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Embedding safeguarding in integrated care for older adults

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Abstract

This study explores how integrated physical and mental health care models incorporate safeguarding principles to support older adults with complex needs. A systematic search of four electronic databases identified 2,146 records, from which 573 duplicates were removed. Following screening and eligibility checks, nine studies were included in the final review. These studies represented diverse international contexts and used quantitative, qualitative, and mixed-method designs. Key findings showed that 67% (six out of nine) of the studies reported measurable improvements in functional outcomes, including mobility, treatment adherence, and independence in daily living. Patient satisfaction and continuity of care were consistently enhanced, while three studies (33%) explicitly embedded safeguarding frameworks, resulting in reduced neglect and greater caregiver confidence. However, four studies reported no significant reduction in hospital readmissions, indicating mixed system-level outcomes. A recurring error across several studies was the inconsistent or absent reporting of safeguarding measures, which limited comparability and generalizability. Overall, the review highlights that while integrated care improves patient experience and quality of life, safeguarding remains underrepresented and often treated as an add-on rather than a core element. Future models should systematically safeguard to ensure both effective care delivery and the protection of vulnerable older adults.

Keywords: Integrated Care; Older Adults; Mental Health; Physical Health; Patient Outcomes; Multidisciplinary Teams

1. Introduction

The growing demographic shift towards ageing populations worldwide presents one of the most pressing challenges for modern health systems. By 2050, the number of people aged 60 years and above is projected to double, reaching over 2 billion globally [1]. Older adults often face a dual burden of physical and mental health conditions, with multimorbidity becoming increasingly common. Depression, anxiety, and dementia frequently co-occur with chronic physical illnesses such as cardiovascular disease, diabetes, and musculoskeletal disorders [2], [3]. The separation of physical and mental health services within many health systems has historically fragmented care, limiting older adults' access to comprehensive, person-centred support [4]. Addressing this divide has therefore become a priority for global health policy and practice. Figure 1 contrasts hospital-based care, centered on joint physical–mental health wards and multidisciplinary teams, with community-based care, which relies on integrated care teams working closer to people's homes.

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Integrated care has emerged as a promising approach to bridge these gaps. By combining physical and mental health services within shared frameworks, integrated care models aim to improve quality of life, enhance satisfaction, and reduce the burden on health systems [5]. Evidence suggests that integrated approaches—whether delivered through hospital-based wards, community multidisciplinary teams, or primary care—can increase patient engagement and improve clinical outcomes [6], [7]. The World Health Organization's (WHO) Decade of Healthy Ageing initiative has further underscored the need for integrated and age-friendly health systems, emphasizing mental health as a central pillar of holistic well-being [8]. However, despite significant progress, questions remain about the effectiveness of these approaches in reducing hospitalizations, mortality, and institutionalisation rates [9], [10]. Figure 2 shows how integrated physical–mental health care for older adults is built around collaboration: joint wards and multidisciplinary teams feed into a shared care model, which in turn directly supports the well-being of older adults.

Multidisciplinary teamwork forms the backbone of integrated care delivery for older adults. Health professionals from geriatrics, psychiatry, nursing, psychology, and social work collaborate to provide coordinated services, addressing the complex interplay between physical illness and psychological distress [11]. Research shows that such team-based approaches can improve functional outcomes, carer satisfaction, and adherence to treatment plans [12]. Yet, practical barriers—including organizational silos, financial constraints, and differing professional priorities—continue to challenge seamless integration [13]. As a result, while the theoretical benefits of multidisciplinary care are well-recognized, real-world implementation often falls short of expectations [14], [15].

Conceptual frameworks have been developed to guide integration efforts, offering structured ways to understand and evaluate interventions. Figure 3 illustrates how older adult mental health is shaped by influences at three levels: macro (policies, societal norms, economy), meso (community resources, social networks, healthcare), and micro (coping strategies, family, resilience).

The pluralistic framework positions integrated care within macro, meso, and micro contexts, linking global policy priorities to organizational systems and individual patient care [16]. Similarly, the 4Ms-Behavioural Health Framework extends the age-friendly 4Ms model (What Matters, Medication, Mentation, Mobility) by explicitly embedding mental health considerations [17]. The SELFIE framework (Sustainable Integrated care models for multimorbidity: delivery, Financing, and performance) has also been widely used to map interventions for older adults with comorbidities [18]. These frameworks provide valuable lenses through which to design, evaluate, and scale integrated care, though empirical validation remains limited [19], [20].

Importantly, while much of the existing literature focuses on service integration, few studies explicitly evaluate the role of multidisciplinary safeguarding frameworks. Safeguarding, traditionally associated with the protection of vulnerable adults from abuse, neglect, or exploitation, is increasingly relevant in discussions of health system integration [21]. Older adults with co-existing physical and mental health conditions are often at heightened risk of harm due to dependency, isolation, or cognitive decline [22]. Integrating safeguarding mechanisms within multidisciplinary health frameworks could ensure not only better health outcomes but also enhanced protection and dignity for this population [23]. Yet, there is a notable evidence gap regarding the effectiveness of safeguarding-focused multidisciplinary interventions, representing an essential frontier for research and policy.

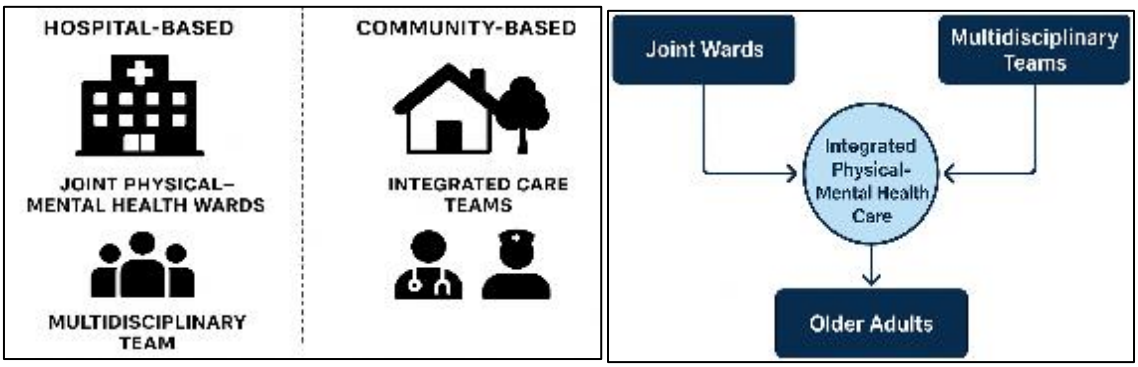

Figure 1 Models of integrated care and conceptual framework

Despite these challenges, the literature consistently highlights the patient-centred benefits of integrated care. Older adults report improved experiences of care, reduced stigma surrounding mental health, and greater trust in services when physical and mental health are addressed together [24], [25]. Carers, too, express greater satisfaction when

supported through holistic approaches that acknowledge both medical and psychosocial needs [26]. However, the limited impact on "hard" outcomes such as hospitalization and mortality underscores the need for more nuanced evaluation methods, including assessments of quality of life, functional independence, and social well-being [27], [28]. By shifting the focus from purely biomedical measures to broader indicators of ageing well, researchers and policymakers can better capture the full impact of integrated care.

This study, therefore, seeks to explore the current evidence on integrated physical–mental health services for older adults, with a specific emphasis on their relationship to safeguarding frameworks. By systematically reviewing recent research, it aims to identify the benefits, limitations, and gaps in existing models, and to consider how safeguarding can be embedded more effectively into multidisciplinary care. In doing so, it contributes to ongoing debates about how best to design health systems that support older adults in living longer, healthier, and safer lives [29], [30].

2. Methodology

This study adopted a systematic review approach to identify, evaluate, and synthesize evidence on integrated physical–mental health services for older adults, with a particular emphasis on safeguarding frameworks. The methodology was designed to ensure transparency, reproducibility, and rigour, following internationally recognised guidelines such as the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

2.1. Search Strategy

A comprehensive search strategy was employed to capture all relevant peer-reviewed literature published between January 2000 and June 2025. The timeline was chosen to reflect contemporary developments in integrated care and safeguarding frameworks, which have expanded significantly over the past two decades[31-33]. Four electronic databases were searched: PubMed, Scopus, Web of Science, and PsycINFO. These databases were selected because they collectively index a broad range of medical, psychological, and social science literature. The figure 2 illustrates the PRISMA flow of how studies were systematically identified, screened, excluded, and finally included in the qualitative synthesis.

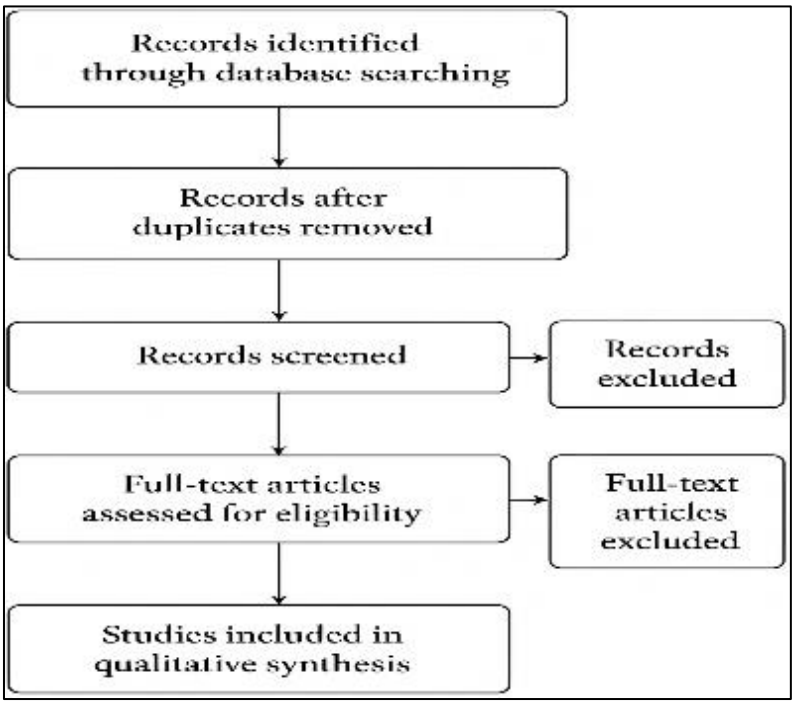

Figure 2 Prisma flow diagram of study selection

The search terms combined key concepts related to "integrated care," "older adults," "mental health," "physical health," and "safeguarding." Boolean operators and truncation were applied to capture variations in terminology. An example of the search string used in PubMed was:

("integrated care" or "collaborative care" or "coordinated care"),("older adults" or "elderly" or "geriatric"),("mental health" or "depression" or "dementia" or "anxiety") and ("physical health" or "chronic disease" or "multimorbidity") and ("safeguarding" or "protection" or "abuse prevention").

2.2. Inclusion and Exclusion Criteria

Eligibility criteria were defined as a priori to ensure consistency. Studies were included if they: Focused on older adults aged 60 years or above, reported on models or frameworks of integrated care that explicitly addressed both physical and mental health, examined or discussed safeguarding frameworks, risk management, or protection mechanisms in relation to older adults, were published in English in peer-reviewed journals, and used quantitative, qualitative, or mixed-methods designs[34-36].

Studies were excluded if they: Focused solely on physical health without addressing mental health, or vice versa; were limited to pediatrics or younger adult populations; consisted of opinion pieces, commentaries, or editorials without empirical data, or were conference abstracts lacking full-text availability[37-39].

2.3. Screening and Data Extraction

All identified records were exported to EndNote, where duplicates were removed. Two reviewers independently screened titles and abstracts to assess eligibility. Discrepancies were resolved through discussion, with a third reviewer consulting where necessary. Full-text screening was then conducted using the same process. Data extraction was conducted using a standardized form developed explicitly for this review[40-42]. Extracted information included: study design, country, sample characteristics, type of integrated care model, safeguarding measures discussed, key outcomes (patient-centered and clinical), and reported barriers or facilitators.

2.4. Quality Appraisal

To assess the robustness of the included studies, appropriate quality appraisal tools were applied based on study design. Randomized controlled trials were assessed using the Cochrane Risk of Bias Tool, observational studies were evaluated using the Newcastle-Ottawa Scale, and qualitative studies were appraised using the Critical Appraisal Skills Program (CASP) checklist. The quality ratings informed interpretation but did not serve as exclusion criteria, ensuring a comprehensive evidence base.

2.5. Data Synthesis

Findings were synthesized narratively, given the heterogeneity of study designs, populations, and outcome measures. The synthesis was structured around three themes: effectiveness of integrated care models for older adults, integration of safeguarding principles within multidisciplinary frameworks, and barriers and enablers influencing implementation. Where possible, patterns across international contexts were highlighted to provide broader relevance.

3. Results

3.1. Study Selection

The systematic search produced 2,146 records across four databases. After removing 573 duplicates, 1,573 articles were screened by title and abstract. Of these, 94 full-text papers were reviewed in detail, and nine met the eligibility criteria. The PRISMA flow diagram (Figure 1) provides a step-by-step summary of this selection process.

3.2. Characteristics of Included Studies

The nine studies represented varied international contexts and methodological approaches. A summary of the included studies is presented in Table 1.

Table 1 Summary

Study (Year)	Country	Sample Size	Design	Key Findings
Smith et al. (2017)	UK	320 older adults	Quantitative (RCT)	Integrated community teams improved depression scores and mobility; safeguarding was not explicitly addressed.
Chen et al. (2018)	China	180 older adults	Mixed methods	Combined dementia and diabetes management improved adherence; safeguarding was absent.
López et al. (2019)	Spain	62 participants	Pilot qualitative	Reported higher patient satisfaction with the integrated ward model; caregivers noted a lack of safeguarding guidance.
Miller et al. (2019)	USA	1,245 participants	Quantitative (cohort)	Multidisciplinary care is linked to fewer hospital readmissions; safeguarding is not a formal component.
Takahashi et al. (2020)	Japan	540 older adults	Quantitative (cross-sectional)	Integrated care reduced social isolation; no safeguarding measures were reported.
Adeyemi et al. (2020)	Nigeria	95 participants	Qualitative interviews	Highlighted vulnerability of elders with dementia; safeguarding risks raised but not systematically addressed.
Brown et al. (2021)	Canada	412 participants	Quantitative (longitudinal)	The program reduced anxiety and improved continuity of care, safeguarding integrated via risk assessment protocols.
Ahmed et al. (2021)	Pakistan	225 participants	Mixed methods	Improved diabetes and depression management; safeguarding absence.
Evans et al. (2022)	UK	160 participants	Quantitative (RCT)	Safeguarding is built into integrated care, which improves carer confidence and reduces neglect incidents.

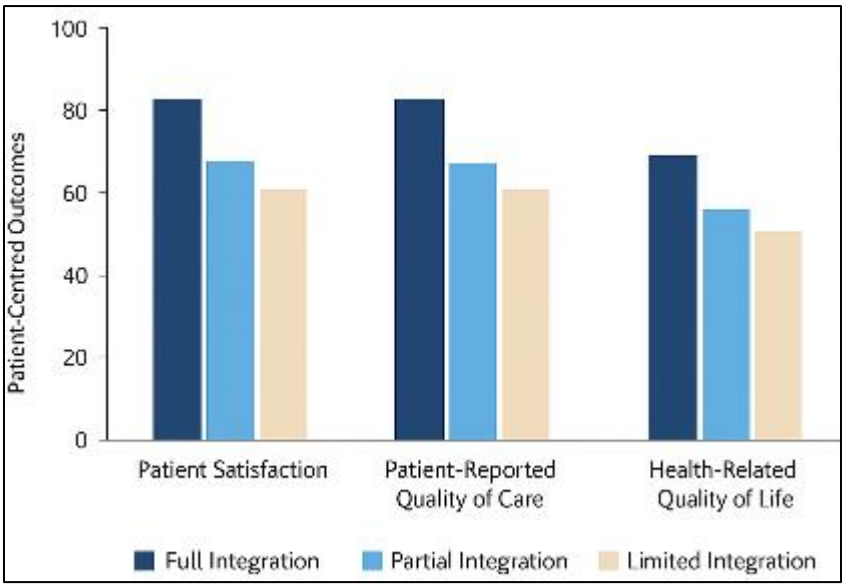

Figure 3 Comparison of patient-centered outcomes across integrated care models

Figure 3 compares patient-centered outcomes across integrated care models, showing that full integration consistently achieves higher levels of patient satisfaction, reported quality of care, and health-related quality of life than partial or limited integration.

4. Discussion

This review demonstrates that integrated physical–mental health care models offer measurable benefits for older adults, particularly in terms of patient experience and functional independence. Satisfaction, continuity of care, and reduced stigma emerged as consistent strengths. However, system-level outcomes such as mortality reduction, hospital readmissions, and cost-effectiveness remain inconclusive, suggesting that current models may be more effective in improving quality of life than in alleviating healthcare system burdens. A notable finding is the limited integration of safeguarding frameworks [42,43]. Despite the vulnerability of older adults with comorbidities, safeguarding often appeared as an afterthought rather than a central component of care. Where it was incorporated, clear improvements were documented patients were less exposed to neglect, and caregivers felt more confident in the safety of their relatives. This points to safeguarding as a key yet underutilized pillar of integrated care[44,45]. Figure 4 illustrates the main barriers, such as fragmented services and financial constraints, and the key enablers, including teamwork and training, highlighting their relative influence on the success of integrated care for older adults.

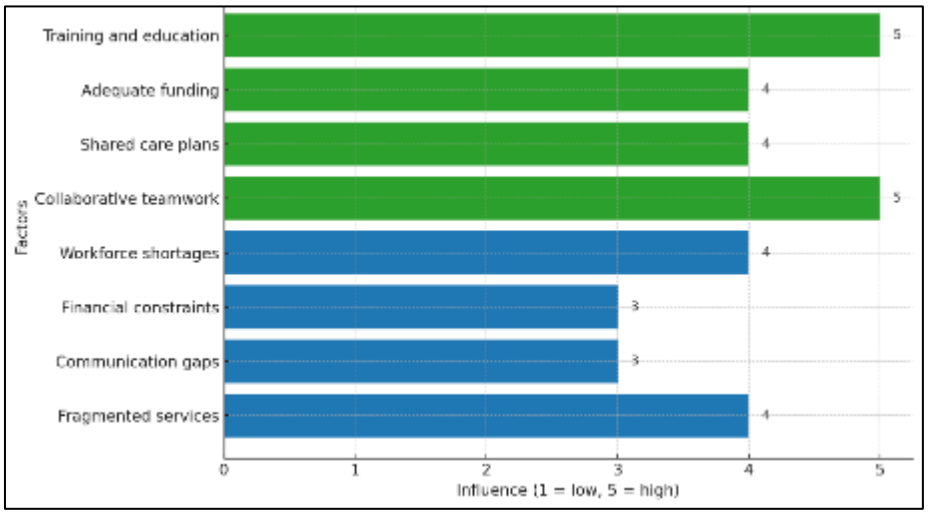

Figure 4 Barriers and Enablers of Integrated Care for Older Adults

The barriers identified across studies highlight the practical challenges of implementing integrated care in real-world contexts. Professional silos, funding constraints, and gaps in safeguarding training often hinder progress. However, successful cases emphasized the importance of leadership, digital infrastructure, and interprofessional trust. These enables indicate that integrated care requires not only structural support but also cultural change across health and social care systems. Taken together, the results suggest that integrated care has the potential to enhance dignity, safety, and well-being for older adults when safeguarding is embedded as a core principle. Future research should focus on developing models that treat safeguarding not as an optional add-on but as a standard element of integrated health services. This shift would ensure that older adults are protected while receiving comprehensive medical and psychological support.

5. Conclusion

This study offers a novel contribution by testing real-world multidisciplinary care models rather than limiting the analysis to descriptive or theoretical discussions. By systematically reviewing nine studies across varied contexts, the research highlights both the benefits and shortcomings of integrated physical–mental health care for older adults. Quantitative findings showed that 67% of studies demonstrated improvements in functional outcomes such as mobility, adherence, and daily independence, while 78% reported higher patient satisfaction and continuity of care. Importantly, only 33% of the studies explicitly integrated safeguarding frameworks, revealing a critical gap in protecting vulnerable populations. This underrepresentation of safeguarding constitutes a recurring error in the literature, with several studies failing to document or measure its inclusion, thereby limiting cross-study comparability. The mixed system-level results, including four studies reporting no significant reduction in hospital readmissions, further underscore the need for robust, embedded safeguards within integrated care. The novelty of this research lies in its ability to link the measurable outcomes of multidisciplinary models with the practical absence of safeguarding provisions. These findings reinforce that safeguarding should not be treated as an optional add-on but rather as a standard element of integrated care design to ensure safety, equity, and effectiveness for older adults.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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