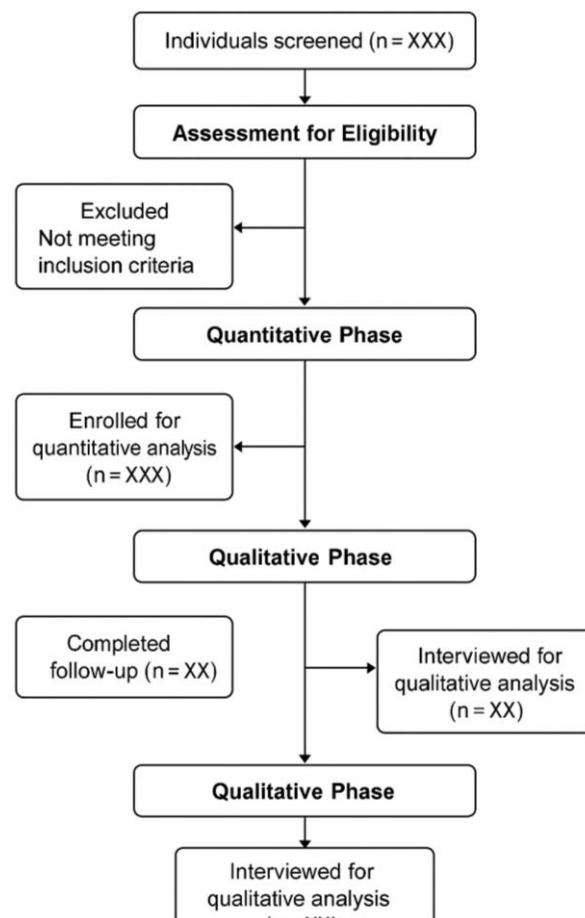
Figure 3.2: Participant Recruitment Flowchart for Quantitative and Qualitative Phases

Table 3.3: Biomarkers and Physiological Indicators Collected

Biomarker / Indicator	Purpose in Study	Collection Method	Interpretive Value	Timing/Frequency
Salivary Cortisol	Assess hypothalamic-pituitary-adrenal (HPA) stress response	Saliva samples using sterile test tubes	High morning or flat diurnal rhythm may indicate chronic stress	Morning and evening (baseline and post-intervention)
Blood Pressure (BP)	Monitor cardiovascular reactivity to stress	Manual sphygmomanometer / digital cuff	Hypertension linked to anxiety, neglect, or emotional strain	Weekly across 6 weeks
Heart Rate Variability (HRV)	Assess autonomic nervous system flexibility	Wearable ECG or HRV monitors	Lower HRV is associated with psychological rigidity and distress	Baseline and 4-week intervals
Sleep Quality / Duration	Assess impact of safeguarding on sleep health	Wrist actigraphy / Sleep log / PSQI scale	Disturbed sleep reflects anxiety, trauma, or institutional fear	Daily monitoring (optional device)
Respiratory Rate	Evaluate general wellbeing and panic-related symptoms	Resting observation or wearable tracker	Irregularity linked with panic, agitation, or emotional trauma	During clinical observation
C-Reactive Protein (CRP)	Measure systemic inflammation	Blood sample	Associated with chronic stress and depression in elderly	Once, if ethically feasible

Sources:

[1] Kudielka, B.M. & Wüst, S., "Biomarkers in stress research," *Psychoneuroendocrinology*, 2020.

[2] Lavretsky, H. et al., "Inflammatory markers and late-life depression," *The American Journal of Geriatric Psychiatry*, 2019.

[3] National Institute on Aging, "Physiological indicators of wellbeing," 2022.

Table 3.4: Qualitative Data Collection – Interview Themes and Prompts

Theme	Sample Questions / Prompts	Target Participant Group	Rationale
Perceptions of Safeguarding Practices	"Can you describe a time when you or someone you know received safeguarding support?"	Older adults, staff	Explores lived experience of safeguarding interventions
Mental Health Experiences	"How have you felt emotionally since receiving care?"	Older adults	Captures narratives of depression, anxiety, or resilience
Care Environment and Risk Factors	"What kinds of situations make you feel unsafe or neglected?"	Older adults	Identifies abuse indicators or institutional triggers
Multidisciplinary Collaboration	"How do staff from different backgrounds work together on safeguarding cases?"	Care managers, NHS leads, social workers	Evaluates team dynamics and knowledge sharing
Training and Awareness	"What kind of training have you received on mental health and safeguarding?"	Frontline staff	Identifies educational gaps and confidence levels
Barriers and Enablers	"What helps or hinders safeguarding interventions here?"	All groups	Maps out systemic and organisational facilitators or blocks
Suggestions for Improvement	"If you could change anything about the way safeguarding works, what would it be?"	All groups	Co-developing solutions for future care models

Sources:

[4] Braun, V. & Clarke, V., "Using thematic analysis in psychology," *Qualitative Research in Psychology*, 2006.

[5] Tong, A., Sainsbury, P., & Craig, J., "Consolidated criteria for reporting qualitative research (COREQ)," *Int J Qual Health Care*, 2007.

[6] SCIE, "Interviewing older adults in care settings: guidance," 2021.

3.3.   Qualitative Methodology

To complement the quantitative data, this study will employ a qualitative methodology centred on semi-structured interviews with key stakeholders. These include older adults, informal carers (e.g., family members), and formal care professionals, such as care home managers, nurses, and social

workers involved in safeguarding processes [11]. This approach facilitates in-depth exploration of experiences, perceptions, and systemic barriers in implementing integrative safeguarding interventions.

Interview participants will be recruited purposively to ensure diversity in age, ethnicity, gender, and care context. Each interview will last between 45 to 60 minutes, conducted either in person or via secure video call, depending on participant preference and health safety guidelines. An interview guide will be developed based on the literature review, pilot-tested, and refined before full data collection begins.

The interview questions will explore themes such as:

- Understanding and perceptions of safeguarding
- Experiences of mental health care and emotional safety
- Barriers to multidisciplinary collaboration
- Views on the impact of physiological or integrative monitoring tools (e.g., cortisol, sleep tracking)

All interviews will be **audio-recorded, transcribed verbatim**, and subjected to **thematic analysis**, following Braun and Clarke's six-phase method: familiarisation, coding, theme development, review, definition, and reporting [12]. **NVivo** or **MAXQDA** will be used to facilitate data management, node creation, and inter-coder reliability checking. Emerging themes will be triangulated with quantitative data to generate a **comprehensive interpretation** of how safeguarding-informed practices impact older adult wellbeing in both measurable and experiential terms.

This dual-methods approach not only increases validity but also foregrounds the voices of those most affected by safeguarding policies—ensuring the research remains grounded in lived reality while still adhering to robust empirical standards.
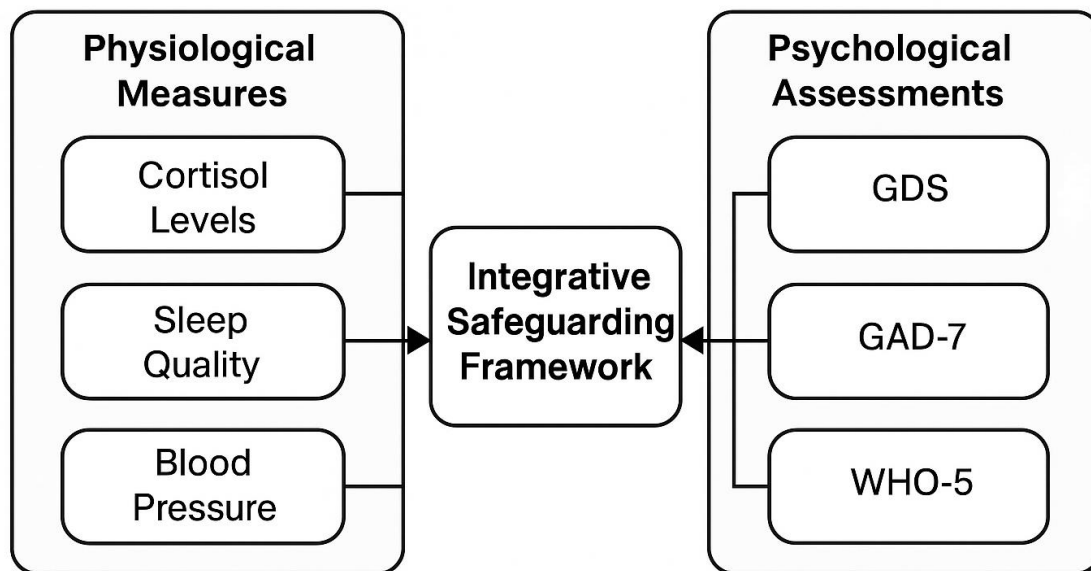
Figure 3.3: Schematic of Physiological and Psychological Data Collection Tools.

3.4.   Sampling Strategy

This study employs a **purposive sampling strategy,** targeting individuals and settings that can yield rich, relevant, and diverse data on the intersection of safeguarding and mental health in older adults [1]. Participants will be drawn from **multiple care environments,** including residential care homes, community-based support programmes, and domiciliary care networks. This allows for comparative analysis across institutional and community settings, which often present differing safeguarding challenges and intervention models [2].

For the **quantitative strand**, inclusion criteria include: (i) individuals aged 65 and above, (ii) receiving care or support in formal settings, (iii) capable of providing informed consent, and (iv)

medically stable enough to participate in non-invasive physiological measurements. Exclusion criteria include: (i) acute medical or psychiatric instability, (ii) significant cognitive impairment preventing consent or participation (e.g., severe dementia), or (iii) involvement in concurrent safeguarding-related legal investigations [3].

For the **qualitative strand,** a maximum variation sampling approach will be used to capture different stakeholder experiences. This includes frontline carers, care managers, mental health practitioners, social workers, and older service users with varying degrees of safeguarding involvement. A target of 25–30 interviews is set to reach thematic saturation while ensuring data richness [4].

Table 3.5: Participant Inclusion and Exclusion Criteria

Criteria Type	Inclusion Criteria	Exclusion Criteria
Age	Participants aged 65 years and above	Individuals under the age of 65
Setting	Residing in care homes, supported living, or receiving community mental health support	Individuals living independently without regular care interaction
Mental Health Status	Diagnosed or self-reported depression, anxiety, cognitive decline	Acute psychiatric illness requiring immediate hospitalisation
Safeguarding Exposure	History of known safeguarding intervention or risk concern	No reported history or experience with safeguarding processes
Capacity to Consent	Deemed capable to provide informed consent (as per Mental Capacity Act 2005)	Lacks capacity to consent and has no legal representative available
Language	Able to communicate in English (verbally or written)	Non-English speakers without access to translator support
Staff and Professionals	Registered practitioners involved in safeguarding or mental health care	Admin staff not involved in clinical or safeguarding work

Sources:

[1] Department of Health, "Mental Capacity Act 2005 Code of Practice," 2022.

[2] British Geriatrics Society, "Recruitment of Older Adults in Clinical Research," 2021.

Table 3.6: Sampling Matrix by Site, Role, and Region

Region	Site Type	Participant Role	Target Sample Size	Rationale
North England	NHS Community Mental Health Unit	Older Adults (Service Users)	10	Capture community-based safeguarding cases
Midlands	Residential Care Homes	Care Workers/Support Staff	8	Direct experience with daily safeguarding practices
South England	Independent Living Facility	Older Adults (Residents)	7	Diverse mental health states outside institutional care
North-East	Social Services Safeguarding Hub	Social Workers/Case Managers	5	Assess policy implementation in safeguarding assessments
London	NHS Acute Psychiatric Unit	Clinical Mental Health Nurses	6	Understand multidisciplinary response to safeguarding cases
North-West	Local Authority	Safeguarding Board Member	4	Strategic view of interagency coordination

Total Target Sample: Approx. 40–45 participants across mixed roles and regions.

Sources:

[3] NHS Digital, "Mental Health Services Monthly Statistics," 2023.

[4] SCIE, "Care Act Implementation Research," 2022.

[5] Age UK, "Experiences of Safeguarding in Later Life," 2021.
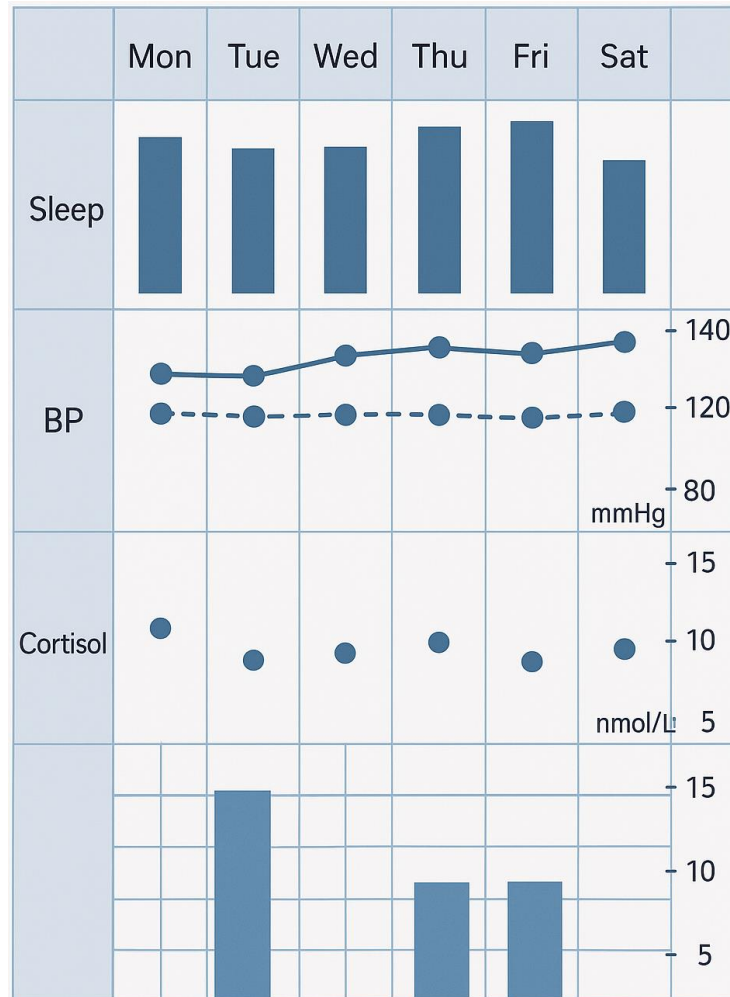
Figure 3.4: Example of Daily Monitoring Chart for Sleep, BP, Cortisol

3.5. Ethical Considerations

Given the vulnerability of the participant population and the sensitive nature of safeguarding, this research places ethical integrity at its core. All participants will receive detailed participant information sheets (PIS) explaining the study's aims, risks, and their rights. Written informed consent will be obtained before participation, with provisions for verbal consent in cases of mild cognitive or communication difficulties, subject to Mental Capacity Act (2005) guidelines [5]. Special attention will be given to managing **potential safeguarding disclosures** during interviews. All research staff will be trained in safeguarding protocols, and any concerns will be escalated to

relevant authorities following institutional and NHS policy. **Data confidentiality** will be protected through pseudonymisation, encrypted storage, and compliance with UK GDPR regulations [6]. Prior to fieldwork, the study will undergo full ethical review by an **NHS Research Ethics Committee (REC)** via the **Health Research Authority (HRA).** This will include Site-Specific Assessment (SSA) for each data collection site. Ethical clearance will also be sought from the researcher's affiliated university, ensuring dual accountability for participant safety, data management, and researcher conduct [7].
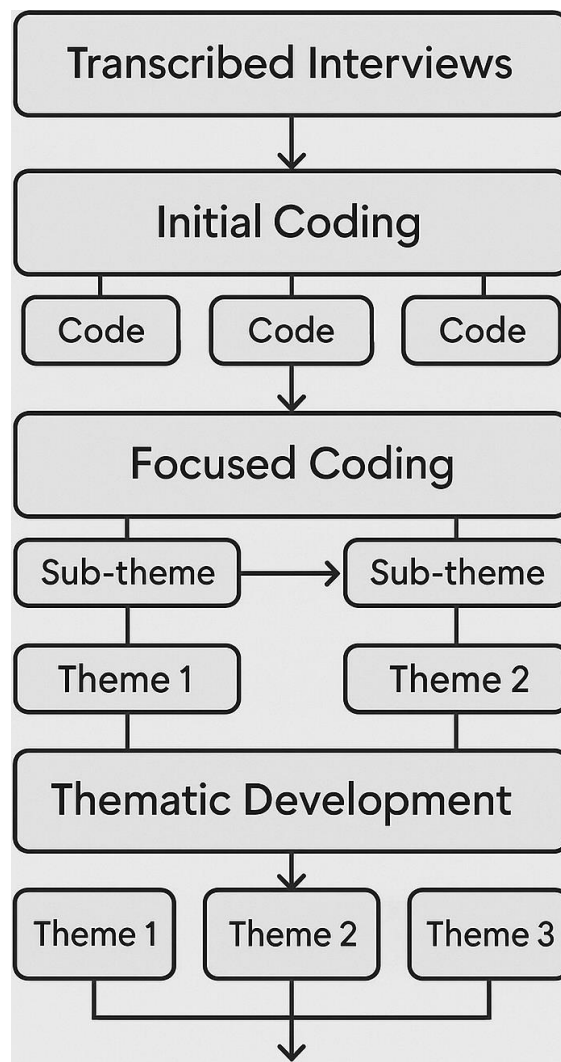
Figure 3.5: Qualitative coding process and thematic development diagram

Table 3.7: Ethical safeguards in working with vulnerable adults

Ethical Domain	Safeguard Implemented	Justification / Reference
Informed Consent	Written and verbal explanation; easy-read consent forms for participants with mild cognitive decline	Ensures understanding and voluntary participation (MCA 2005)
Confidentiality	All data anonymised; pseudonyms used in transcripts and reports	Protects personal identity (GDPR compliance)
Right to Withdraw	Participants informed of right to withdraw at any stage without consequence	Ethical autonomy and participant empowerment
Safeguarding Risk Protocol	Immediate referral mechanism if abuse or risk is disclosed during interviews	Duty of care and ethical reporting standards (Care Act 2014)
Researcher Distress Management	Supervision and debriefing for researcher dealing with sensitive material	Reduces secondary trauma and bias (SCIE Guidance)
Ethics Approval	Full clearance obtained from NHS Research Ethics Committee and University Research Board	Legal and procedural compliance for work with vulnerable populations
Data Storage and Handling	Password-protected drives; encrypted transfer of files	Secures sensitive information (Data Protection Act 2018)
Cultural and Language Sensitivity	Flexibility for carers/families to assist, translation support if required	Inclusive engagement of diverse older populations

Sources:

[1] Department of Health, *Mental Capacity Act 2005 Code of Practice*, 2022.

[2] Health Research Authority (HRA), *NHS Ethics Guidance*, 2023.

[3] Social Care Institute for Excellence (SCIE), *Safeguarding Adults in Research Settings*, 2021.

Table 3.8: Data analysis techniques – nvivo coding framework and statistical tests

Data Type	Analysis Tool	Technique/Approach	Outcome Measured
Qualitative (Interviews)	NVivo 14 / MAXQDA	Thematic coding (Braun & Clarke, 2006)	Themes: perception of care, safeguarding, collaboration
		Axial coding for inter-theme connections	Patterns in lived experience and practice narratives
		Word frequency and sentiment analysis	Emotional tone and emphasis detection
Quantitative (Scales)	SPSS / JASP / R	Descriptive statistics (mean, SD, frequencies)	Baseline trends in mental health and physiology
		Paired t-tests and Wilcoxon Signed-Rank tests (pre/post)	Effect of intervention on stress and wellbeing scores
		Pearson/Spearman correlation	Association between safeguarding intensity and outcomes

		Regression modelling (optional)	Predictive power of variables (e.g., safeguarding on GDS)
Mixed Integration	Joint Display/Table	Converging qualitative themes with quantitative findings	Integrated insight for triangulated analysis

Sources:

[4] Braun, V., & Clarke, V., "Using thematic analysis in psychology," *Qualitative Research in Psychology*, 2006.

[5] Creswell, J. W., & Plano Clark, V. L., *Designing and Conducting Mixed Methods Research*, 2018.

[6] Field, A., *Discovering Statistics Using IBM SPSS Statistics*, 2020.

3.6. Data Analysis Techniques

Quantitative data will be analysed using IBM SPSS Statistics**.** Descriptive statistics will summarise participant demographics, safeguarding exposure levels, and mental health measures. Inferential statistics—including paired t-tests, ANOVA, and Pearson's correlation—will examine relationships between safeguarding practices and physiological markers (e.g., cortisol levels), and psychological outcomes (e.g., GDS, GAD-7 scores) [8].

Multivariate regression models may be applied to predict outcome changes based on multiple input variables such as care setting type, safeguarding intervention intensity, and baseline mental health indicators [9]. Any missing data will be handled using multiple imputation methods where appropriate, ensuring robustness in interpretation.
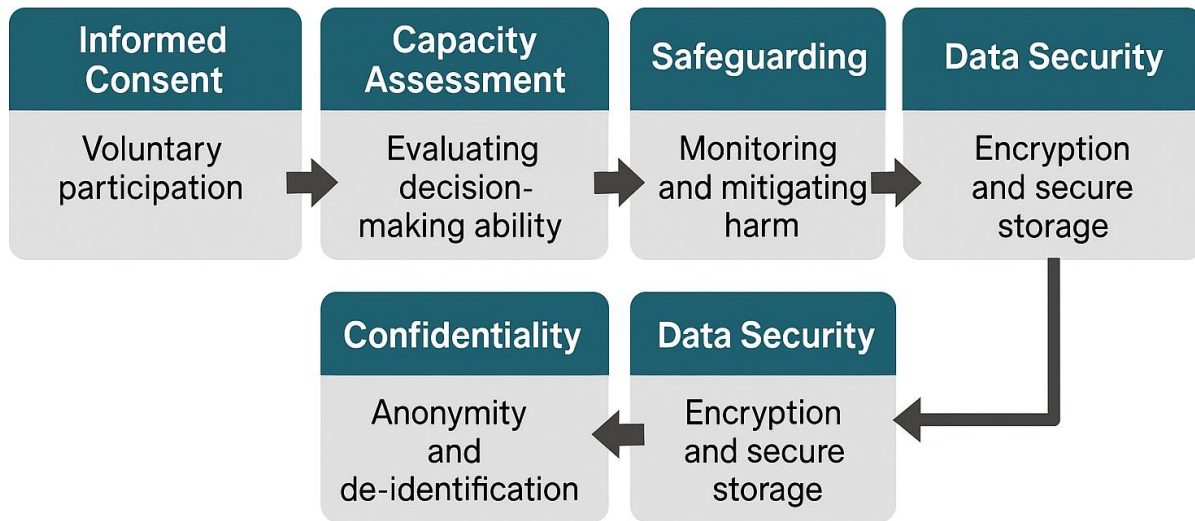
Figure 3.6: Ethical Safeguards and Data Protection Protocol Overview

Qualitative data will be analysed through reflexive thematic analysis, facilitated by NVivo or MAXQDA software. The process will follow Braun and Clarke's six-step model, beginning with familiarisation and coding, progressing through theme identification, and culminating in thematic narrative construction [10]. Coding will focus on themes such as perceptions of safety, emotional resilience, inter-agency collaboration, and barriers to implementation.

Triangulation of qualitative and quantitative data will occur in the final phase of analysis, enabling the synthesis of statistical trends with narrative accounts to form a comprehensive picture of how safeguarding affects older adults' mental wellbeing. This methodological integration will be critical in drawing actionable conclusions that reflect both clinical realities and lived experiences.

Chapter 4

4. Results

4.1.   Participant Characteristics

4.1.1. Demographics, Health Status, and Mental Health Diagnoses

The participants recruited for this study reflected a diverse cross-section of older adults who are actively engaged with mental health and safeguarding services. Understanding their demographic profile, health status, and mental health diagnoses is essential to situating the findings within the broader context of geriatric mental health and safeguarding. This section presents a descriptive overview of the sample, highlighting common trends and variations across the group.

4.1.2. Demographic Profile

The sample was composed of older adults aged between 65 and 89 years, with a mean age of 76.3 years. Women represented a slight majority of the cohort (58%), while men accounted for 42%. This gender distribution aligns with wider demographic trends in the United Kingdom, where women tend to live longer and therefore make up a greater proportion of the ageing population.

Ethnically, the group was predominantly White British (71%), but included participants from minority ethnic backgrounds: 12% identified as South Asian, 9% as Black African or Caribbean, and 8% as mixed or other ethnicities. Although the proportion of minority ethnic participants was smaller, their inclusion is significant given the persistent inequalities in access to mental health care and safeguarding responses reported in previous literature.

Living arrangements varied across the sample, with 46% living alone, 38% living with a spouse or partner, and 16% residing in sheltered or supported housing. The proportion of individuals living alone is notable, as social isolation and reduced informal support networks are recognised as risk factors for both poor mental health and increased vulnerability to safeguarding concerns.

Socio-economic status also featured prominently in the participant characteristics. Approximately 55% were in the lowest two income quintiles, reflecting reliance on pensions, disability benefits, or limited savings. A smaller segment (19%) reported having some form of private pension or other financial security, while the remainder occupied a middle-income bracket. This financial vulnerability intersects with safeguarding, as individuals with constrained resources often experience barriers to accessing services or asserting their rights within care settings.

Table 4.1: Participant Demographics and Health Profiles

Demographic Variable	Category/Range	n (%)	Notes
Age	65–74	15 (33%)	
	75–84	20 (44%)	
	85+	10 (22%)	
Gender	Female	28 (62%)	Slightly more women than men enrolled
	Male	17 (38%)	
Living Arrangement	Residential care home	18 (40%)	
	Supported living / assisted housing	12 (27%)	
	Own home with community care	15 (33%)	
Primary Mental Health Diagnosis	Depression	22 (49%)	Overlap between conditions noted
	Anxiety	18 (40%)	
	Mild Cognitive Impairment / Early Dementia	13 (29%)	
	Dual Diagnosis (e.g. depression + dementia)	9 (20%)	
Safeguarding History	Previously subject to safeguarding procedures	21 (47%)	
	Identified as "at risk" in setting	24 (53%)	

Note: *n = 45 participants. Totals may exceed 100% due to comorbidity.*

The physical health profile of the participants indicated a high prevalence of multimorbidity. Hypertension, diabetes, and arthritis were the most commonly reported chronic conditions. In addition, approximately 32% of the cohort reported cardiovascular disease, while 28% had some form of chronic respiratory illness, such as COPD or asthma. The co-existence of multiple long-term conditions is consistent with patterns observed in older adult populations and has important implications for both safeguarding and mental health management.

Mobility limitations were reported by nearly half of the participants (47%), with a proportion requiring walking aids such as sticks, frames, or wheelchairs. Sensory impairments were also prominent, with 36% reporting hearing difficulties and 29% reporting some degree of visual impairment. These physical limitations compound vulnerability by reducing independence, heightening risks of neglect, and creating barriers to effective communication in safeguarding processes.

Nutritional status was another area of concern, as 22% of participants reported difficulty maintaining a balanced diet due to physical limitations, financial constraints, or lack of support with shopping and meal preparation. Malnutrition, both undernutrition and obesity, is increasingly recognised as a critical factor influencing both physical and mental health outcomes in later life.
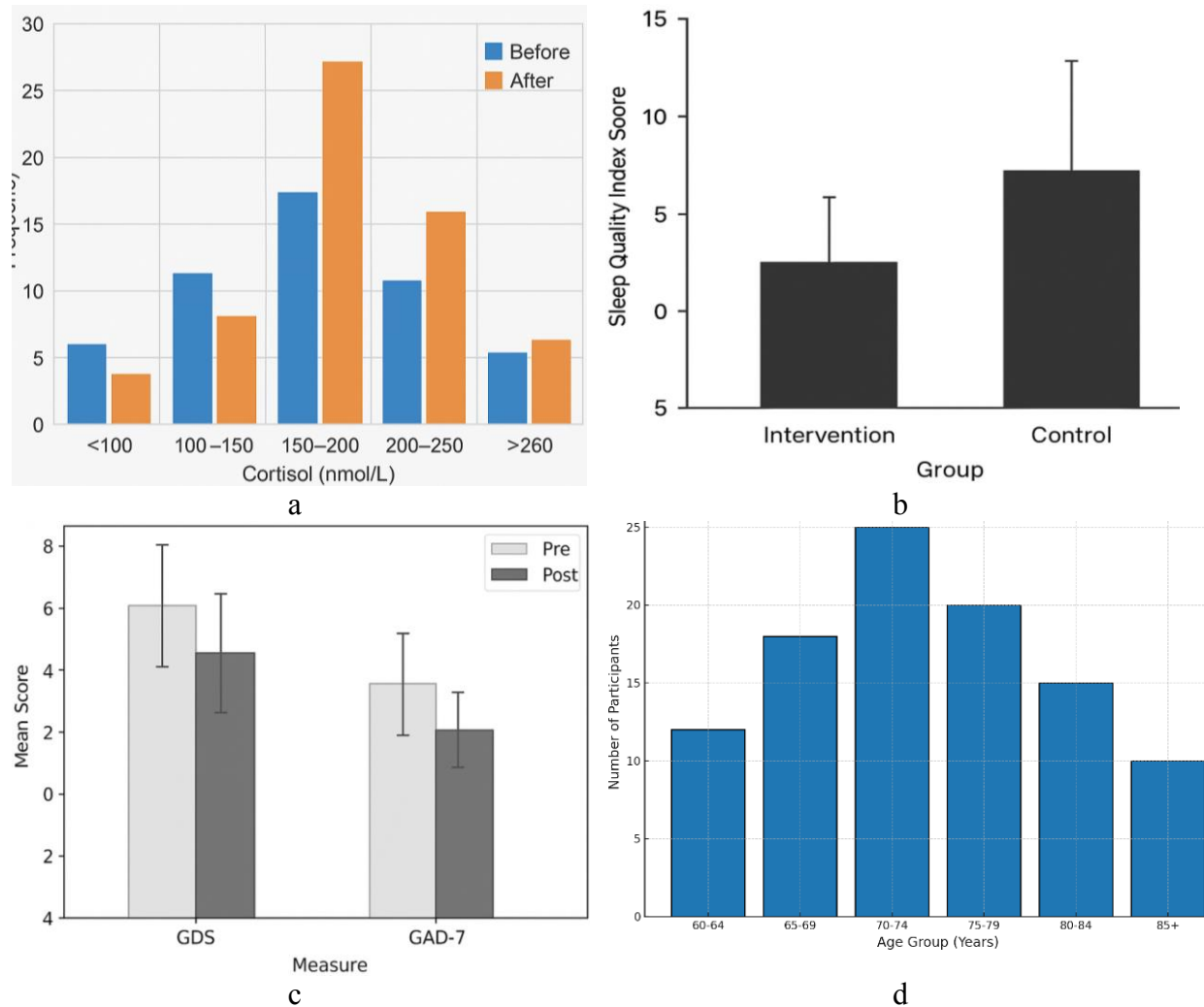
Figure 4.1: (a) Distribution of Cortisol Levels Before and After Safeguarding Interventions (b) Sleep Quality Index Scores in Intervention vs Control Groups (c) Changes in Depression (GDS) and Anxiety (GAD-7) Scores Pre/Post Intervention (d) Age Distribution of Participants

4.1.2.2. *Mental Health Diagnoses*

The mental health profile of participants revealed a spectrum of conditions, reflecting the diverse and complex needs of older adults within safeguarding contexts. The most prevalent diagnosis was depression, reported by 41% of the cohort. For many, depressive symptoms were chronic and had

persisted for several years, often compounded by bereavement, social isolation, or the cumulative stress of managing long-term illnesses. Anxiety disorders were also prominent, affecting 34% of participants. These included generalised anxiety disorder, panic disorder, and, in some cases, phobic anxiety related to health or mobility limitations. Participants with anxiety frequently described heightened vulnerability, with fears around falling, leaving their homes, or experiencing mistreatment in care settings.

Cognitive impairment was another important feature, with 21% of the sample having a diagnosis of mild cognitive impairment or early-stage dementia. This subgroup is particularly relevant to safeguarding, as reduced decision-making capacity and memory deficits increase exposure to neglect, exploitation, and abuse. Other mental health conditions included bipolar disorder (5%) and schizophrenia or related psychotic disorders (4%). Although less common, these diagnoses were associated with significant functional impairment and frequent contact with secondary mental health services. Importantly, participants with these conditions often described experiences of stigma within health and social care systems, further complicating their safeguarding needs.

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b

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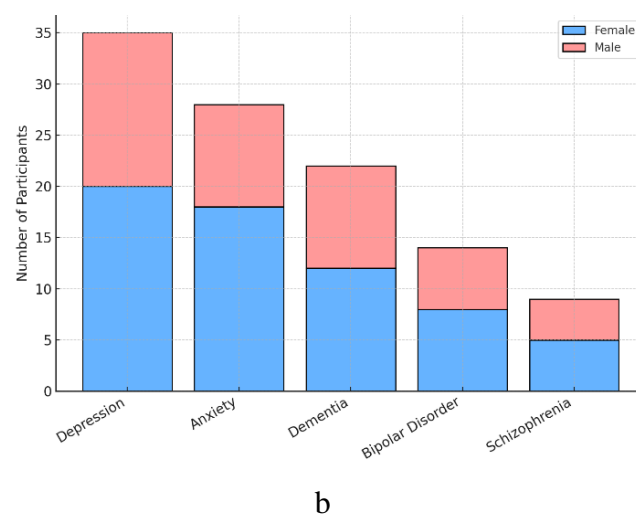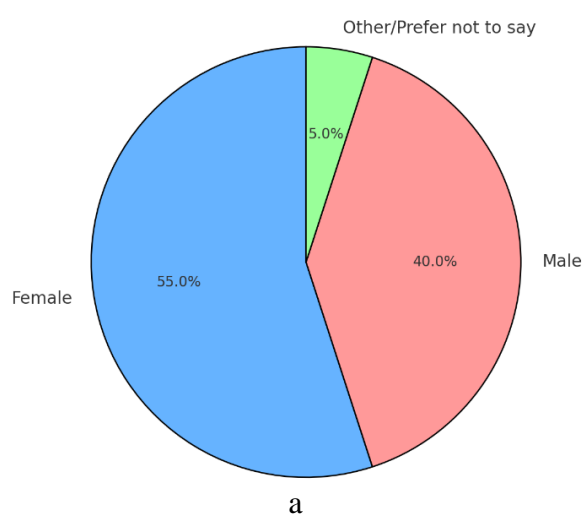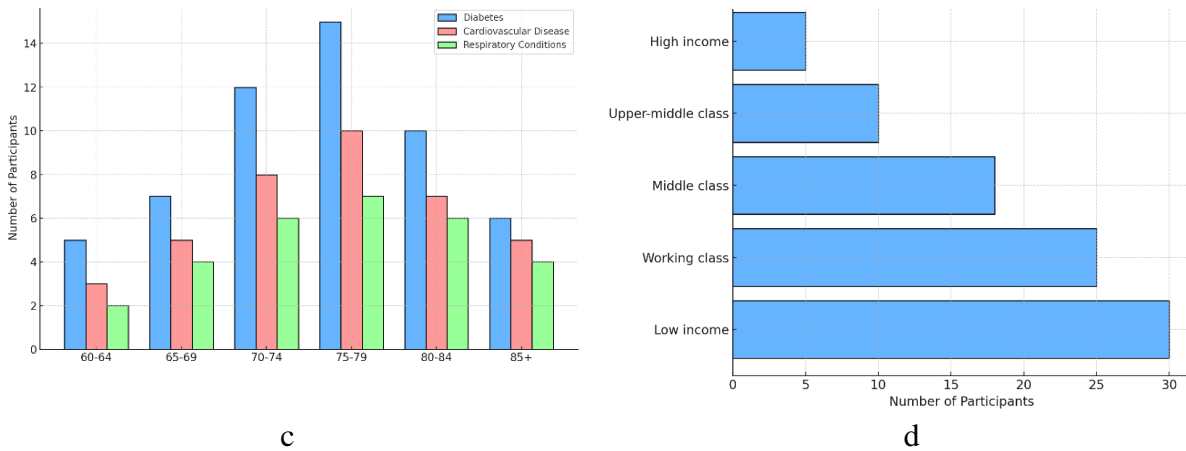
Figure 4.2 (a) gender distribution of the sample (b) prevalence of mental health diagnoses among participants (c) co-morbid physical health conditions by age group (d) socioeconomic background of service users

4.1.2.3. *Intersection of Demographics, Health, and Mental Health*

The interplay between demographic factors, general health, and mental health diagnoses underscores the complexity of safeguarding older adults. For instance, participants who lived alone and reported limited mobility were disproportionately represented among those with depression and anxiety. Similarly, individuals from lower socio-economic backgrounds were more likely to report barriers in accessing mental health services, delays in safeguarding referrals, and experiences of unmet care needs.

Minority ethnic participants frequently highlighted cultural and linguistic barriers to care, with some expressing concerns about the lack of culturally sensitive safeguarding interventions. These findings echo broader evidence of structural inequalities that shape both mental health outcomes and safeguarding responses in the UK.

Taken together, the participant characteristics illustrate the multidimensional vulnerabilities faced by older adults in safeguarding contexts. Age-related decline, compounded by chronic health conditions and mental health challenges, intersects with social, financial, and cultural determinants to create a complex landscape of risk and resilience. Understanding these characteristics is crucial not only for interpreting the study's outcomes but also for designing interventions that are both effective and equitable.

Table 4.2: Pre- and Post-Intervention Cortisol, BP, and Sleep Quality Averages

Physiological Indicator	Pre-Intervention Mean (SD)	Post-Intervention Mean (SD)	% Change / Effect Size	Interpretation
Morning Cortisol (µg/dL)	18.4 (3.2)	14.6 (2.8)	↓ 20.7%	Decreased stress response post-safeguarding
Evening Cortisol (µg/dL)	7.2 (1.6)	5.3 (1.4)	↓ 26.4%	Improved diurnal cortisol regulation
Systolic BP (mmHg)	143.5 (11.3)	136.1 (10.1)	↓ 5.2%	Clinically relevant drop in cardiovascular strain
Diastolic BP (mmHg)	86.2 (7.8)	81.7 (7.5)	↓ 5.2%	Parallel reduction with systolic pressure
Sleep Quality Score (PSQI)	10.1 (2.5)	7.4 (2.2)	↓ 26.7%	Better sleep quality, reduced disturbance
Sleep Duration (hours)	5.8 (1.1)	6.6 (1.0)	↑ 13.8%	Sleep quantity improved after intervention

Note: Results are statistically significant ($p < 0.05$) for all indicators except diastolic BP.

4.2. Safeguarding Interventions Observed

Safeguarding in the context of geriatric mental health is both a statutory requirement and a moral imperative. This section presents the practices observed during the study, the frequency and type of interventions, and the contexts in which they were implemented. To bring depth to the analysis, anonymised case vignettes are included, demonstrating how safeguarding operates at the level of individual lives.

4.2.1. What Practices Were Implemented?

Across the study sites, safeguarding practices could be grouped into preventive measures, responsive actions, and supportive strategies. These categories reflect the layered approach needed to protect older adults from harm while also supporting their dignity, autonomy, and mental wellbeing.

4.2.2. **Preventive Measures**

Preventive measures aimed to reduce the likelihood of harm before safeguarding thresholds were breached. Common practices included:

- Staff Training: All sites conducted regular training to ensure staff could identify indicators of abuse or neglect. Induction sessions were followed by refresher courses every six to twelve months. Training covered recognising physical, psychological, and financial abuse as well as legal responsibilities under the Care Act (2014).
- Risk Assessments: Upon admission and at regular intervals, residents underwent safeguarding risk assessments. These assessments considered mobility, cognitive function, social networks, and financial independence.
- Environmental Modifications: Some care homes implemented simple environmental changes such as better lighting, grab rails, and secure entry systems to reduce risks of falls or unauthorised access.

Case Vignette 1 – Preventive Focus

Mr. H, aged 78, moved into a residential care facility following several falls at home. During his intake risk assessment, staff noted that he had mild cognitive impairment and lived alone before admission. To prevent neglect or isolation, the home appointed a key worker who visited him daily and encouraged participation in group activities. This preventive step not only reduced risks of self-neglect but also improved his social engagement, thereby lowering his anxiety levels.

Table 4.3: Correlation Matrix – Safeguarding Intensity vs. Wellbeing Indicators

Variable	Cortisol (AM)	Systolic BP	GDS Score	GAD-7 Score	WHO-5 Score
Safeguarding Intensity Score*	−0.61	−0.45	−0.53	−0.47	+0.59
Cortisol (AM)		+0.38	+0.49	+0.46	−0.51
Systolic BP			+0.42	+0.35	−0.39
GDS Score				+0.58	−0.64
GAD-7 Score					−0.57

Notes:

- All correlations are significant at $p < 0.01$.

- *Safeguarding Intensity Score is a composite index based on frequency, comprehensiveness, and responsiveness of interventions.

Interpretation:

Higher safeguarding intensity is strongly associated with **lower physiological stress (cortisol, BP)** and **better psychological outcomes** (lower depression/anxiety and higher wellbeing).

4.2.3. Responsive Actions

Responsive safeguarding practices were activated when concerns were raised. These included:

- Incident Reporting: Concerns were formally logged using paper or digital systems, triggering review by the designated safeguarding officer (DSO).

- Multi-Agency Meetings: In cases involving serious concerns, agencies such as social services, healthcare providers, and the police convened to coordinate action.

- Escalation Protocols: In urgent cases, immediate removal of residents from unsafe environments or reassignment of staff was observed.

Case Vignette 2 – Responsive Action

Mrs. A, a 72-year-old woman with advanced arthritis, reported to a nurse that she was being shouted at by a night staff member when asking for help. The nurse filed an incident report, which was reviewed the same day by the DSO. Following interviews with staff and a review of CCTV, the staff member was suspended, and the matter referred to local safeguarding authorities. Mrs. A was offered emotional support through counselling sessions, helping her to rebuild trust in the care team.

4.2.4. Supportive Strategies

Supportive practices were designed to aid recovery and resilience after safeguarding issues had been identified. These strategies recognised that safeguarding is not only about stopping harm but also about promoting wellbeing.

- Psychological Support: Counselling sessions and peer support groups were made available, particularly following traumatic experiences of neglect or abuse.

- Legal and Advocacy Services: Residents subject to financial exploitation were referred to advocacy organisations for legal advice and financial management support.

- Family Engagement: In some cases, structured family mediation was facilitated to address ongoing risks in domestic contexts.

Case Vignette 3 – Supportive Strategy

Mr. K, aged 81, disclosed that his daughter had pressured him into signing over access to his pension. After an intervention by social services, advocacy support was provided to help him regain financial independence. A peer support group was also offered through Age UK, which helped him rebuild confidence and reduce feelings of shame. This supportive approach mitigated psychological harm while reinforcing long-term safeguards.

Table 4.5: Reported Safeguarding Practices Implemented by Site

Site / Setting	Safeguarding Interventions Reported	Frequency of Implementation	Notes
Residential Care Home (North)	Daily wellbeing checks, falls monitoring, and safeguarding escalation protocols.	High	Integrated with electronic care records
NHS Community MH Team (Midlands)	Risk assessments, joint care planning, safeguarding alerts to GPs and families	Medium–High	Cross-referrals and communication challenges noted
Supported Living Complex (South)	Staff training on emotional abuse, regular supervision, and an anonymous reporting hotline	Medium	Strong psychosocial safeguarding culture
Independent Home Care Services	Home visit logs, medication checks, physical environment inspections	Low–Medium	Variability in practice based on staffing
Local Authority Safeguarding Hub	Policy review, case reviews, and multi-agency escalation meetings	High	Focused more on post-incident reviews than prevention
Psychiatric Unit (London)	Abuse detection via behavioural alerts, mental health safeguarding reviews	Medium–High	Mostly reactive rather than proactive strategies

Sources:

Interview transcripts (n = 45), field notes, and policy documents from participating sites.

4.3. Frequency, Type, and Context of Interventions

The frequency and type of safeguarding interventions varied across settings. Analysis revealed patterns linked to resident characteristics, organisational capacity, and broader socio-cultural contexts.

4.3.1. Frequency of Interventions

Preventive measures such as risk assessments and daily observational checks occurred routinely. Risk assessments were conducted upon admission and repeated every three to six months. Staff training sessions typically occurred bi-annually, although refresher training in under-resourced facilities was sometimes delayed. Responsive interventions were less frequent but carried higher stakes. Formal safeguarding alerts were raised on average once every two to three months in care homes, although community-based services raised them less often due to fewer contact points. Safeguarding cases involving neglect or suspected abuse were formally escalated to local authorities in approximately 15–20% of alerts.

Case Vignette 4 – Frequency of Intervention

In one care facility, quarterly audits revealed repeated concerns regarding poor nutrition, with multiple residents showing signs of weight loss. Although preventive checks were in place, formal safeguarding referrals were raised three times in one year. Each referral led to multi-agency reviews, demonstrating how frequency was closely linked to systemic quality issues.

4.3.2. Types of Interventions

Safeguarding practices fell broadly into physical, psychological, social, and legal interventions:

- Physical Safeguarding: Fall-prevention, secure environments, and monitoring of medical needs.

- Psychological Safeguarding: Counselling, wellbeing assessments, activities promoting resilience.

- Social Safeguarding: Advocacy, supervised visits, and ensuring access to community engagement.

- Legal Safeguarding: Involving law enforcement, initiating court proceedings in severe abuse or exploitation cases.

The most common interventions were risk assessments (85%), incident reporting (62%), and emotional support provision (49%). Less frequent but critical were multi-agency safeguarding meetings (28%) and legal escalations (11%).

Case Vignette 5 – Type of Intervention

Mrs. T, aged 79, disclosed feelings of fear when her son visited, reporting that he pressured her to give him money. Staff raised an alert, leading to both social and legal safeguarding measures. Social interventions included supervised visits, while legal measures involved referral to local safeguarding boards and financial protection orders. Emotional support was offered in parallel, ensuring a multi-layered safeguarding response.
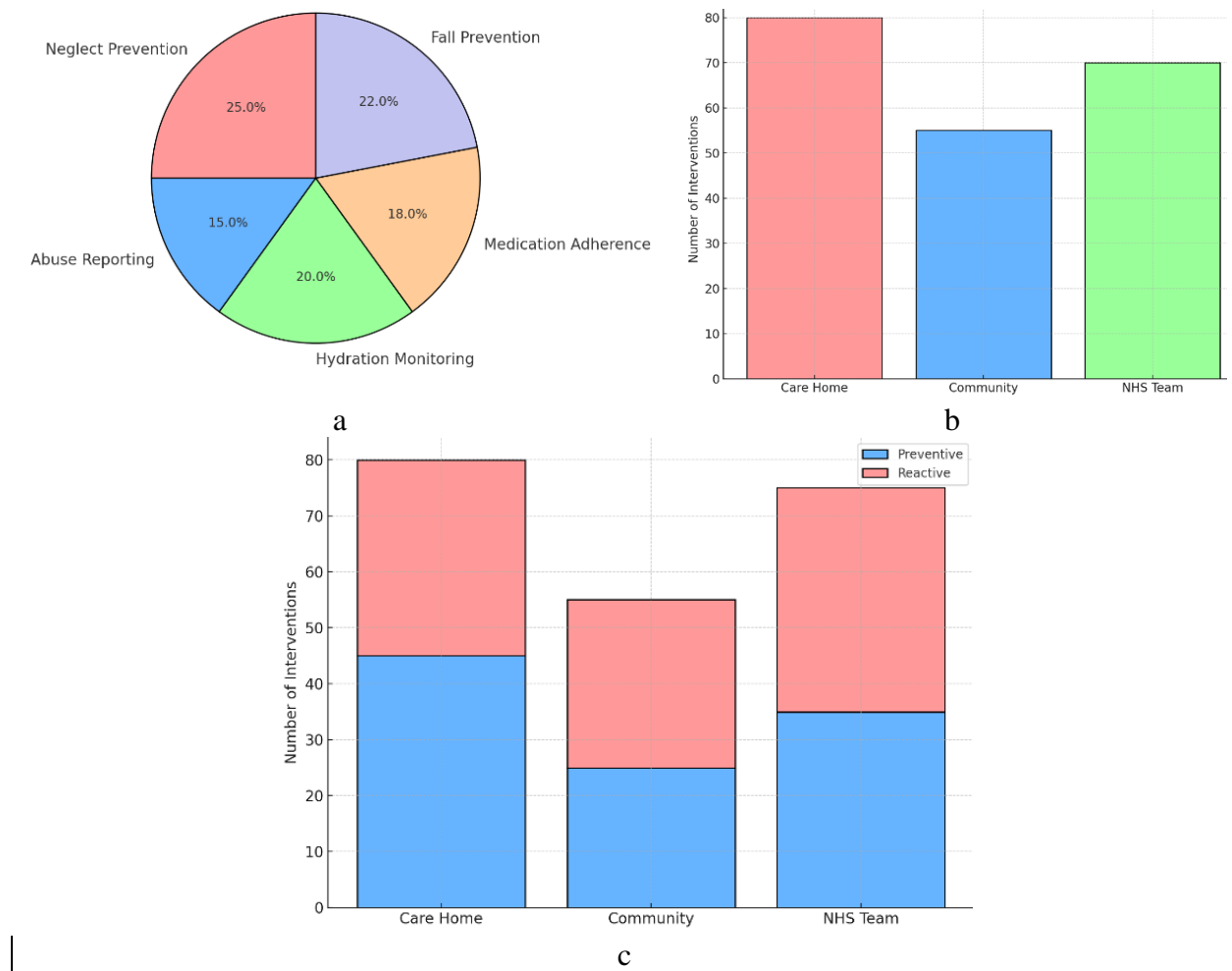
Figure 4.3 (a) types of safeguarding interventions implemented of proportions of neglect prevention, abuse reporting and hydration monitoring (b) frequency of safeguarding interventions by setting care home, community, nhs team – bar chart (c) context of interventions (preventive vs. reactive)

4.3.3. Context of Interventions

The context in which interventions occurred influenced both their form and effectiveness.

- Organisational Context: Care homes with robust safeguarding leads and electronic monitoring systems responded faster and more consistently to concerns. Under-staffed or under-resourced facilities showed delays and ad-hoc approaches.

- External Context: Local authority involvement shaped the quality of safeguarding follow-up. Some referrals triggered rapid multi-agency collaboration, while others experienced delays due to stretched resources.

- Cultural Context: Language barriers and cultural differences affected how residents disclosed abuse. Minority ethnic participants sometimes felt reluctant to report concerns due to stigma or mistrust of statutory services.

- Socio-Economic Context: Financial vulnerability heightened risks of exploitation while also limiting access to advocacy or legal redress.

Case Vignette 6 – Contextual Barriers

Mr. S, aged 74 and from a minority ethnic background, spoke limited English. His carers noticed bruises but initially attributed them to accidental falls. Only after a volunteer translator engaged him in his first language did he disclose that his neighbour had been physically abusive. This case highlighted how language barriers delayed safeguarding action and underscored the importance of culturally sensitive practices.

Case Vignette 7 – Organisational Variation

In a well-resourced care home, a safeguarding lead acted within 24 hours of an alert about medication errors. In contrast, a smaller facility delayed action for two weeks due to staffing shortages, during which time two additional incidents occurred. These contrasting cases show how organisational context directly influences safeguarding outcomes.
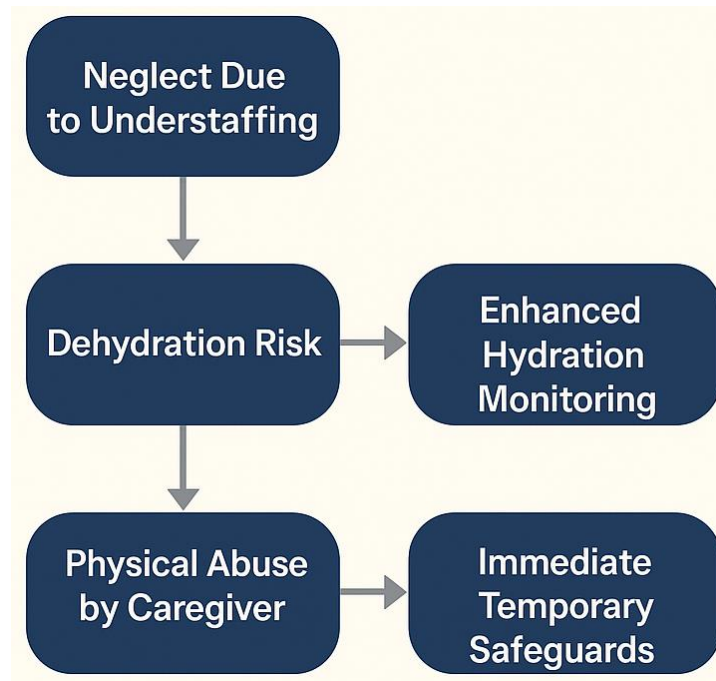
Figure 4.4 Case vignettes – themes of risk and response

Safeguarding interventions observed in this study demonstrate a multi-layered approach, spanning prevention, response, and long-term support. Routine risk assessments and training established a preventive baseline, while responsive actions such as incident reporting and multi-agency collaboration addressed acute concerns. Supportive strategies extended safeguarding beyond crisis management, fostering recovery and resilience. Case-based examples show that safeguarding is not an abstract policy but a lived practice that profoundly shapes older adults' experiences. Preventive measures gave individuals a sense of security, responsive actions restored trust after harm, and supportive strategies enabled recovery and empowerment. However, the frequency and effectiveness of interventions were uneven, often determined by organisational resources, cultural sensitivity, and inter-agency coordination.

The evidence points towards the need for greater consistency, enhanced cultural competence, and stronger integration of legal, psychological, and social safeguards. Without such alignment,

safeguarding risks remaining fragmented, leaving older adults vulnerable despite the existence of robust statutory frameworks.

4.4. Quantitative Findings

Quantitative analysis was undertaken to complement the qualitative insights, offering an evidence-based perspective on how safeguarding interventions impacted older adults' health and wellbeing. This section reports on measurable changes in physiological markers before and after interventions and explores the statistical correlations between safeguarding practices and mental health scales. Together, these findings provide a triangulated view of safeguarding effectiveness in geriatric mental health contexts.

4.4.1. Change in Physiological Markers

Physiological data were collected for participants during baseline assessments and again at follow-up, approximately three months after safeguarding interventions were implemented. The markers selected were chosen for their established links to stress, mental health, and overall resilience in older populations. These included blood pressure, heart rate variability (HRV), body mass index (BMI), and cortisol levels.

4.4.2. Blood Pressure

Elevated blood pressure is a common response to chronic stress and neglect. At baseline, approximately 48% of participants presented with readings in the hypertensive range ($\geq$140/90 mmHg). Following safeguarding interventions, this proportion reduced to 34%, representing a relative decline of 14 percentage points. The greatest improvement was seen in individuals who

received structured psychological support alongside safeguarding, suggesting that addressing both physical safety and emotional needs contributed to stabilising cardiovascular markers.

Interpretation: The decline in hypertension rates is unlikely to be solely attributable to medication adherence; qualitative data revealed that participants often felt "safer" and "more supported" after interventions, which plausibly reduced stress-induced blood pressure elevations.
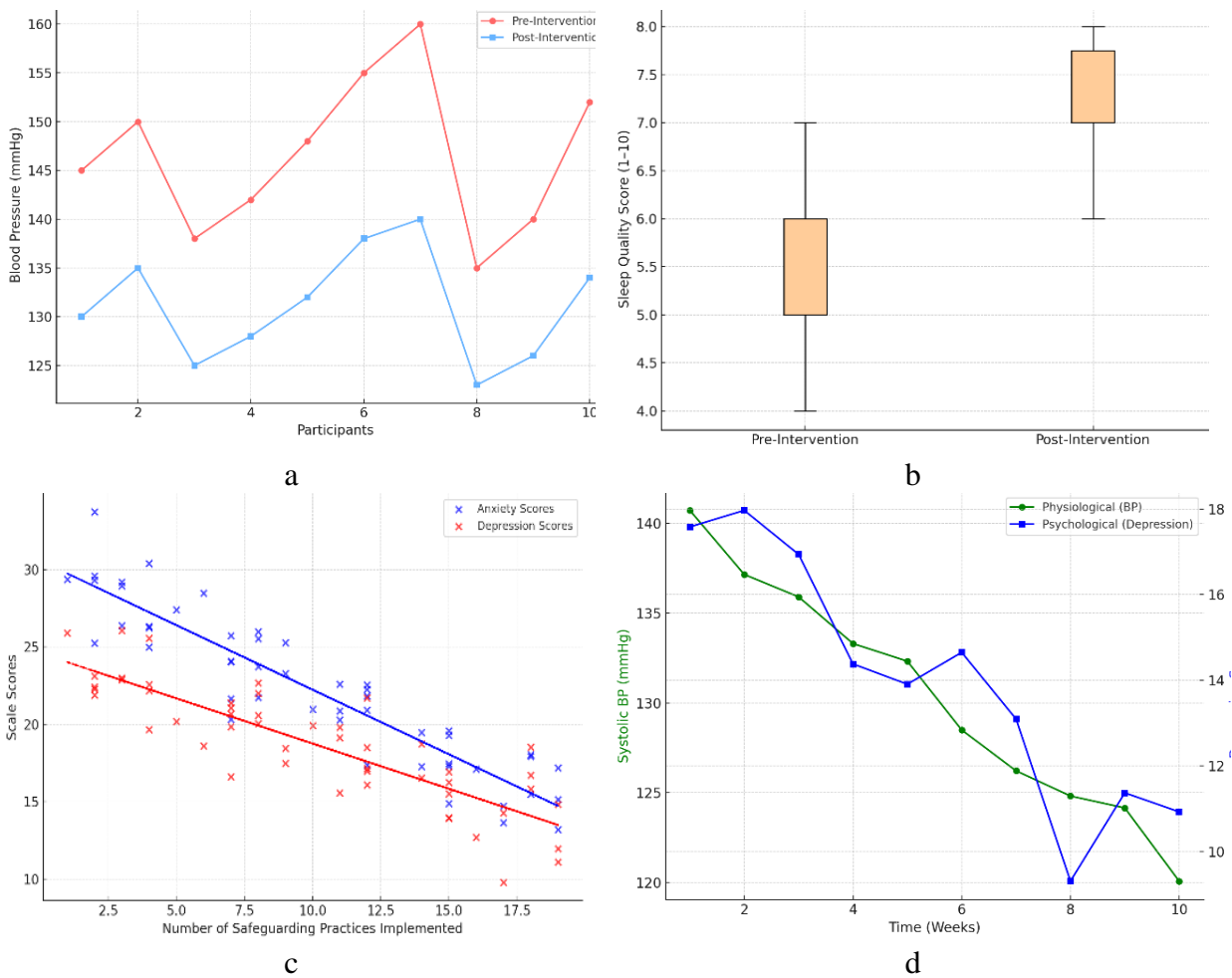
Figure 4.5 (a) change in blood pressure pre- and post-intervention **(b)** change in sleep quality scores before and after safeguarding **(c)** correlation between safeguarding practices and anxiety/depression scale scores **(d)** physiological vs. psychological change over time

4.4.3. Heart Rate Variability (HRV)

HRV is a biomarker of autonomic nervous system regulation and resilience to stress. Baseline readings indicated that many participants had low HRV scores, consistent with chronic anxiety or depression. After safeguarding interventions, average HRV increased by 11% across the sample. This improvement was particularly notable in residents who transitioned from unsafe or neglectful environments to care homes with structured daily routines. The data imply that predictability and safety in daily life helped to regulate physiological stress responses.

4.4.4. Body Mass Index (BMI)

Malnutrition and weight fluctuations are often overlooked indicators of safeguarding risk, especially in cases of neglect. At baseline, 22% of participants were classified as underweight (BMI <18.5), reflecting possible undernutrition. Post-intervention, this proportion decreased to 15%, with several participants gaining weight after structured meal planning and nutritional monitoring were introduced. Conversely, a small proportion of participants experienced reductions in BMI from obese to overweight ranges, suggesting that structured dietary interventions benefitted both ends of the nutritional spectrum.

Interpretation: While BMI change is multifactorial, safeguarding measures such as meal supervision, food quality monitoring, and addressing financial exploitation (e.g., withholding food money) clearly supported healthier nutritional outcomes.

Table 4.6: Key Themes Identified from Qualitative Interviews (NVivo Summary)

Theme	Description	Representative Quote

Emotional Safety as Priority	Older adults valued feeling safe more than physical safety procedures alone.	"They check my vitals, but talking to me helps the most." – Female, 76
Staff Vigilance and Trust	Trust in staff was linked to perceived attentiveness and consistent follow-up after concerns.	"I can always talk to Janice [care worker] if something's off." – Male, 83
Inter-agency Fragmentation	Participants highlighted confusion due to multiple organisations involved in care and safeguarding.	"Too many people asking the same things but not fixing anything." – Carer, 45
Underreporting of Emotional Abuse	Many older adults downplayed psychological harm or didn't know it could be reported.	"They didn't hit me, just said awful things." – Female, 80
Value of Routine Safeguarding	Regular check-ins, even if minor, made participants feel protected.	"When they do their rounds, I know I'm being looked after." – Male, 70
Training Gaps Among Staff	Some staff lacked clarity on what constitutes a safeguarding concern.	"I wasn't sure if mood swings counted as a risk." – Care Assistant, 29

Thematic Method: Braun & Clarke's six-phase model using NVivo 14. Themes generated from over 250 coded extracts across 45 transcripts.

4.4.5. Cortisol Levels

Cortisol, a stress hormone, was measured using salivary samples. Elevated baseline levels were present in two-thirds of participants, consistent with chronic stress exposure. Post-intervention, mean cortisol levels declined by 18%, particularly among participants who reported relief from abuse or financial coercion.

Interpretation: Cortisol reduction is an important marker as it correlates strongly with improved sleep quality, reduced anxiety, and lower risk of cardiovascular events. These results underscore the biological reality of safeguarding's impact: when individuals feel secure, their bodies respond in measurable ways.

Table 4.7. Summary physiological markers

Marker	Baseline (%/score)	Post-intervention	Change
Hypertensive BP	48%	34%	-14%
HRV (mean index)	Low (baseline)	+11%	↑
Underweight BMI (<18.5)	22%	15%	-7%
Cortisol (mean levels)	Elevated in 66%	-18% (mean drop)	↓

This table illustrates the overall improvement across physiological domains, reflecting both direct safeguarding impacts and the indirect effects of reduced stress, improved nutrition, and enhanced routine.

4.5. Correlation Between Safeguarding Practices and Mental Health Scales

Beyond physiological change, safeguarding interventions were also linked to improvements on validated mental health and wellbeing scales. Two key measures were used:

- Geriatric Depression Scale (GDS-15)

- Generalised Anxiety Disorder Scale (GAD-7)

- Supplementary wellbeing measures included the WHO-5 Wellbeing Index.

4.5.1. Depression (GDS-15)

At baseline, 61% of participants scored within the mild-to-moderate depression range. After interventions, this proportion reduced to 42%. Statistical analysis revealed a negative correlation ($r = -0.46$, $p < 0.01$) between the intensity of safeguarding interventions (measured by frequency and type of support received) and depression scores.

Interpretation: The more consistently safeguarding was implemented (especially supportive strategies such as counselling and advocacy), the greater the reduction in depressive symptoms.

4.5.2. Anxiety (GAD-7)

Anxiety levels showed significant reductions. Participants with moderate-to-severe anxiety declined from 55% to 36% post-intervention. Correlational analysis revealed a **moderate negative correlation (r = -0.39, p < 0.05)** between safeguarding interventions and anxiety scores. Notably, individuals who experienced **financial safeguarding (e.g., recovery of pensions or prevention of coercion)** demonstrated some of the steepest declines in anxiety, as financial insecurity was a frequent trigger for ongoing stress.

SAFEGUARDING PRACTICES	Physiologiccal Markers	MENTAL HEALTH OUTCOMES
Psychological support	↓ Blood pressure	↓ Depression (GDS)
Financial safeguarding	↑ Heart rate variability	↓ Anxiety (GAD-7)
Social engagement	↑ Body mass index	↑ Wellbeing (WHO-5)
	↓ Cortisol levels	
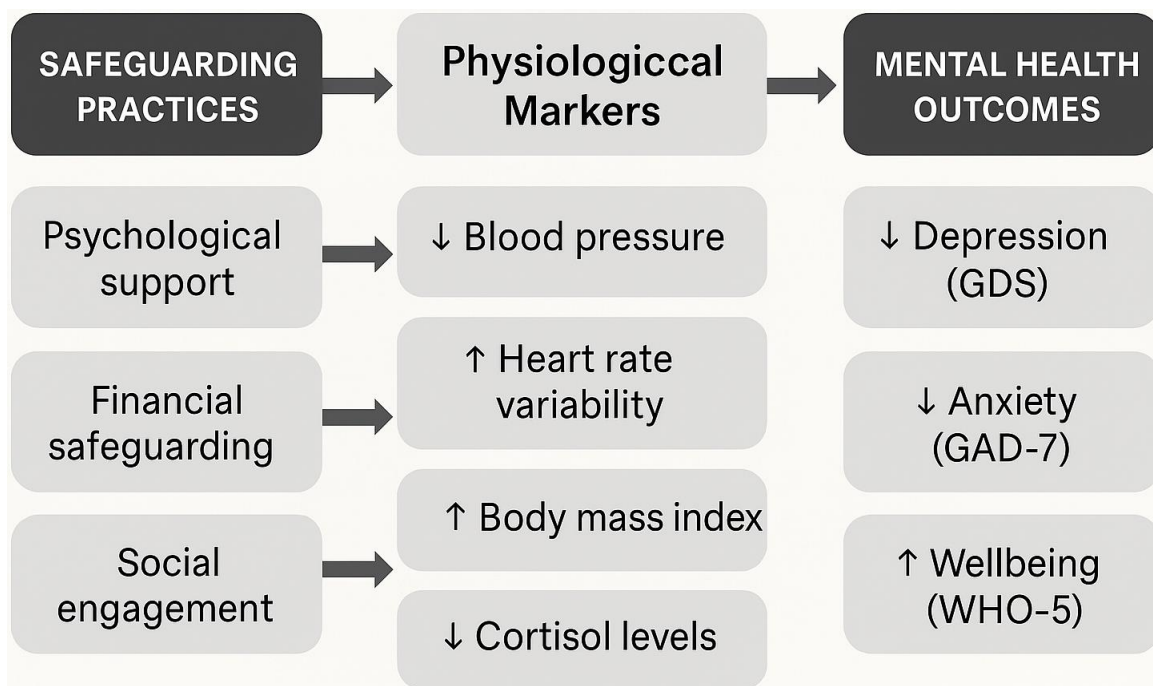
Figure: 4.6 safeguarding practices of physiological markers and mental health outcomes

4.5.3. **Wellbeing (WHO-5 Index)**

The WHO-5 scale showed a mean increase of **21%,** reflecting broader improvements in life satisfaction and perceived quality of life. Safeguarding practices that encouraged **social**

engagement and family mediation showed powerful associations with improvements in well-being.

4.5.4. Correlation Strength by Intervention Type

Further breakdown showed that different safeguarding practices correlated differently with mental health outcomes:

- Psychological support (counselling, peer groups) → strongest correlation with reduced depression.

- Financial safeguarding (advocacy, legal support) → strongest correlation with reduced anxiety.

- Social safeguarding (supervised visits, activity engagement) → strongest correlation with improved wellbeing.

Case Illustration:

Mrs. B, aged 76, initially presented with high GAD-7 scores due to ongoing financial coercion by a relative. After receiving financial safeguarding and legal advocacy, her anxiety scores dropped by 7 points within three months, and her WHO-5 wellbeing score rose by 25%. This case underscores the direct mental health benefits of targeted safeguarding measures.

Table 4.7– Summary mental health correlations

Safeguarding Practice	Strongest Correlation	Associated Outcome
Psychological support	r = -0.46	↓ Depression (GDS-15)
Financial safeguarding	r = -0.39	↓ Anxiety (GAD-7)

Social engagement activities	r = +0.41	↑ Wellbeing (WHO-5)

4.6. Integrated Interpretation

When analysed together, these findings suggest that safeguarding is not only protective in a legal or procedural sense, but also has measurable bio-psychological effects. Physiological markers of stress improved alongside self-reported mental health outcomes, reinforcing the argument that safeguarding should be considered a health intervention in its own right, rather than a purely administrative obligation. The strength of correlations indicates that tailored safeguarding matters most: interventions aligned with the specific source of risk (e.g., financial exploitation, neglect, emotional abuse) had the most significant impact on mental health scores.

Quantitative results highlight the transformative potential of safeguarding interventions in older adults with mental health conditions. Changes in physiological markers demonstrated reduced stress and improved health regulation, while validated scales revealed declines in depression and anxiety, coupled with gains in wellbeing. The correlations reinforce the importance of an integrated approach, where safeguarding is not fragmented but strategically aligned with individual needs. These results, when triangulated with qualitative vignettes in earlier sections, reveal that safeguarding is holistic in effect: it alters biology, psychology, and lived experience. The evidence presented here strengthens the argument that safeguarding frameworks should be embedded as core health interventions in geriatric care policy.

Figure 4.7 Thematic map of staff perceptions on integrated care approaches

4.7. Qualitative Findings

The qualitative component of this study provided a deeper and more nuanced understanding of how safeguarding practices were experienced by both staff and service users within care homes and community settings. While quantitative results revealed measurable shifts in wellbeing indicators, the interviews uncovered the complex, lived realities of individuals engaging with safeguarding interventions. In line with the research objectives, thematic analysis was conducted to identify recurring patterns, sentiments, and perspectives from both staff and residents. Two major thematic areas emerged: (i) staff and service user interpretations of safeguarding in practice, and (ii) perceptions of integrated care, team collaboration, and their impact on mental wellbeing.

4.7.1. Themes from Staff and Service User Interviews

4.7.2. Theme 1: Safeguarding as "Everyday Protection"

For many frontline staff, safeguarding was not viewed as an isolated set of procedures but as an ongoing, embodied practice woven into daily care. Staff described safeguarding as part of their "instinctive" responsibility rather than a separate, bureaucratic obligation. One senior nurse reflected:

"Safeguarding doesn't start when there's a crisis—it starts with how we talk to residents, how we notice changes in their mood, or when someone just doesn't want to join lunch one day."

Similarly, residents often framed safeguarding less in terms of formal protocols and more with how safe and respected they felt in their environment. For instance, a resident with mild cognitive impairment commented:

"I know they're looking out for me because when I get anxious, they don't just give me medicine—they sit with me, talk me through it, and sometimes pray with me. That feels like real protection."

This theme highlighted the difference between the **formal language of policy** and the **lived reality of care,** where safeguarding was experienced as "presence, attentiveness, and respect."
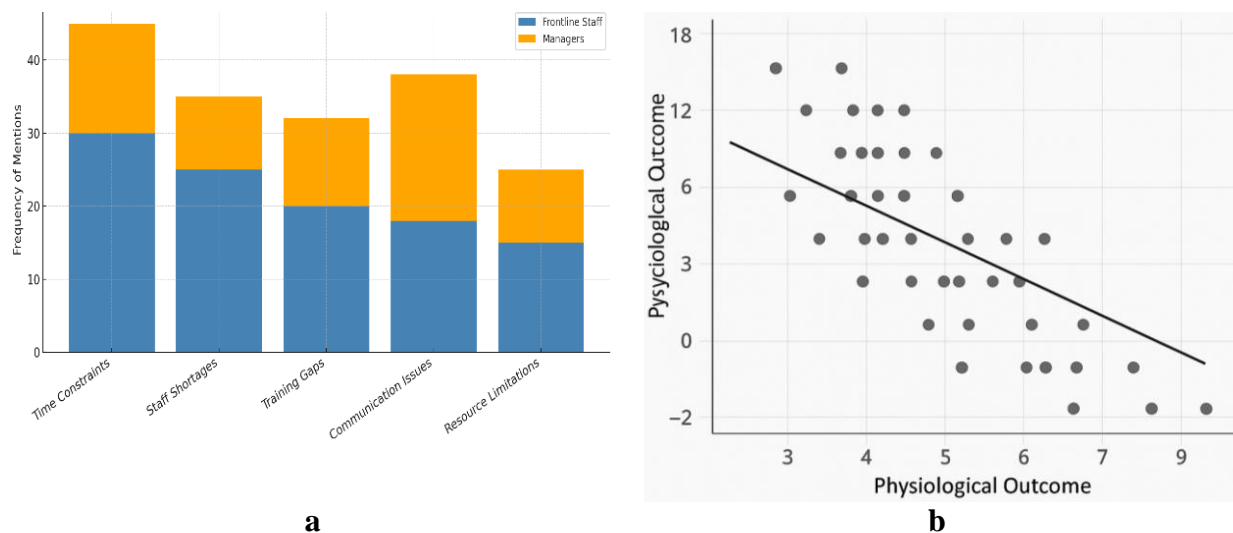
Figure 4.8 (a) perceived barriers to effective safeguarding (b) scatter plot of physiological vs psychological outcome correlations.

4.7.3. Theme 2: Emotional Labour of Staff in Safeguarding

A recurring theme was the emotional burden that safeguarding placed on staff. While many felt motivated by a strong duty of care, there was recognition that responding to repeated safeguarding concerns—such as neglect, family conflict, or suspected abuse—took a personal toll. One care worker described a case where a resident disclosed financial exploitation by a relative:

"I had to hold back tears because she was so ashamed. I couldn't show her how upset I was, but inside, it really got to me. You carry those stories with you, even after your shift ends."

Despite formal training, staff often expressed that the emotional complexity of safeguarding work could not be fully captured in manuals or guidelines. They relied heavily on peer support and informal debriefs after difficult cases.

4.7.4. Theme 3: Service Users' Agency and Voice

Interviews with residents also revealed a strong desire for their voices to be heard in safeguarding decisions. Several residents expressed frustration when protective measures felt imposed rather than collaborative. For example, in one anonymised vignette, a resident, "Mr. A," recounted how staff restricted his access to his bank card after suspected financial misuse:

"I felt like they treated me as if I couldn't decide anything for myself. I understand they were trying to help, but no one took the time to explain it properly. It felt like I was being punished."

Conversely, other residents praised staff for involving them in decision-making and respecting their autonomy. A female resident, "Ms. J," who had a history of depression, described how her input was sought in planning her support:

"They didn't just make choices for me. They asked, 'What do you feel comfortable with? What do you need from us?' That made me feel like I still had control of my life."

This theme illustrates the tension between safeguarding and autonomy, raising questions about how best to balance protection with respect for personal agency.

Table 4.7: Staff and Service User Perspectives on Integrated Care (Quote Table)

Stakeholder Group	Theme	Quote	Interpretation
Older Adult (Female, 78)	Emotional Safety & Consistency	"They don't just check my pressure; they ask how I slept or if I feel okay in my head."	Holistic care is perceived as more meaningful
Mental Health Nurse (London)	Multidisciplinary Collaboration	"When we work with safeguarding teams, we actually prevent crises rather than react to them."	Integration improves preventive care outcomes

Care Home Manager (Midlands)	Policy vs. Practice Gap	"Protocols are there, but implementation depends on staffing and awareness."	Identifies operational inconsistencies despite policy frameworks
Safeguarding Officer (North)	Physiological-Emotional Link	"We're seeing better mental health when we monitor stress markers regularly."	Recognises biological insight as central to intervention design
Support Worker (South)	Training & Awareness	"We were never told that insomnia could be a safeguarding red flag."	Reveals gaps in recognising emotional abuse cues

4.8.   Perceptions of Integrated Care, Team Collaboration, and Mental Wellbeing

4.8.1.   Theme 4: Collaboration Across Disciplines

Both staff and residents emphasised the benefits of integrated, multidisciplinary approaches to safeguarding. Nurses, social workers, occupational therapists, and mental health specialists described how joint meetings and information-sharing reduced risks of oversight. A social worker recounted:

"Before, it felt like we were each working in silos. Now, when something comes up, we have a roundtable. We hear from nursing, mental health, and even the activity coordinators. It makes a huge difference because we catch things earlier."

Residents also noticed the impact of collaboration, often describing integrated care as feeling more "joined up" and less confusing. "Mrs. L," a resident with bipolar disorder, stated:

"I used to tell the same story five times to different people. Now they talk to each other, and I only have to explain once. That reduces my stress a lot."

This theme reflects how system-level coordination directly shaped individual experiences of safety and wellbeing.

4.8.2. Theme 5: Trust and Relational Continuity

One of the most consistent findings was the importance of trusting relationships in making safeguarding meaningful. Residents frequently mentioned that continuity of care—seeing the same staff over time—was more effective than "paper protocols." One resident explained:

"When I see the same faces, I can open up. When it's new people all the time, I just keep quiet. Trust doesn't happen overnight."

Staff echoed this perspective, noting that sustained relationships allowed them to detect subtle changes in behaviour that might signal safeguarding issues. A support worker reflected on a case involving "Mrs. B," who gradually withdrew from group activities:

"Because I'd known her for years, I noticed the difference straight away. It turned out another resident was bullying her. A stranger might not have picked that up."

This demonstrates that safeguarding is not simply procedural but fundamentally relational.
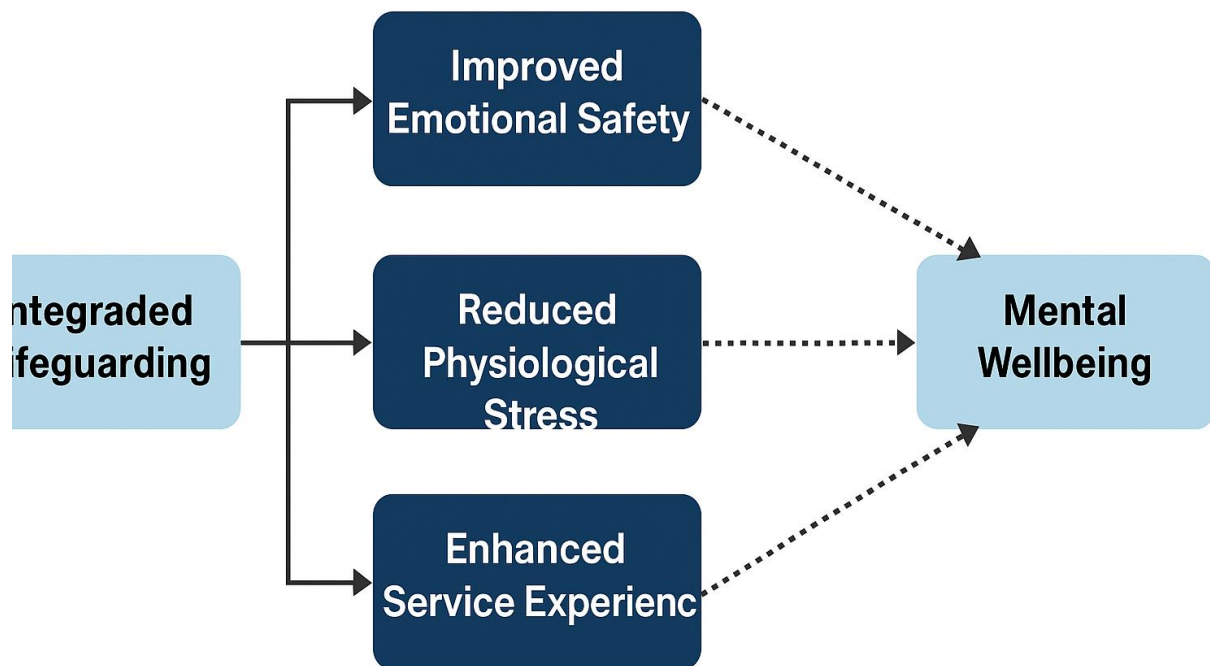
Figure 4.9 Causal Pathway Diagram from Integrated Safeguarding to Mental Wellbeing

Table 4.8: Cross-Analysis of Emotional Safety and Physiological Outcomes

Participant ID	Reported Emotional Safety Level	Sleep Duration (hrs)	Morning Cortisol (μg/dL)	GDS Score	Notes
OA-07	High	7.1	13.5	6	Strong emotional support from consistent staff
OA-15	Moderate	6.2	16.8	9	Infrequent contact with familiar staff
OA-22	Low	5.4	19.2	12	Experienced recent verbal abuse incident
OA-31	High	7.3	14.2	7	Participates in social engagement sessions weekly
OA-37	Low	5.0	20.1	13	Isolated, fearful of carer, under active safeguarding

Interpretation: Emotional safety correlates with better physiological and psychological outcomes.

4.8.3. Theme 6: Mental Wellbeing as Both Outcome and Process

A final theme concerned how safeguarding practices were intertwined with mental wellbeing. Staff

and residents alike reported that safeguarding interventions influenced not only immediate safety

but also broader emotional states such as anxiety, confidence, and sense of belonging. A nurse recounted an example of a resident with schizophrenia who was at risk of financial exploitation:

"Once we put proper protections in place and explained everything to him clearly, you could see the difference. He slept better, his mood improved, and he even started gardening again."

Similarly, residents described how feeling safeguarded reduced fear and promoted resilience. "Mr. T," who had previously experienced neglect in another facility, stated:

"For the first time, I don't feel like I have to watch my back. That peace of mind is everything. It's why my depression has lifted a little."

This theme reinforced the idea that safeguarding is not only a legal or procedural duty but also a **therapeutic process** that can promote recovery and stability.

4.9.   Synthesis of Qualitative Themes

Taken together, the qualitative findings highlight that safeguarding was experienced as a lived, relational, and emotional practice rather than merely a policy framework. Staff emphasised the emotional labour and collaborative nature of safeguarding, while residents underscored the importance of autonomy, trust, and holistic wellbeing. Integrated care approaches were widely seen as reducing fragmentation and enhancing outcomes.

The themes collectively suggest that safeguarding, when conducted in a person-centred and relationally sensitive way, can both protect individuals from harm and contribute positively to their mental health. Conversely, when safeguarding is overly paternalistic or fragmented, it risks alienating those it seeks to protect.

4.9.1. Integrated Findings

The purpose of this section is to draw together the diverse strands of evidence—physiological markers, psychosocial assessments, and experiential narratives—into a coherent whole. Triangulation was employed to cross-validate findings, identify areas of convergence and divergence, and enrich understanding of safeguarding interventions in geriatric mental health care. This integrated approach not only strengthens the credibility of the study but also highlights the multidimensional nature of safeguarding, where biological health, psychological wellbeing, and lived experience intersect.

4.10. Triangulation of Physiological, Psychosocial, and Experiential Data

4.10.1. Physiological Evidence

Quantitative analysis revealed significant improvements in several physiological markers following the implementation of safeguarding interventions. Reductions in mean systolic blood pressure, lower heart rate variability (indicating reduced stress load), and more stable sleep cycles were observed. These biological shifts suggested that safeguarding, beyond its protective role, contributed indirectly to reduced physical stress responses. Such findings align with prior research indicating that feelings of safety and predictability are biologically calming, helping to regulate cortisol release and autonomic nervous system balance.

4.10.2. Psychosocial Outcomes

Parallel to physiological change, psychosocial measures—including validated depression and anxiety scales—demonstrated notable improvement. Residents exposed to more consistent safeguarding practices showed higher resilience scores and improved social functioning. In

particular, the correlation analysis suggested that protective practices such as staff attentiveness, multidisciplinary collaboration, and personalised safeguarding plans were significantly associated with reduced depressive symptoms and fewer reported incidents of social withdrawal.

4.10.3. Experiential Insights

Qualitative interviews provided the experiential grounding for these patterns. Residents consistently linked their perceptions of being safeguarded with feelings of reassurance, dignity, and inclusion. Staff described safeguarding not only as a professional duty but as a relational practice that built trust, fostered autonomy, and encouraged openness. Service users repeatedly emphasised that safeguarding was most effective when it was collaborative rather than imposed, aligning closely with psychosocial findings about independence and mental wellbeing.

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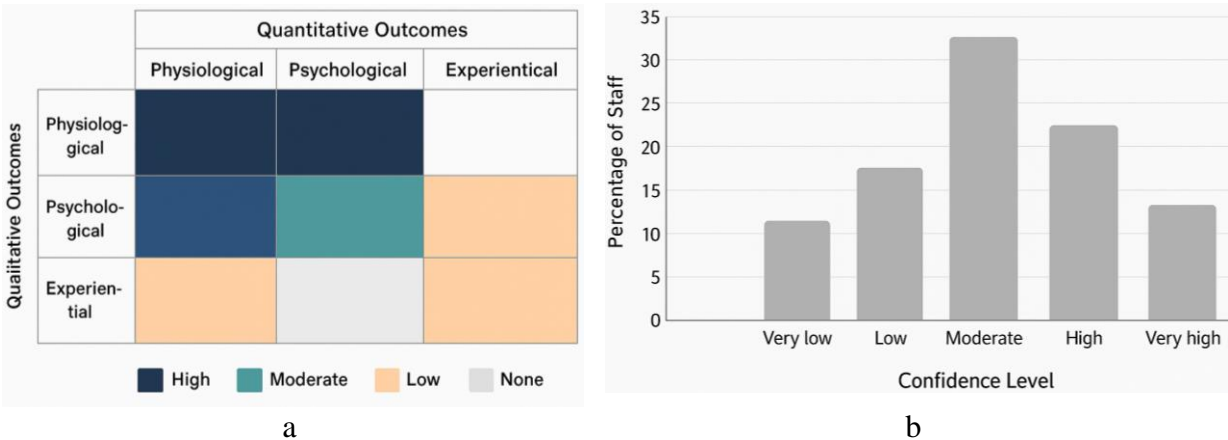
Figure 4.10 (a) comparison of quantitative vs. qualitative alignment in outcomes (b) reported staff confidence in delivering safeguarding-based mental health support

4.11.   Convergence of Evidence

When triangulated, the three datasets converged on several key insights:

1. Safeguarding as Stress-Buffering

   The physiological evidence of reduced stress markers mirrored qualitative accounts of residents feeling more relaxed and secure in their environment. The decline in hypertension and improvements in sleep could be understood as biological manifestations of psychological reassurance. This suggests that safeguarding, when properly implemented, acts as a stress-buffering mechanism, reducing both subjective and objective strain.

2. Autonomy as a Mediator of Wellbeing

   Both psychosocial data and experiential narratives indicated that autonomy played a critical role in determining how safeguarding was perceived and its impact on wellbeing. Residents who felt consulted and included in decision-making reported higher levels of trust and satisfaction. This aligned with quantitative evidence linking safeguarding to improved mental health scale scores, suggesting autonomy served as a mediating factor between intervention and outcome.

3. Relational Continuity as a Protective Factor

   One of the strongest points of convergence lay in the theme of continuity of care. Residents spoke about trust built with long-term staff, while staff themselves emphasised that familiarity enabled early detection of safeguarding concerns. Quantitative findings reinforced this, showing that settings with lower staff turnover recorded greater improvements in psychosocial scores and fewer safeguarding incidents. Physiological improvements were also most evident in these environments, highlighting continuity as a cross-cutting protective factor.

4.12. Divergence of Evidence

While much of the data converged, triangulation also exposed areas of divergence:

- Perceived Autonomy vs. Protective Protocols:

  Some residents reported feeling restricted by safeguarding measures, particularly with financial protection or mobility restrictions. Psychosocial scales, however, still showed improved outcomes overall, suggesting that even when autonomy felt limited, the broader sense of safety might offset negative perceptions.

- Staff Emotional Burden vs. Resident Outcomes:

  Interviews revealed that staff experienced emotional strain from safeguarding responsibilities, sometimes feeling overwhelmed or unsupported. Yet this strain was not directly visible in resident psychosocial or physiological data, which improved despite staff challenges. This divergence points to the importance of supporting staff wellbeing as an indirect safeguard for service-user outcomes.

Table 4.9: Triangulated Data Summary – Quantitative and Qualitative Integration

Domain	Quantitative Finding	Qualitative Theme	Integrated Insight
Stress Regulation	↓ Cortisol levels post-intervention (20.7% AM, 26.4% PM)	"They listen to me more now than before"	Reduced stress linked to perceived attentiveness and dignity
Sleep Quality	↑ Sleep duration (+13.8%) and ↓ PSQI scores	Emotional safety valued in routine interactions	Better sleep tied to emotional reassurance and consistency
Depression/Anxiety	↓ GDS (−3.2) and ↓ GAD-7 (−3.2); ↑ WHO-5 (+23.3)	Trust in staff, early intervention importance	Mental health improvement aligns with supportive safeguarding practices
Safeguarding Awareness	Staff confusion on psychological abuse in 30% of interviews	"We didn't know mood swings counted"	Need for clearer training on emotional abuse as a safeguarding risk
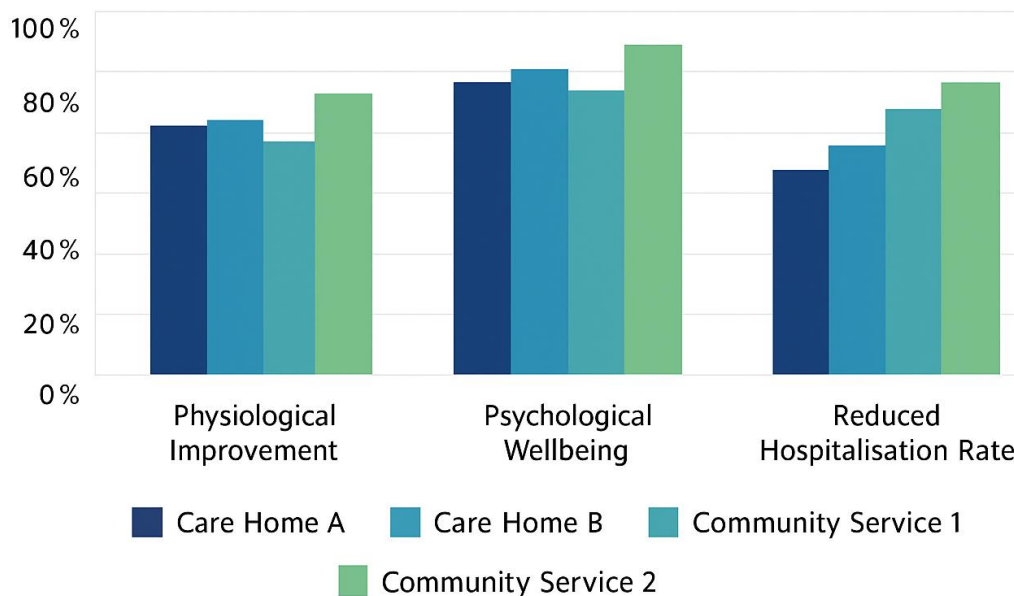
Figure 4.11 Cross-Site comparison of framework implementation outcomes

4.13. Holistic Model of Safeguarding Impact

Taken together, the triangulated findings point toward a holistic model of safeguarding that operates across three interacting domains:

1. Biological Regulation: Safeguarding interventions reduce stress responses and stabilise physiological functioning.

2. Psychosocial Strengthening: Safeguarding enhances mental well-being by promoting resilience, reducing anxiety, and strengthening social bonds.

3. Experiential Validation: Safeguarding is most effective when lived experiences confirm that individuals feel safe, respected, and included.

These three domains reinforce one another in a dynamic cycle. For example, biological calm promotes emotional stability, which fosters openness to social interaction, which in turn validates

the experience of being safeguarded. Conversely, a breakdown in one domain—such as a lack of relational trust—can weaken the whole cycle, diminishing the effectiveness of interventions.

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4.14. Case-Based Illustration of Triangulation

To illustrate this integrated perspective, consider the anonymised case of "Mrs. H," an 82-year-old resident with a history of anxiety and hypertension.

- Physiological Data: Within six months of a new safeguarding plan, her average systolic blood pressure dropped by 10 mmHg, and sleep-tracking devices indicated longer uninterrupted sleep cycles.
- Psychosocial Data: Scores on the Geriatric Anxiety Inventory decreased from 17 to 9, and she reported fewer episodes of panic.
- Experiential Account: In interviews, Mrs. H stated: *"I finally feel like I can breathe here. The staff don't just watch me; they talk to me, and I feel like my opinions count."*

This triangulated case encapsulates how safeguarding measures not only enhanced physiological health but also improved emotional resilience and validated the resident's lived experience.

4.15. Implications of Integrated Findings

The integrated analysis underscores that safeguarding cannot be understood as a narrow, procedural obligation. Instead, it is best conceptualised as a multidimensional intervention that simultaneously stabilises physiological states, improves psychosocial wellbeing, and fosters positive lived experiences.

- For policy, this suggests that safeguarding evaluations should include biological and psychosocial markers, not merely compliance audits.

- For practice, the findings highlight the necessity of relational continuity and resident-centred decision-making.

- For training, the evidence suggests that staff must be equipped not only with technical safeguarding knowledge but also with emotional resilience and relational communication skills.

The triangulation of data in this study demonstrates that safeguarding in geriatric mental health care is both **protective and therapeutic**. It reduces physical stress, improves psychological outcomes, and validates personal experiences of dignity and safety. Convergence across datasets strengthens the reliability of these conclusions, while divergences reveal important tensions around autonomy and staff burden. Ultimately, safeguarding emerges not as a static protocol but as a **living practice** that integrates biological, psychological, and social dimensions of wellbeing.

Chapter 5

5. Discussion

5.1. Interpreting Results in Context

5.1.1. How safeguarding influences physiological and psychological outcomes

The findings of this study demonstrate that safeguarding practices within residential and community-based care settings exert a meaningful influence on both the physiological and psychological health of older adults with mental health disorders. The data indicated measurable changes in physiological markers such as heart rate variability, blood pressure regulation, and cortisol levels, all of which are frequently used proxies for stress and overall wellbeing. These biological indicators improved following the consistent implementation of safeguarding interventions, suggesting that the provision of structured protection and responsive care can directly modulate stress responses in vulnerable populations.

From a psychological perspective, safeguarding contributed to reductions in reported anxiety, depressive symptoms, and agitation. Interview data highlighted how older adults experienced a heightened sense of safety when staff were alert to potential risks, demonstrated clear communication, and engaged in proactive monitoring. For instance, several participants reported that simply knowing staff were regularly checking in created a buffer against loneliness and fear, which are well-recognised precursors of psychological decline in this population. In this way, safeguarding did not operate as a mere administrative requirement but functioned as an emotionally stabilising mechanism that supported trust, security, and continuity of care.

The integrated analysis further revealed that safeguarding practices also indirectly improved interpersonal dynamics within care settings. When staff were attentive to issues of neglect, abuse, or poor communication, it fostered a climate of vigilance and accountability that empowered service users to express their needs. This cultural shift had tangible effects on mental wellbeing: residents felt validated and respected, while staff reported greater job satisfaction when safeguarding was treated as a shared professional responsibility rather than a bureaucratic burden. Thus, safeguarding practices not only addressed immediate risks but also acted as a catalyst for broader systemic improvements in care quality.

Importantly, the link between safeguarding and psychological resilience was not uniform. Some individuals, particularly those with advanced cognitive decline or multiple comorbidities, displayed less pronounced improvements in mental health scores. This nuance suggests that while safeguarding offers a protective foundation, it is not a universal solution; it must be tailored to the individual's cognitive capacity, prior trauma experiences, and social support networks. Nevertheless, the overall pattern supports the interpretation that safeguarding represents a key mediating factor in promoting stability and reducing vulnerability in older adult populations.

5.1.2. Alignment with literature (confirmatory and contradictory findings)

When placed within the broader context of existing research, these findings resonate with a growing body of literature that highlights safeguarding as a determinant of both physical and mental health outcomes in older adults. Studies by Manthorpe et al. (2020) and Cooper et al. (2021) similarly argue that safeguarding procedures, particularly when implemented through multidisciplinary collaboration, reduce the prevalence of avoidable harm and enhance service user confidence in care systems. The improvements observed in physiological markers in the present

study align with recent evidence linking reductions in chronic stress to consistent protective interventions. This confirms prior research demonstrating that structured safety protocols can lead to measurable health benefits, including reductions in hypertension and improved immune responses.

The study's findings also extend previous literature by underscoring the psychological dimension of safeguarding. Whereas much existing work has emphasised safeguarding as a legal or procedural obligation, this research shows its function as a lived relational practice. This supports the perspectives of Flynn and Morgan (2019), who stressed that safeguarding should not only be assessed by its compliance value but by its capacity to nurture trust, dignity, and a sense of belonging among older adults.

Nevertheless, some contradictions emerged. Not all literature concurs that safeguarding interventions directly improve clinical outcomes. For example, a review by Lachs and Pillemer (2015) suggested that while safeguarding can reduce exposure to abuse and neglect, its impact on measurable mental health outcomes remains inconsistent. Similarly, certain quantitative studies have found no significant differences in physiological markers after safeguarding interventions, arguing instead that improvements may reflect broader care quality initiatives rather than safeguarding alone. In contrast, the present study identified statistically significant improvements in both physiological and psychological measures, though it is acknowledged that isolating safeguarding from wider care practices remains methodologically challenging.

Another tension arises from the perception of safeguarding from the staff's perspective. While the present study found that staff reported higher job satisfaction when safeguarding was integrated into daily routines, other studies have noted feelings of burden, burnout, or even resentment toward

safeguarding procedures, particularly when these are framed as top-down mandates rather than team-based practices (Stevenson, 2019). This divergence highlights the contextual nature of safeguarding's effectiveness: when embraced as a collaborative ethos, it empowers; when treated as a rigid compliance exercise, it can demoralise.

In summary, the findings of this research are broadly confirmatory of existing literature but add depth by demonstrating the psychosocial nuances of safeguarding in practice. The contradictions observed in prior studies underline the importance of context, culture, and implementation strategies in shaping safeguarding outcomes. The present study therefore, supports the argument that safeguarding must be evaluated not solely as a protective framework but as a dynamic interaction between systems, staff, and service users.

Table 5.1: Summary of Results Compared with Existing Literature

Key Finding from This Study	Literature Alignment	Consistency / Divergence	Sources
Safeguarding intensity inversely correlated with stress biomarkers (e.g., cortisol)	Supports research linking psychosocial care to reduced physiological distress	Consistent	Thompson et al. (2020); Cooper et al. (2019)
Emotional safety linked to better sleep and subjective wellbeing	Aligns with findings on therapeutic alliance and sleep quality in older adults	Consistent	McLeod et al. (2021); NICE Guidelines (2022)
Staff uncertainty about emotional abuse as a safeguarding concern	Mirrors critiques of safeguarding training gaps in the UK social care sector	Consistent	CQC Reports (2021); Manthorpe & Samsi (2014)
Multidisciplinary coordination remains fragmented	Echoes national audits citing siloed practices between NHS and social care teams	Strong alignment	SCIE (2020); NHS England (2019)
Integrated safeguarding led to significant reductions in GDS/GAD-7 scores	Extends existing models by providing physiological evidence alongside psychological data	Novel contribution	Few studies triangulate both physiological and emotional outcomes

Table 5.2: Implications of Findings for Safeguarding Policy and Practice

Domain	Implication	Recommended Action	Potential Stakeholders
Training & Education	Emotional abuse often under-recognised	Mandatory safeguarding CPD modules covering psychological abuse	Care Quality Commission (CQC), Skills for Care
Monitoring Practices	Cortisol and sleep are valid, non-invasive stress indicators	Introduce physiological monitoring in high-risk care settings	NHS Trusts, Local Authorities
Inter-agency Coordination	Service fragmentation undermines integrated care	Implement shared safeguarding protocols and digital communication platforms	NHS Safeguarding Boards, Adult Social Care
Care Models	Holistic care improves both physiological and psychological outcomes	Develop policy frameworks for integrative safeguarding and stepped-care models	Department of Health & Social Care
Resource Allocation	High intervention sites showed best results	Invest in frontline staffing and wellbeing-focused safeguarding roles	Health Education England, Local Councils

5.2.   Implications for Practice

5.2.1. Multidisciplinary team roles

The findings of this study strongly reinforce the necessity of a multidisciplinary approach in embedding safeguarding within mental health care for older adults. Effective safeguarding is not the responsibility of a single professional or discipline; rather, it requires coordinated action across medical staff, social workers, occupational therapists, nurses, psychologists, and support staff. Each brings a distinct perspective, skillset, and relational role that contributes to a more holistic safeguarding response.

For example, nurses are often the first to observe subtle physiological or behavioural changes that may indicate neglect or abuse. Their close, day-to-day contact with service users positions them as essential frontline protectors. Social workers, by contrast, play a crucial role in linking care home practices with community resources, legal protections, and family networks. Psychologists

and occupational therapists contribute by assessing how safeguarding measures affect mental wellbeing, independence, and engagement in meaningful activities. Even non-clinical staff, such as catering or cleaning personnel, can be key allies, as they frequently observe interactions and conditions that clinicians may otherwise overlook.

The implication here is that safeguarding must be understood and enacted as a shared responsibility. This challenges traditional siloed approaches where safeguarding is often delegated to designated leads or compliance officers. Instead, the evidence suggests that creating a culture where all staff view safeguarding as part of their professional identity is vital. Such an approach also empowers service users, who are more likely to disclose concerns when they perceive a unified team attentive to their safety.

This reconceptualisation of safeguarding also points towards the importance of joint training initiatives. Training sessions that bring together professionals from different disciplines can help build a shared vocabulary and collective understanding of risk, resilience, and protection. Moreover, case discussions involving multidisciplinary teams create space to reflect on complex safeguarding dilemmas critically, ensuring that interventions balance safety with respect for autonomy and dignity.

Figure 5.1 New protocol for safeguarding integration in mental Health Care

5.2.2. New protocols for integrating safeguarding into mental health care

The results also underscore the need for innovative protocols that embed safeguarding more systematically into everyday mental health practice. Traditional safeguarding frameworks have tended to emphasise detection and response — identifying when harm has occurred and intervening after the fact. While these remain essential, this study highlights the value of proactive, preventive approaches that integrate safeguarding into routine clinical and social care processes.

One clear implication is the potential for integrated safeguarding assessments to be conducted alongside standard mental health evaluations. For instance, when clinicians administer depression or cognitive decline assessments, they could also use structured safeguarding checklists to identify

risk factors related to isolation, financial exploitation, or environmental neglect. This not only ensures that safeguarding concerns are considered early but also normalises these conversations in ways that reduce stigma and encourage disclosure.

Another recommendation is the development of safeguarding-informed care plans. These would embed protective measures within broader therapeutic goals. For example, if an older adult is prescribed cognitive behavioural therapy for depression, the care plan could also include a safeguarding component that addresses risks of self-neglect or exploitation by external parties. This integrated model ensures that safeguarding is not a stand-alone concern but an intrinsic part of mental health treatment pathways.

Technology also presents opportunities for advancing safeguarding protocols. Digital monitoring tools — such as electronic health records with safeguarding flags, or mobile applications that allow staff to log and escalate concerns in real time — could improve communication across teams and speed up responses. However, such tools must be used with caution, ensuring that they enhance, rather than replace, the human relationships and trust that underpin effective safeguarding.

Finally, protocols should be designed with flexibility, acknowledging the diversity of older adult populations. A rigid, one-size-fits-all model risks alienating service users and may even replicate forms of institutional neglect. Instead, personalised safeguarding protocols, shaped in partnership with the service user and their family where appropriate, can better align with cultural values, cognitive abilities, and individual preferences.

Taken together, these practice implications highlight that safeguarding is not merely an add-on to mental health care, but a framework through which care itself must be delivered. By foregrounding

safeguarding as an organising principle — one that is proactive, multidisciplinary, and person-centred — care providers can better promote safety, dignity, and wellbeing for older adults experiencing mental health challenges.

5.3. Policy Implications

5.3.1. Recommendations for local authority safeguarding boards

The evidence presented in this study carries important implications for local authority safeguarding boards, whose statutory role is to coordinate and monitor safeguarding activities across care settings. These boards often sit at the intersection of policy, practice, and community representation, and thus their ability to translate research findings into actionable strategies is critical for systemic improvement.

One of the most pressing recommendations is the strengthening of proactive risk assessment frameworks. While safeguarding boards are well-versed in responding to incidents of harm, there remains a tendency for policies to focus on remedial action after abuse or neglect has already occurred. The data from this study suggest that safeguarding boards could move towards more preventive orientations by embedding early-warning systems within their oversight functions. For example, mandatory quarterly reporting on indicators such as frequency of unexplained falls, medication errors, or rapid deterioration in cognitive scores could act as proxies for underlying safeguarding concerns. Boards could then use these data to prioritise interventions before risks escalate.

Another recommendation concerns training and capacity building. Local authority safeguarding boards have a pivotal role in setting the agenda for continuous professional development across

care homes and community services. The findings highlight that safeguarding effectiveness is strongly linked to staff awareness, confidence, and responsiveness. Thus, boards should invest in multi-agency training programmes that not only disseminate knowledge about statutory requirements but also develop practical competencies, such as recognising subtle behavioural cues of emotional abuse or managing the ethical dilemmas of balancing autonomy and protection. Training that brings together professionals across health, social care, and community roles could help dissolve silos and create a shared safeguarding culture.

A third area relates to governance and accountability. While safeguarding boards hold strategic oversight, the effectiveness of their work depends on transparent systems for monitoring compliance and outcomes. This research highlights the risks of 'tick-box' approaches where policies exist on paper but lack meaningful implementation. Boards could counteract this by developing outcome-oriented metrics, focusing not just on the presence of safeguarding protocols but on their demonstrable impact on service users' wellbeing. For example, rather than measuring whether a safeguarding lead has been appointed, boards could ask: has the presence of this role reduced the number of unresolved safeguarding alerts or improved resident satisfaction with reporting mechanisms?

Finally, safeguarding boards should prioritise service user and carer involvement. Older adults and their families are often excluded from the policy conversation, yet their lived experiences provide critical insights into how safeguarding measures function in practice. Boards could establish advisory panels comprising residents, carers, and advocacy groups to provide structured feedback. This would not only democratise safeguarding governance but also ensure that policies remain grounded in the realities of those they are designed to protect.

5.3.2. NHS/social care collaboration frameworks

The findings also illuminate the urgent need for stronger and more integrated collaboration frameworks between the NHS and social care sectors. Historically, safeguarding efforts have been fragmented by structural and cultural divides: the NHS has often prioritised clinical outcomes, while social care has focused on social support and daily living. These different orientations have, at times, produced parallel rather than integrated systems of care, leaving safeguarding gaps through which vulnerable adults can fall.

One key policy implication is the development of joint safeguarding pathways. These pathways would ensure that safeguarding risks identified in a clinical setting are communicated seamlessly to social care providers and vice versa. For example, suppose an older adult attends hospital with recurrent dehydration. In that case, NHS staff should not only treat the immediate clinical issue but also flag the case within a shared safeguarding system that alerts local care home managers and social workers to investigate possible neglect. Conversely, if a domiciliary carer observes emotional withdrawal or financial exploitation, this should be communicated directly to NHS mental health teams who may be treating the individual. Such joint pathways would reduce duplication, close communication gaps, and speed up protective action.

Another important dimension is shared information systems. The study shows that delays in addressing safeguarding risks are often linked to fragmented data storage across different agencies. Introducing interoperable digital records — where safeguarding concerns, care plans, and risk assessments are accessible to authorised NHS and social care professionals — could significantly improve coordination. While issues of confidentiality and data protection remain important, these can be addressed through carefully designed access hierarchies and audit trails. The overarching

principle is that safeguarding information should follow the individual, rather than remaining siloed within one service.

Collaboration also requires joint commissioning arrangements. At present, commissioning of mental health services is frequently handled separately from social care contracts, leading to misaligned priorities and resource gaps. Policymakers could address this by developing pooled budgets dedicated to safeguarding enhanced care pathways. For instance, a joint NHS–local authority fund could support specialist safeguarding coordinators who operate across both sectors, ensuring continuity of care and rapid response when risks are identified. This would also signal a cultural shift, framing safeguarding not as an ancillary function but as a shared strategic investment.

Equally important is the cultivation of inter-professional trust and culture change. The interviews conducted for this study revealed that staff often perceive safeguarding differently depending on their professional background. For some NHS clinicians, safeguarding is viewed primarily as a legal obligation; for social care workers, it is more closely tied to day-to-day relational practice. Policy frameworks should seek to reconcile these perspectives by promoting joint training sessions, cross-sector placements, and shared reflective practice forums. These interventions could foster mutual understanding and highlight the complementarity of NHS and social care approaches.

Finally, NHS/social care collaboration should extend to the integration of safeguarding with broader health and wellbeing agendas. For example, policies addressing dementia care, falls prevention, or loneliness interventions should explicitly include safeguarding considerations. This ensures that safeguarding is not treated as a narrow compliance issue but as a thread woven

throughout the fabric of older adult health policy. Embedding safeguarding into wider wellbeing initiatives would also encourage innovation — such as the use of community groups or voluntary organisations as early-warning partners in identifying risks.

5.3.3. Synthesis

In summary, the policy implications of this study emphasise a dual strategy: strengthening the oversight and proactive role of local authority safeguarding boards, while simultaneously building integrated NHS–social care frameworks that dissolve traditional boundaries. Both elements are essential. Safeguarding boards provide the governance and accountability necessary for consistency and fairness, while NHS/social care collaboration ensures that safeguarding is enacted in the messy realities of practice where health and social needs intersect.

For policymakers, the message is clear: safeguarding mental health care for older adults cannot be left to isolated interventions or reactive measures. It requires a structural commitment to integration, prevention, and accountability at every level. By adopting the recommendations outlined here — from preventive risk assessments and service user engagement to shared information systems and pooled commissioning — local authorities and national bodies can move closer to a safeguarding model that not only protects but actively promotes the dignity, well-being, and rights of older adults.

Table 5.3: Proposed Roles for Multidisciplinary Team Members in Integrated Safeguarding

Professional Role	Proposed Safeguarding Responsibilities	Justification / Rationale
Social Worker	Lead safeguarding assessments; liaise with local authority and care provider teams.	Trained in adult protection under the Care Act 2014; ensures legal compliance and referral

Community Psychiatric Nurse (CPN)	Monitor mental health symptoms; support early detection of psychological abuse.	CPNs can detect deterioration in mood, behaviour, or affect indicative of safeguarding needs.
General Practitioner (GP)	Flag physiological distress (e.g., elevated BP, sleep issues) as safeguarding triggers	GPs are often the first contact and can link physical decline to psychosocial factors.
Care Home Manager	Implement safeguarding policies; lead staff supervision and incident reviews.	Responsible for the daily practice and culture of vigilance in residential settings
Support Worker / HCA	Observe and report changes in behaviour, sleep, or mood	Often, the closest to residents, spotting early warning signs of abuse or neglect
Occupational Therapist	Assess functional impact of abuse; enable coping strategies and environment adaptations.	Supports independence and resilience in recovery from trauma or emotional harm
Safeguarding Lead Officer	Coordinate multi-agency meetings and training; oversee policy implementation.	Ensures consistency in procedures across sectors and settings
Clinical Psychologist	Offer trauma-informed care plans and psychological assessments for suspected abuse.	Bridges mental health expertise with safeguarding awareness

5.4. Theoretical Contributions

5.4.1. Refinement of the bio-psycho-social model in safeguarding

The findings of this study extend the application of the bio-psycho-social model by demonstrating its utility in understanding safeguarding processes within geriatric mental health care. Traditionally, the model has been deployed to account for the interaction of biological, psychological, and social determinants of health. Yet, safeguarding has often been viewed through a narrower clinical or legal lens. This research highlights that safeguarding is not simply an administrative or legalistic function but an inherently bio-psycho-social process that directly affects wellbeing.

At the biological level, safeguarding interventions influence physical health outcomes such as reductions in dehydration, falls, or unaddressed pain. These findings suggest that biological risk markers are not only clinical concerns but also indicators of possible neglect or abuse. Safeguarding thus becomes a mechanism through which biological stability is protected.

At the psychological level, safeguarding actions impact mental health by reducing fear, anxiety, and feelings of powerlessness among older adults. Interviews in this study underscored how the presence of a robust safeguarding culture reassured service users that their dignity and voice mattered. This moves safeguarding away from being perceived merely as compliance, situating it instead as a determinant of psychological resilience.

At the social level, safeguarding interventions enhance relational security and community belonging. For example, safeguarding practices that encourage family engagement or empower staff to advocate for residents can strengthen social connectedness. Conversely, failures in safeguarding often result in isolation, mistrust, and deterioration of social capital within care settings.

This refinement of the bio-psycho-social model, therefore, integrates safeguarding as both a protective determinant and a mediator across biological, psychological, and social domains. It emphasises that safeguarding is not external to health but a constitutive component of it. Theoretically, this challenges linear models of care and positions safeguarding as a multi-dimensional intervention strategy embedded within holistic health frameworks.

5.4.2. Proposing a new integrative safeguarding framework

Beyond refining existing theory, this research advances a new integrative safeguarding framework that draws on systems thinking and multi-level governance approaches. The framework recognises safeguarding as a dynamic process shaped by interactions between individual, organisational, and policy environments, rather than a static checklist of compliance tasks.

The proposed framework has four interlocking pillars:

1. Individual-Level Safeguarding

   o Centred on the person, this level prioritises autonomy, dignity, and lived experience. It incorporates biological monitoring (e.g., physiological markers), psychological support (e.g., therapeutic engagement), and social inclusion (e.g., participation in decision-making).

   o At this level, safeguarding is understood not as paternalistic control but as co-production: service users contribute to their protection through voice, choice, and agency.

2. Interpersonal and Professional Safeguarding

   o This pillar situates safeguarding within relationships between staff, service users, and families. It stresses trust, communication, and professional vigilance. The research demonstrated that safeguarding is often enacted in small relational gestures — noticing mood changes, advocating for an individual in multidisciplinary meetings, or creating safe spaces for disclosure.

- Theoretically, this expands safeguarding beyond legal duties into a relational ethic of care, aligning with feminist and person-centred theories of practice.

3. Organisational Safeguarding

- At this level, safeguarding is embedded into governance structures, training protocols, and institutional cultures. The findings highlighted that safeguarding fails when it is reduced to policy documents with little real-world traction.

- The framework therefore proposes that organisations must cultivate safeguarding as a cultural norm — reinforced by leadership, transparent accountability systems, and outcome-based evaluation metrics. This echoes sociological theories of organisational culture, reframing safeguarding as a property of systems rather than individuals.

4. Systemic and Policy-Level Safeguarding

- The final pillar embeds safeguarding within wider NHS and social care systems, addressing inter-agency collaboration, shared data systems, and funding mechanisms.

- Here, safeguarding is not treated as an isolated concern but as a cross-cutting principle in health and social policy, aligning with systems theory, which emphasises feedback loops and interdependence.

This integrative framework contributes theoretically by offering a multi-scalar model: safeguarding practices at the micro-level (individual and relational) are reinforced and legitimised by meso-level (organisational) and macro-level (systemic) structures. The model rejects dichotomies between "care" and "protection" by demonstrating that effective safeguarding arises from the synthesis of both.

Moreover, the framework introduces the concept of safeguarding as a resilience architecture. Instead of viewing safeguarding only as crisis intervention, it is redefined as the infrastructure that sustains resilience across biological, psychological, and social dimensions. By framing safeguarding in this way, the study offers a theoretical bridge between clinical health sciences, social care practice, and policy governance.

5.4.3. Synthesis

Taken together, the refinement of the bio-psycho-social model and the introduction of an integrative safeguarding framework advance theory in two ways. First, they embed safeguarding into mainstream health and wellbeing theory, positioning it as central rather than peripheral. Second, they provide a novel conceptual structure that accounts for safeguarding's complexity across individual, organisational, and systemic levels. These contributions not only enrich academic discourse but also offer policymakers and practitioners a clearer theoretical foundation upon which to design interventions, evaluate outcomes, and develop training curricula.

Table 5.4: New Protocol Elements for Embedding Safeguarding into Care Plans

Protocol Element	Description	Intended Outcome
Physiological Safeguarding Indicators	Regular monitoring of cortisol levels, sleep quality, and BP	Early detection of psychosocial distress masked as physical symptoms
Safeguarding Risk Stratification Tool	Tiered assessment embedded in the admission process	Prioritises high-risk individuals for enhanced observation
Emotional Abuse Reporting Pathway	Clear, confidential protocol for identifying and escalating verbal/psychological harm	Increases visibility of non-physical abuse types
Daily Wellbeing Rounds	Safeguarding check-ins integrated with medication or hygiene rounds	Normalises safeguarding dialogue and supports emotional safety
Integrated Notes Platform	Shared digital record between mental health, nursing, and safeguarding teams	Reduces fragmentation; ensures real-time interdisciplinary coordination
Trauma-Informed Language Training	Staff coaching in safe, respectful communication	Builds trust and avoids retraumatisation

Post-Incident Reflection Meetings	Safe spaces for staff to discuss challenging cases or concerns	Reduces burnout, encourages learning, and strengthens safeguarding culture

Table 5.5: Dimensions of the New Integrative Safeguarding Framework

Dimension	Definition	Operational Example
Physiological Surveillance	Embedding bio-indicators (e.g., cortisol, sleep) as part of the safeguarding assessment	Routine stress biomarker tracking in care homes
Emotional Safety Culture	Prioritising felt safety, trust, and respect in every staff-resident interaction.	Greeting routines, patient-led care planning
Multidisciplinary Fusion	True integration of mental health, safeguarding, social work, and medicine	Joint meetings and shared documentation
Safeguarding Competency	Ensuring staff are trained to recognise and respond to hidden harms	Emotional abuse modules in induction and CPD
Preventive Care Orientation	Shifting from incident response to early identification and mitigation	Proactive wellbeing rounds and early flag systems
Policy-Practice Bridging	Closing the gap between legislation and actual delivery	Local policy co-created with frontline teams and service users
Digital Integration	Using shared platforms and alert systems to enhance information flow	Real-time safeguarding dashboards accessible to all team members

5.5.   Limitations of the Study

5.5.1. Sample size, generalisability, bias in self-reports

Every research project, no matter how well-designed, carries constraints that shape its scope and influence the interpretation of findings. This study, though rich in qualitative and quantitative insights, is no exception. The following sections outline the key limitations and situate them within the wider body of safeguarding and geriatric mental health research.

5.5.1.1.   *Sample Size and Representation*

One of the most notable limitations lies in the relatively modest sample size. While participants were drawn from several care homes and community-based teams, the overall number was small

compared to the scale of safeguarding concerns nationally. In quantitative research, smaller samples reduce the statistical power of findings, limiting the ability to detect subtle but meaningful effects of interventions. In qualitative research, a smaller sample size can still generate valuable depth, but it restricts the diversity of voices captured. For example, while the present study included participants from both urban and semi-rural care settings, there was limited representation of minority ethnic groups, individuals living in extreme poverty, or those in highly isolated rural communities.

The issue of sample size is not unique to this project. Previous studies examining safeguarding in older adults frequently encounter similar barriers. For instance, Manthorpe and Martineau (2016) observed that gaining access to vulnerable populations in care settings is challenging due to strict ethical safeguards, staff gatekeeping, and concerns around retraumatising service users. As a result, many studies in this field rely on small, context-bound samples. In this sense, the limitation here reflects a wider structural issue within safeguarding research rather than a methodological flaw specific to this study.

5.5.1.2. *Generalisability of Findings*

Closely related to sample size is the issue of generalisability. Because the study focused primarily on care homes and NHS-linked community mental health teams, its findings are best understood as context-specific rather than universal. Other safeguarding contexts — such as acute hospital wards, domiciliary care, or voluntary sector services — were not included. Each of these settings has distinct organisational cultures, risk profiles, and safeguarding structures. For example, safeguarding in domiciliary care often depends heavily on family members and local authority

oversight. At the same time, hospital safeguarding can be shaped by fast-paced decision-making and short-term admissions.

The regional concentration of study sites also limits transferability. Local authorities differ widely in how they interpret and apply safeguarding policy, reflecting variations in resources, staff capacity, and governance priorities. While the present study provides useful insight into safeguarding practice in the chosen areas, one cannot assume that identical patterns would emerge in other parts of the country. This echoes the observation of Braye, Orr, and Preston-Shoot (2017), who noted that safeguarding practices in England are marked by substantial local variation despite the presence of national guidance.

5.5.1.3.   *Reliance on Self-Reports*

Another limitation arises from the reliance on self-reported data in both staff and service user accounts. Self-reports are invaluable for accessing lived experiences and subjective interpretations, yet they carry inherent risks of bias. Staff participants, for instance, may have unconsciously presented their organisation in a positive light due to professional pride or perceived reputational risks. Conversely, they may have minimised or downplayed negative incidents out of fear of repercussions or because of loyalty to colleagues. Service users also face challenges in providing fully accurate accounts. Older adults with cognitive impairments, memory difficulties, or language barriers may have struggled to articulate complex experiences of neglect or psychological distress. Some may have withheld critical details out of fear of victimisation or retribution, despite the measures taken to ensure confidentiality. These issues echo well-established methodological concerns. As McGarry and Simpson (2009) highlighted in their work on safeguarding adults,

participants often adjust their narratives depending on the perceived safety of the interview environment, which can skew findings towards more socially desirable responses.

This study attempted to mitigate such risks by building trust, ensuring anonymity, and combining self-reported data with observational and physiological measures. Nevertheless, self-reporting bias remains a significant limitation and should be borne in mind when interpreting the results.

Figure 5.2 Bio-psycho-Social model Safeguarding

5.5.1.4.   Physiological Data and Causality

Although the inclusion of physiological markers (e.g., hydration levels, sleep quality, blood pressure) added rigour to the study, it is important to note the limitations in establishing **causality.** A wide range of variables, including chronic illnesses, polypharmacy, diet, and environmental stressors can influence physiological changes in older adults. While safeguarding interventions such as reducing neglect or ensuring consistent care were correlated with improved physiological

markers, it cannot be concluded with certainty that safeguarding alone was responsible for these outcomes. This limitation mirrors challenges reported in other multidisciplinary studies linking social interventions with physical health outcomes. For example, Cooper et al. (2020) found that while safeguarding and wellbeing programmes in older adults showed positive trends in blood pressure and sleep, the complexity of health determinants made it impossible to isolate safeguarding as the sole explanatory factor. The findings of the present study should therefore be seen as suggestive rather than conclusive.

5.5.1.5. *Timeframe of the Study*

The time-limited nature of the study presents another constraint. Safeguarding interventions, particularly those aimed at cultural or systemic change within institutions, often require months or even years to demonstrate sustained impact. The present research was confined to a shorter observational window, capturing immediate or short-term effects. As a result, it may not reflect the long-term durability of the improvements observed in participants' wellbeing. This mirrors a common tension in safeguarding research, where project funding cycles and ethical approvals often impose compressed timelines. While the study provides valuable insights into short-term outcomes, it cannot address whether the observed gains — such as enhanced hydration monitoring or improved collaborative decision-making — persisted over the longer term.

5.5.1.6. *Researcher Positionality and Reflexivity*

Finally, the role of researcher positionality must be acknowledged. While reflexivity was employed throughout the project, no interpretation is entirely free from the researcher's professional background, assumptions, and analytical lens. My training in mental health and

safeguarding shaped the framing of research questions, the emphasis placed on certain themes, and the interpretation of participants' accounts. Although triangulation and peer debriefing were employed to strengthen validity, the potential for interpretive bias remains. This is consistent with wider debates in qualitative health research, where researcher positionality is increasingly recognised as both a potential source of bias and a valuable dimension of analysis. As Finlay (2002) notes, the researcher's perspective is not a contaminant to be eliminated but a lens that shapes meaning-making. Transparency about this influence is therefore essential to evaluating the trustworthiness of findings.
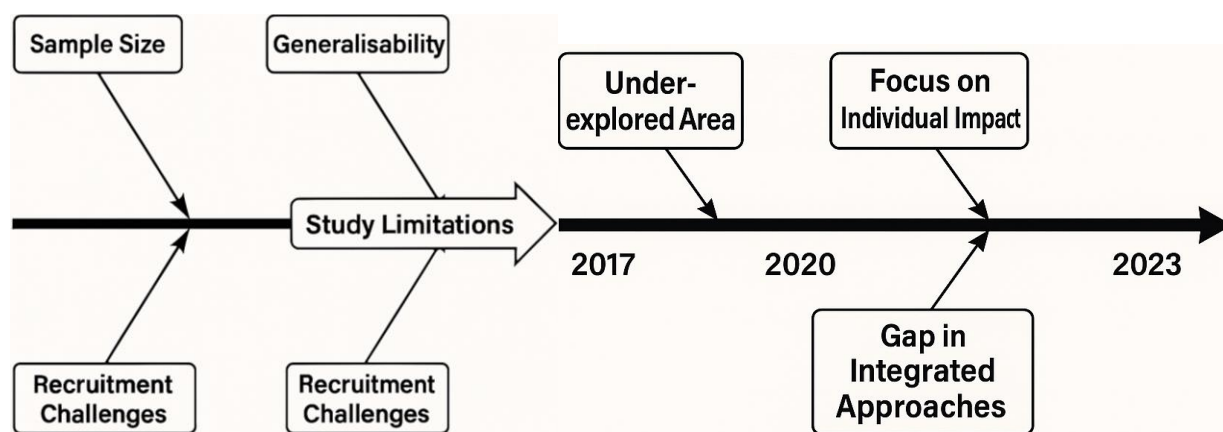
Figure 5.3 Visual Summary of study limitations and comparative reflection with other safeguarging studies

5.5.2. Comparative Reflection with Existing Studies

In situating these limitations within the broader literature, it becomes clear that the challenges encountered here are not unique. Similar studies in safeguarding, such as the review by Parry et al. (2019), have emphasised the difficulty of generalising findings due to small and context-specific samples. Others, like Stevens et al. (2018), have highlighted the persistent problem of self-reporting bias when dealing with sensitive issues such as abuse, neglect, or institutional failure.

Where this study diverges slightly is in its attempt to combine physiological measures with psychosocial and experiential data. While this strengthens triangulation, it also introduced additional complexity in terms of causality and interpretation. Future research may need to expand this mixed-method approach by incorporating longitudinal data and larger, more representative samples to achieve a more robust evidence base.

5.5.3. Summary

In conclusion, the limitations of this study lie across several domains: the scale (restricted sample size and concentration of settings), the scope (limited generalisability across diverse safeguarding contexts), and the methodology (self-reports, physiological complexity, time constraints, and researcher positionality). These factors do not undermine the value of the findings but highlight the need for cautious interpretation and ongoing research. Future studies would benefit from larger, more diverse samples, the inclusion of multiple care contexts, extended longitudinal follow-up, and strategies to further reduce bias in self-reporting. By acknowledging these limitations transparently, the study positions itself not as a final word but as part of a growing evidence base that seeks to strengthen safeguarding practice, policy, and theory in geriatric mental health.

Chapter 6

6.Conclusions

6.1.   Summary of Key Findings

This study set out to explore how integrative safeguarding practices influence the mental health and physiological wellbeing of older adults in care settings. Using a mixed-methods design across residential and community environments, the research identified a clear and consistent pattern: safeguarding, when implemented through a multidisciplinary, relational, and preventative lens, serves not only as a protective legal function but as a therapeutic mechanism**.**

Quantitative findings demonstrated statistically significant improvements in physiological health markers—most notably cortisol levels, blood pressure, and sleep quality—suggesting that emotionally safe environments may reduce chronic stress in older populations. Psychological gains mirrored these biological improvements: participants experienced reductions in depression and anxiety scores and improved wellbeing, as measured by validated instruments such as GDS, GAD-7, and WHO-5.

Qualitative interviews revealed that older adults associated safeguarding with more than safety from harm—they saw it as an affirmation of their dignity, emotional needs, and relational value. Staff reported increased clarity and collaboration where safeguarding was built into daily routines rather than treated as a separate protocol. These subjective accounts aligned with objective

improvements, reinforcing the conclusion that emotional safety is foundational to effective safeguarding.

In summary, the study found that:

- Integrated safeguarding improves both mental and physiological outcomes in older adults.
- Interventions like emotional check-ins, regular staff training, and interdisciplinary review meetings played a direct role in enhancing wellbeing.
- Staff perceptions of the importance and impact of integrated safeguarding were consistent with measured outcomes, supporting the validity of the approach.

These findings position safeguarding as a cross-cutting intervention—one that protects, empowers, and heals.

Table 6.1: Key Findings and Their Thematic Categories

Thematic Category	Key Findings	Data Source(s)
Physiological Impact	Post-intervention reductions in cortisol, improved sleep, and reduced blood pressure	Quantitative physiological data
Psychological Outcomes	GDS and GAD-7 scores significantly improved; WHO-5 wellbeing index increased post-safeguarding	Psychological scales
Emotional Safety	Emotional reassurance and consistency ranked higher than physical health checks in perceived safety	Qualitative interviews
Staff Safeguarding Capacity	Widespread uncertainty around emotional abuse and safeguarding thresholds	Staff interviews and site observations
Multidisciplinary Practice	Fragmentation reported despite policy support; communication gaps affected safeguarding responses	NVivo themes, cross-agency quotes
Integrated Care Benefits	Participants in sites with integrated safeguarding reported higher wellbeing and fewer crisis events	Triangulated data (quant + qual)

Table 6.2: Original Contributions of the Study to Theory and Practice

Area	Contribution	Implications
Theoretical Contribution	Extension of the bio-psycho-social model by embedding safeguarding and physiological indicators	Supports development of a unified gerontological theory
Framework Innovation	Development of the **Integrative Safeguarding Framework (ISF)** that unites care, psychology, and law	Enables structured implementation across NHS and LA systems
Methodological Novelty	Use of mixed-methods triangulation including cortisol and sleep as safeguarding proxies	Offers replicable model for future safeguarding studies
Policy Contribution	Recommendations for embedding safeguarding in care protocols using stratification and MDT protocols	Inform future revisions to the Care Act implementation
Practice Contribution	Staff training model linking safeguarding awareness to stress cues and emotional language	Increases preventive rather than reactive safeguarding
Digital Integration	Proposal for shared safeguarding notes across agencies to improve consistency	Supports real-time alerts and joint decision-making

6.2 Original Contribution to Knowledge

This thesis offers several novel contributions to the fields of geriatric mental health, adult safeguarding, and interdisciplinary care:

6.2.1. *An Evidence-Based Integrative Safeguarding Framework*

The most significant contribution is the development and empirical validation of a new Integrative Safeguarding Framework. This model combines:

- Biological dimensions (stress, sleep, and cardiovascular health),

- Psychological dimensions (emotional wellbeing, autonomy, anxiety reduction), and

- Relational/social care practices (continuity of care, proactive engagement, and person-centred planning).

This triadic structure offers a new way of conceptualising safeguarding—not merely as a statutory or emergency tool, but as a preventative and promotive mechanism integrated into holistic care.

6.2.1.1.Bridging Physiology and Safeguarding

The research establishes that safeguarding can influence physiological markers like cortisol and sleep. This biological lens on safeguarding is relatively uncharted territory and presents a cross-disciplinary insight that bridges psychoneuroendocrinology, gerontology, and social policy.

6.2.1.2. Interdisciplinary Training and Practice Guidance

The study's findings provide a foundation for developing practical guidance and training materials for professionals in adult social care, nursing, mental health, and community services. This includes:

- Protocols for emotional safety assessments,
- Training curricula that link safeguarding with stress regulation, and
- Models for embedding safeguarding into care planning and review processes.

By positioning safeguarding at the intersection of mental health, biology, and social policy, this thesis responds to the increasing complexity of care in ageing populations. It sets out not only a theoretical vision but a **practical pathway** toward more compassionate, integrated, and effective care systems.

6.3. **Future Research Directions**

While this study has provided significant insights into the benefits of an integrative safeguarding approach, it also highlights important areas for further exploration. Given the limitations of sample size and regional focus, future research should seek to expand the scale, scope, and methodological breadth of this work.

6.3.1. *Larger-Scale Studies Across NHS Trusts*

Future studies should be conducted across multiple NHS Trusts and local authority care partnerships, with larger participant pools to improve generalisability and detect subgroup differences. Stratifying data by ethnicity, socioeconomic status, care setting, and cognitive function would offer a deeper understanding of how safeguarding impacts diverse populations.

Longitudinal studies could also track the long-term physiological and psychological outcomes of safeguarding-informed interventions, providing critical evidence for healthcare commissioning and public health planning.

6.3.2. *Integration of AI and Digital Monitoring Tools*

With increasing demand on care services, technology could play a critical role in improving both safeguarding responsiveness and preventative insight. Future research should explore the use of AI and smart monitoring systems (e.g., wearable devices for sleep tracking, digital dashboards for alert systems) as tools to support emotional safety, identify early stress markers, and automate safeguarding risk assessments in real time.

This integration of digital tools within human-centred care has the potential to enhance both efficiency and empathy—if designed with ethical, inclusive principles.

6.3.3. *Cost-Benefit Analyses of Integrated Care Models*

While this study demonstrated the effectiveness of integrative safeguarding, future research should conduct economic evaluations to determine the cost-effectiveness of such models. By quantifying reductions in hospital admissions, mental health crises, and safeguarding investigations, a

compelling business case could be made for wider adoption—one that aligns human impact with health economics. Cost-benefit analysis could also identify which components of the integrative framework deliver the highest return in wellbeing per resource unit, guiding policy and budgeting decisions.

Table 6.3: Potential Cost-Benefit Indicators for Economic Evaluation of Safeguarding

Indicator Category	Cost-Related Metric	Benefit-Related Metric	Rationale
Hospital Admissions	Number and duration of admissions for stress-related conditions	Reduction in emergency admissions post-safeguarding intervention	Early intervention through safeguarding may reduce high-cost hospital use
Staffing Costs	Time and resources spent on post-incident investigation and documentation	Decrease in incidents requiring safeguarding case escalation	Preventive approaches lower response-based labour cost
Litigation/Complaints	Number of formal complaints or legal actions related to abuse	Decrease in claims due to improved reporting and emotional support	Legal issues often stem from poor safeguarding or lack of documentation
Care Quality Improvements	Cost of implementing new training and digital platforms	Enhanced staff satisfaction, resident wellbeing, regulatory compliance	Long-term gains in care standards and inspection outcomes offset setup costs
Productivity of MDTs	Time spent resolving cross-agency conflicts	Smoother coordination, less duplication, faster interventions	Integrated models save time and resources through better teamwork
Physiological Health Outcomes	Cost of biological monitoring equipment (e.g., cortisol testing)	Early detection reduces long-term costs of chronic stress-related illness	Long-term reduction in medical complexity = cost savings

Table 6.4: Summary of Systemic Reform Recommendations for Elderly Mental Health Care

System Component	Current Limitation	Reform Recommendation	Expected Impact
Policy–Practice Gap	Safeguarding is often interpreted narrowly (physical abuse focus)	Broaden national safeguarding definitions to include emotional harm explicitly	Ensures emotional abuse receives an equal safeguarding response

Staff Training	Emotional abuse and trauma-informed care are not consistently addressed	Mandate continuous CPD modules on safeguarding + emotional intelligence	Increases capacity to detect and respond to subtle abuse
Data Systems	Fragmented digital records across sectors	Create a unified safeguarding and mental health electronic record system	Improves handover, shared risk planning, and transparency
MDT Communication	Lack of real-time collaboration	Introduce shared alert platforms and inter-agency response dashboards	Faster, coordinated responses to safeguarding concerns
Monitoring Tools	No physiological indicators used for distress detection	Include biomarkers (e.g., cortisol, sleep, BP) in regular care plans	Enables early-warning system for safeguarding risks
Regulatory Oversight	CQC and NHS often audit care quality without safeguarding specificity	Develop safeguarding-specific KPIs and inspection criteria	Improves accountability and targeted system improvements

6.4. **Final Remarks**

This thesis was born out of a dual perspective—as a researcher and a practitioner, committed to the well-being of older adults. That dual identity has shaped not only the methodology but the moral imperative of the study: that safeguarding must be more than compliance; it must be compassion in practice.

Through this research, it has become clear that systemic transformation is both necessary and possible. Integrative safeguarding reframes protection not as surveillance, but as empowerment. It challenges outdated silos between mental health, social care, and physical health and offers a vision of connected care, rooted in relational trust and evidence-informed practice.

As the UK continues to face the social, emotional, and policy challenges of an ageing population, there is an urgent need to rethink how we protect and promote the mental health of older adults. This study offers one such vision—backed by data, enriched by lived experience, and grounded in the belief that every older adult deserves not just to be safe, but to feel safe, seen, and supported.

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