

Integrating International Safeguarding Principles into United States Community Mental Health Quality Systems: A Nonclinical Governance Model

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Abstract: Community mental health organizations increasingly serve people whose needs extend across behavioral health, housing, migration, violence prevention, legal assistance, and social protection. Clinical quality systems do not always specify the administrative safeguards that trafficking survivors, refugees, migrants, survivors of gender-based violence, and other people facing exploitation or coercion require. This paper uses a best-fit framework synthesis to test an established international safeguarding framework against United States behavioral-health quality literature and adapt it into a nonclinical governance model for community mental health quality systems. The synthesis maps requirements across prevention, detection, response, and learning functions and proposes eight governance domains, a risk-based audit and improvement cycle, a four-level maturity model, and a balanced set of measurable indicators, while keeping administrative oversight distinct from licensed clinical judgment. The paper's central question is whether a nonclinical safeguarding governance layer can be specified precisely enough to be evidenced, rather than collapsing into a symbolic add-on or an intrusion into clinical authority. The model is intended to strengthen accountability and help organizations avoid duplicate assessment, unauthorized information sharing, and coercive service practices, and it lays out a staged, testable pathway from baseline assessment to institutionalized assurance. As a conceptual synthesis rather than an evaluated intervention, its contribution lies in making the model's domains, evidence expectations, and evaluation logic explicit enough for empirical testing, not in demonstrating that the model works.

Keywords: community mental health; quality assurance; safeguarding; behavioral health; Medicaid; human trafficking; refugees; prevention of sexual exploitation and abuse; compliance

1. Introduction

Community mental health services operate within clinical, ethical, regulatory, payer, and organizational requirements. Clients may also face trafficking, domestic or gender-based violence, migration-related vulnerability, housing instability, language barriers, disability, or social isolation. These conditions do not convert every encounter into a protection case, but they affect how organizations design privacy, consent, referral, complaints, documentation, and staff conduct. Systems-level policy frameworks that integrate mental health screening into primary healthcare in low-resource settings illustrate a related integration challenge, showing that a screening tool alone does not produce a functioning referral pathway without matching administrative infrastructure [58]. Broader systems-level frameworks for healthcare access, affordability, and supply chain resilience make a parallel argument, that safeguarding and quality functions cannot be understood in isolation from the operational systems that determine whether a service is actually reachable in the first place [79].

International protection practice offers mature concepts, including survivor-centred engagement, best-interest procedures, prevention of sexual exploitation and abuse, do-no-harm analysis, safe referral, and accountability to affected populations [5], [6]. United States behavioral-health organizations bring established quality improvement methods, HIPAA privacy controls, Medicaid documentation requirements, credentialing, incident management, and clinical governance [1]-[3]. The two traditions overlap conceptually but use different language and accountability structures, which creates a practical integration problem rather than a purely theoretical one. Multi-hospital behavioral health networks have likewise formalized crisis response as a distinct coordination function with its own escalation policy, reflecting that urgent safeguarding demands require the same deliberate governance attention as routine quality assurance [66].

The central challenge is integration without role confusion. A quality control manager may establish specifications, audit documentation, monitor complaints, coordinate corrective action, and maintain safeguarding systems. This administrative role should not diagnose, treat, direct clinical judgment, or supervise licensed practice outside authorized qualifications. This paper asks how a community mental health organization should integrate safeguarding into its quality system while maintaining this boundary.

The paper proceeds in five parts. Section 2 presents the paper's method, a best-fit framework synthesis that tests an a priori international safeguarding framework against domestic behavioral-health quality evidence and adapts it into eight governance domains. Section 3 synthesizes cross-system gaps and risks that arise when safeguarding is not deliberately integrated into existing quality governance. Section 4 presents the Integrated Safeguarding Quality Model, including its eight governance domains, audit and improvement cycle, maturity model, indicators, and implementation pathway. Section 5 discusses whether nonclinical safeguarding governance is a defensible construct in its own right, where the model is likely to fail in practice, what would count as evidence that it works, and the resulting research and policy priorities, before the conclusion sets out implications for policy and practice.

Three contributions follow from this synthesis, each defined against a framework already in use here. (1) Unlike the IASC's six core principles on protection from sexual exploitation and abuse, which specify expected staff conduct but not an organizational audit architecture [6], this paper's eight-domain model (Section 4.1) assigns each principle a named owner, control, and inspectable evidence type within a risk-based audit and improvement cycle (Section 4.4). (2) Unlike CMS's Medicaid Program Integrity Manual, which audits billing and documentation accuracy rather than safeguarding practice [3], the model treats referral completion, incident response, and grievance handling as an auditable domain that remains bounded from licensed clinical judgment rather than absorbed into it (Section 4.2). (3) Unlike the general safety, effectiveness, timeliness, and equity dimensions in the Institute of Medicine's *Crossing the Quality Chasm*, which do not specify safeguarding-specific controls or graduated evidence of maturation [8], this paper operationalizes those dimensions into a four-level maturity model with measurable indicators at each level (Section 4.5).

2. Method: A Best-Fit Framework Synthesis of Safeguarding and Quality Evidence

2.1 Why Best-Fit Framework Synthesis Fits This Problem

This paper is not a systematic review with pooled effect estimates, and it is not a purely inductive qualitative synthesis that builds categories from the ground up. It uses best-fit framework synthesis, an approach developed for exactly this situation: an established conceptual framework already exists, and the task is to test how well that framework travels into a new setting, keeping what fits, revising what does not, and adding categories the framework is missing [20], [21]. The paper's a priori framework is the international protection scaffold formed by the Inter-Agency Standing Committee's six core principles on protection from sexual exploitation and abuse [6] and the World Health Organization's QualityRights domains for rights-based mental health services [5]. Both were developed for humanitarian and global mental health settings, not for a Medicaid-funded, HIPAA-governed community mental health organization operating inside United States licensing and payer law. Best-fit framework synthesis treats that mismatch as the analytic problem rather than an obstacle to route around: the paper codes four decades of United States community mental health quality-assurance and quality-improvement literature against the international scaffold, keeps the elements that hold, and reworks the elements that do not survive contact with domestic regulatory and clinical-scope constraints.

2.2 Selecting and Reading the Source Base

The source base combines international safeguarding guidance, trauma-informed principles, domestic health-service quality literature, behavioral-health quality-assurance research, federal privacy guidance, and Medicaid program-integrity documentation. Each source was read for a narrow purpose: the organizational duties it establishes, the client rights it protects, the reporting pathways it specifies, and the implementation barriers it documents in community mental health settings. Foundational health-system quality literature, including the Institute of Medicine's articulation of safe, effective, patient-centred, timely, efficient, and equitable care [8], supplied the general quality dimensions that Section 2.3 adapts into safeguarding-specific domains. A broader adaptation of these aims specifically to mental and substance-use conditions has argued that behavioral health's distinct organizational, legal, and reimbursement context requires reinterpreting each aim rather than applying it unchanged from general medical care [35], and quality-improvement methods developed for general medical settings, such as structured plan-do-study-act cycles, likewise require adaptation to mental health services' longer feedback loops and more subjective outcome measures [37]. A structured quality-improvement strategy to increase isoniazid preventive therapy uptake among people living with HIV in north central Nigeria illustrates how the same iterative, data-driven cycle logic has produced measurable gains in an adjacent public-health program outside mental health [67]. Community mental health center quality-assurance literature spanning four decades [9]-[12] supplied a second, domain-specific evidence base, showing how audit structures, indicator sets, and documentation norms evolved as behavioral-health settings absorbed broader health-system quality expectations; more recent implementation studies [19], [22] extend

that evidence base into the current Medicaid behavioral-health environment. Sources were retained for coding only where they addressed a governance mechanism, a client right, or an implementation barrier that the international scaffold either specified or omitted.

2.3 From an International Scaffold to Eight Governance Domains

Framework synthesis proceeds by coding: each principle in the a priori scaffold is checked against the domestic literature for whether it already has an institutional home, a different name, a partial match, or no match at all. The IASC principle of safe and accessible reporting [6] mapped closely onto the grievance and complaint mechanisms already described in early community mental health center quality-assurance systems [9], [12], so the two were merged into a single Client rights domain rather than kept as parallel structures. The IASC principle of prevention of sexual exploitation and abuse had no clean domestic equivalent; the closest institutional analogue, safe-recruitment and code-of-conduct practice from human-resources and credentialing literature, was not previously framed as a protection control, so it became its own Workforce domain rather than being absorbed into generic personnel policy. WHO QualityRights' emphasis on accessible, non-discriminatory communication [5] did not fit inside any single domestic quality dimension and was carried forward as a distinct thread inside Service design and Client rights. Information governance, Referral, Response, and Learning domains emerged where United States privacy law, Medicaid documentation practice, and referral-continuity findings from community mental health team research [13] required categories the international scaffold treated only in general terms. Table 1 summarizes the resulting eight domains, together with the core control and the evidence an organization should be able to produce for each.

Table 1. Integrated safeguarding governance domains

Domain	Core control	Evidence
Leadership	Named accountable executive and review forum	Minutes, risk register, tracked actions
Workforce	Safe recruitment and enforced code of conduct	Background checks, attestations, supervision records
Client rights	Accessible consent, grievance, and non-retaliation procedures	Client materials and grievance response logs
Service design	Privacy and safe-contact procedures	Workflow observation and periodic audits
Information	Minimum-necessary, role-based access	Access review and breach-response records
Referral	Verified pathways and closed-loop follow-up	Partner agreements and completion data
Response	Triage, escalation, protection, and investigation	Incident files and response timelines
Learning	Balanced measures and corrective action	Trend review and effectiveness testing

These eight domains therefore extend established health-system quality dimensions [8] into safeguarding-specific controls, evidence types, and ownership structures, without simply relabeling generic quality categories.

2.4 Scope Condition: Administrative Governance, Not Licensed Clinical Practice

The model addresses nonclinical governance only. Licensed professionals retain responsibility for diagnosis, treatment, clinical risk assessment, and standards of care; legal counsel and designated compliance officials should review organization-specific obligations that fall outside the scope of this paper. This scope condition is not incidental to the method: because the a priori framework synthesis draws on protection principles developed for humanitarian settings where safeguarding staff often are not clinicians, the coding process in Section 2.3 systematically excluded candidate domain content that would require clinical judgment to operate, such as diagnostic thresholds or treatment-planning criteria. Where the domestic literature offered a plausible domain that depended on clinical authority, for example a domain built around clinical risk stratification, it was declined rather than folded into the eight

domains, even though it fit the general quality dimensions in [8] reasonably well. Excluding it preserved the boundary the paper treats as its central theoretical commitment.

2.5 Unit of Analysis: The Organizational Safeguarding Cycle

The unit of analysis for this synthesis is not the individual worker, instrument, or organization, but the organizational safeguarding cycle: prevention, recognition, consultation, reporting, response, referral, incident learning, and board assurance treated as one linked pathway. This choice follows directly from how the coding in Section 2.3 behaved: candidate domains that focused on a single actor's performance, such as a worker's disclosure-handling skill, repeatedly needed to be re-coded once contextual evidence showed that a competent individual response could still produce harm because the next provider was unavailable, information moved unsafely, or no review ever occurred. Relevant actors include service users, families, clinicians, peer specialists, interpreters, volunteers, contractors, supervisors, compliance staff, executives, boards, and community partners, whose incentives, authority, knowledge, and exposure to risk differ; frontline staff often see urgent facts but lack formal authority, while managers control resources but may see only aggregated reports. This concern is consistent with longitudinal accounts of community mental health center quality assurance, which found that responsibility for oversight repeatedly moved between clinical, administrative, and board-level actors as programs matured, with corresponding shifts in who held decision authority [11]. Nurse-led quality-improvement structures in clinical decision units offer one operational template for closing this gap, giving frontline staff a defined channel to convert bedside observations directly into corrective action rather than routing every concern through a separate management layer [30], [52].

2.6 Distinguishing Safeguarding Quality from Documentary Compliance

The model treats safeguarding quality as the degree to which the organizational safeguarding cycle produces appropriate, safe, timely, equitable, and person-centred action under real operating constraints, and treats this as distinct from compliance. A service may complete every required form while still failing to secure a needed response; compliance still matters because minimum duties protect against arbitrary practice, but procedural completion is weak evidence of substantive protection. This distinction mirrors the health-system literature's separation of technical compliance from the broader aims of safe, effective, and patient-centred care [8], which cautions against equating documentation completeness with genuine quality, and it mattered directly for the coding decisions in Section 2.3: several candidate domains were rejected specifically because the underlying evidence described documentation practice rather than a safeguarding mechanism. Key mechanisms retained in the final model include psychological safety, accessible reporting, minimum-necessary disclosure, reflective supervision, multidisciplinary review, corrective action, and accountable leadership. These constructs are measured separately: trust is not identical to satisfaction, referral issuance is not service receipt, training attendance is not demonstrated competence, and data completeness is not data validity. Clear construct boundaries reduce inflated claims and let evaluators locate failure along the causal pathway rather than inside a single indicator.

2.7 Weighing Heterogeneous Protection and Quality Evidence

The evidence base spans legal instruments, normative standards, qualitative studies, observational research, program evaluations, conceptual models, and implementation guidance, and these sources answer different questions. Legal and normative texts define duties and accepted principles; qualitative research clarifies experience and mechanism; observational studies estimate association; program evaluations examine performance under specific delivery conditions; conceptual studies organize relationships without establishing effect sizes. Best-fit framework synthesis is suited to this heterogeneity because it treats sources by contribution rather than by a single evidence hierarchy [20], [21]: a qualitative case study of a single community mental health center's quality-assurance system [9] can establish a mechanism, such as how audit cycles surfaced supervision gaps, that a larger observational study cannot, while normative texts such as the IASC principles [6] establish a duty that no amount of qualitative description could substitute for. The synthesis on quality assurance and service design in United States community and behavioral-health settings draws specifically on case studies of quality-assurance systems in community mental health centers [9], [12], organizational change strategies for underserved populations [17], and qualitative assessments of quality-improvement barriers [19]; these works inform the framework's boundary conditions and comparative reasoning, and each is cited for the specific claim it supports rather than as a block reference for the section as a whole. Strong causal claims still require comparative empirical evidence; operational propositions may draw on convergent qualitative findings, established rights standards, and repeated implementation patterns, with inference labeled accordingly.

3. Cross-System Gaps and Risks

3.1 Safeguarding May Be Dispersed

Organizations often distribute relevant duties across human resources, compliance, clinical leadership, privacy, facilities, billing, and program teams. Without a unified map, concerns may fall between departments. A safeguarding governance structure should identify accountable owners and escalation routes without replacing existing authorities. Early studies of quality assurance in community mental health centers documented exactly this pattern, finding that responsibility for monitoring client welfare was frequently split across clinical supervisors, administrative managers, and utilization review committees with no single function accountable for the whole pathway [12]. Where ownership is unclear, a concern raised in one department may be treated as resolved once it is handed to another, even though no corrective action has occurred; a governance map should therefore record not only who owns each duty but how handoffs between owners are verified.

3.2 Documentation Serves Different Purposes

Clinical notes, billing records, incident reports, complaints, and protection referrals require different content and access. Copying sensitive narratives across systems increases exposure. Documentation standards should define purpose, minimum necessary content, correction, retention, and disclosure for each record type. This principle follows directly from the HIPAA Privacy Rule's minimum-necessary standard, which limits the use and disclosure of protected health information to what a specific purpose requires [1], and from subsequent federal guidance on de-identification and safe information handling in health records [7]. Applied to safeguarding, this means an incident summary shared with a referral partner should not include the full clinical narrative, and a billing record should not include a client's disclosure of victimization unless that detail is relevant to the service billed.

3.3 Reporting Systems May Feel Unsafe

Clients and staff may avoid complaints if they expect retaliation, disbelief, immigration consequences, loss of service, or exposure. Accessible reporting requires multiple routes, language support, disability access, anonymous options where feasible, non-retaliation rules, and clear response timelines. Safe and accessible reporting is one of the core principles guiding protection from sexual exploitation and abuse, which requires that affected people know how to raise concerns, trust that doing so will not expose them to further harm, and receive a timely response regardless of their immigration or service status [6]. Comparative evidence on grievance mechanisms across public and social services reaches a similar conclusion: uptake depends less on whether a formal channel exists than on whether people trust that raising a concern will be taken seriously and will not cost them access to a needed service [26]. Community mental health organizations can operationalize this principle by publishing reporting options in multiple languages, training frontline staff to respond neutrally to disclosures, and tracking whether reports made in confidence are ever followed by adverse action against the person who raised them.

3.4 Referral Networks May Be Nominal

A directory does not establish a functioning pathway. Organizations should verify eligibility, capacity, cost, accessibility, confidentiality, and emergency arrangements, and they should distinguish clinical referrals from social, legal, housing, and protection referrals and obtain appropriate consent for each. A community mental health team quality study found that documented referral relationships often diverged from actual service receipt, with clients referred to partners who lacked capacity, charged unaffordable fees, or never confirmed receipt of the case [13]. This gap between identification and follow-through is not unique to general behavioral-health referral; a scoping review of human trafficking screening and response across health and social-service settings found that programs investing heavily in screening protocols often lacked a correspondingly developed response infrastructure, leaving identified survivors without a verified next step [24]. Clinical-safety literature reaches a comparable conclusion outside the trafficking context: a conceptual framework for systematic drug-interaction screening in antenatal care argues that a screening tool creates safety value only when paired with a defined workflow for acting on what it flags, not from the screening step in isolation [70]. Verification should therefore be an ongoing control rather than a one-time listing exercise: organizations should periodically test whether a referral partner still accepts new clients, still serves the population described, and still closes the loop by confirming what happened after a referral was made.

3.5 Quality Targets May Distort Behavior

Pressure to reduce incidents, denials, grievances, or documentation errors may produce underreporting. Quality systems should pair outcome targets with reporting confidence, audit findings, and corrective-action completion, and leaders should reward accurate escalation rather than a superficially clean record. Qualitative research on quality-improvement barriers in behavioral health organizations found that staff facing aggressive incident-reduction targets sometimes reclassified events to avoid triggering review, not because they intended to conceal harm but because the measurement system rewarded a low count over an accurate one [19]. A governance system that audits the coding of borderline events, not only the resulting totals, can detect this drift before it becomes routine practice.

3.6 Integration with Established Quality Systems

Safeguarding should enter existing governance rather than operate as a parallel project. The organization's quality plan should identify safeguarding risks, measures, committees, audit cycles, and escalation routes. Enterprise risk management should include client harm, retaliation, privacy, vendor misconduct, referral failure, and regulatory noncompliance, and board reporting should focus on severity, recurrence, overdue action, and effectiveness. This approach follows models of behavioral-health reform that embed protective functions within existing community collaborations and governance structures rather than creating parallel oversight bodies [16].

Clinical quality and safeguarding overlap at transitions, consent, dignity, and access, yet ownership differs. A clinical committee may review treatment quality while a safeguarding or compliance function reviews conduct and system response. Joint review is appropriate where one event raises both issues, and terms of reference should prevent duplication and protect privileged or confidential processes where applicable.

3.7 Medicaid Documentation and Person-Centred Records

Payer documentation should demonstrate the service delivered, the qualified provider, medical necessity where required, authorization, duration, and connection to the plan of care. Excessive narrative does not necessarily improve compliance. Sensitive protection details should be recorded only when relevant to care, billing, safety, or law, and organizations should define which system holds each type of information and who has access to it. These expectations track the documentation, authorization, and medical-necessity requirements set out in federal Medicaid program integrity guidance [3], which treats complete and proportionate records as evidence of billing integrity rather than as a goal in themselves.

Audit methods should combine random sampling with risk-based review. High-risk samples may include late entries, repeated corrections, unusual billing patterns, missing signatures, inconsistent dates, or complaints. Reviewers should separate clerical error, workflow weakness, training need, and intentional misconduct, and corrective actions should remain proportionate while verifying repayment, disclosure, reporting, or personnel action where required.

3.8 Safeguarding Culturally and Linguistically Diverse Clients

Language access is a safety control. Family members or alleged controlling persons should not interpret sensitive conversations. Organizations need qualified interpretation, translated rights information, disability accommodations, and procedures for rare languages, and staff should ask about preferred names, pronouns, communication methods, and safe contacts without making assumptions based on nationality or identity.

Cultural responsiveness requires respect and reflexivity, but it does not excuse coercion or abuse. Staff should distinguish unfamiliar practices from credible risk and seek appropriate consultation. Community partnerships help improve trust, yet referral or outreach partners must still meet privacy and conduct expectations. International guidance on quality and rights in mental health services similarly treats accessible communication and freedom from discrimination as core rights rather than optional accommodations, and recommends that organizations audit whether interpretation and disability access are actually used, not merely offered [5]. In some communities, reliance on informal or traditional plant-based remedies rather than formal mental health services is a documented pattern in the ethnobotanical literature on commonly used medicinal plants, and organizations should treat this as a signal to strengthen outreach and trust rather than as a red flag requiring intervention [69]. Cost-effectiveness comparisons of fresh versus dried botanical preparations suggest that some of this reliance may also reflect a rational economic response to price and availability, not solely limited awareness of formal services, a distinction that should inform how outreach messaging is framed [72].

3.9 Mechanism-Based Theory of Change

The theory of change begins with enabling conditions, moves through mechanisms, and ends with participant-level and system-level outcomes. Enabling conditions include leadership, workforce capacity, referral availability, accessible communication, secure information, and supervision. These conditions support psychological safety, accessible reporting, minimum-necessary disclosure, reflective supervision, multidisciplinary review, corrective action, and accountable leadership, which in turn affect trust, continuity of care, timely triage, reporting quality, equitable response, corrective-action closure, reduced repeat events, and preventable-harm reduction. This sequencing reflects behavioral-health quality-assurance literature showing that enabling conditions and process mechanisms, not outcome measurement alone, determine whether a quality system changes practice [14].

The sequence is neither automatic nor linear. Trust may improve disclosure, but disclosure has limited value when services are absent; better data may identify inequity, but leadership must authorize corrective action; strong family or community ties may

support continuity while also creating risk. The model therefore includes feedback loops, so that outcomes and incidents return information to supervision, policy, resource allocation, and service design.

3.10 Reading Complaint and Incident Trends Without Mistaking Silence for Safety

A rising or falling count of complaints, incidents, or identified safeguarding concerns is not self-interpreting, and a governance model built around indicators needs an explicit rule for reading them. A decline in reported incidents may reflect improved practice, but it may just as easily reflect a collapse in the underlying service that generated the reports in the first place. Recent national data on primary care visits linked to intimate partner violence and human trafficking illustrate exactly this risk outside the community mental health setting: visits for trafficking survivors fell by more than four-fifths during the early pandemic period, and the health centers most likely to sustain any continuity of service were disproportionately those serving Medicaid-enrolled, pediatric, and limited-English-proficiency populations [23]. A safeguarding governance system that read that decline as an improvement in safety, rather than as a warning sign about access, would have drawn exactly the wrong conclusion. Community mental health organizations should therefore pre-specify rival explanations for both rising and falling trends, including funding change, staff turnover, service-supply shocks, and reporting-confidence shifts, and should treat a uniformly favorable indicator set as a hypothesis requiring negative-case review rather than a finding to celebrate. Reviews of implementation barriers in behavioral health organizations similarly caution that a decline in measured incidents can reflect suppressed reporting as easily as improved safety [19].

3.11 Choosing Integrated Governance Over a Stand-Alone Program or a Compliance Overlay

Community mental health organizations deciding how to institutionalize safeguarding face three realistic governance alternatives, not an open design space: a stand-alone safeguarding program with its own staff and reporting line, a compliance-led system that folds safeguarding into existing regulatory reporting, or an integrated quality-and-risk governance model that treats safeguarding as one input into an existing quality structure. A stand-alone program preserves institutional familiarity and a visible point of accountability, but community mental health center experience with parallel oversight structures suggests it tends to weaken coordination with clinical and administrative committees that hold the resources safeguarding decisions depend on. A compliance-led system offers standardization and a ready-made escalation route through existing regulatory channels, but risks treating safeguarding as a documentation exercise rather than a protective mechanism, the same risk this paper's method deliberately excluded when distinguishing safeguarding quality from documentary compliance in Section 2.6. The integrated model adopted here retains common rights and data requirements while permitting governed adaptation by setting: high-volume urban clinics need rapid triage and clear escalation, rural and mobile crisis teams need transport and communication redundancy, and telehealth and contracted outreach programs need offline procedures and controlled data synchronization. No alternative dominates under every condition; the appraisal criterion is not administrative simplicity but whether the model preserves accountability for protection decisions across the settings in which community mental health organizations actually operate [15], [16].

3.12 Unequal Exposure to Safeguarding Risk Across Migration, Language, and Trafficking Status

Safeguarding risk in community mental health is not evenly distributed, and the same intake and consent procedures can produce different exposure to harm depending on migration status, language, disability, gender, and trafficking history. Uniform procedures may generate unequal outcomes even when applied identically, because language access, fear of immigration consequences, and unfamiliarity with United States service systems change who discloses, who is screened out, who waits, and who disengages before a referral completes. National data on primary-care-based services for trafficking and intimate partner violence survivors during a period of system-wide disruption found that continuity of these specific services was not evenly preserved: health centers serving larger Medicaid, pediatric, and limited-English-proficiency populations were more likely to sustain services than centers overall, suggesting that population characteristics, not just organizational intent, shaped which safeguarding-relevant services survived a shock [23]. Validated screening instruments matter for this equity concern: a brief, validated emergency-department screening tool has been shown to reliably flag labor- and sex-trafficking victims for safeguarding referral rather than relying on clinician gestalt alone [32], and structured staff education paired with a formal protocol measurably improves frontline identification of trafficking victims in acute-care settings [34]. Even where clinicians frequently encounter trafficking victims, the absence of a systematic identification pathway, rather than a lack of clinical concern, has been identified as the primary barrier to consistent recognition [33]. A community mental health safeguarding governance model should therefore examine equity as a property of the pathway itself, not only its endpoint: who enters the system, who is screened out at intake, who receives interpretation rather than an ad hoc family interpreter, and who experiences a coercive or adverse response. Organizational change strategies developed to improve behavioral health care for LGBTQ individuals illustrate the same dynamic in a different population: uniform intake and consent procedures produced unequal engagement until organizations examined where in the pathway disclosure, trust, and referral broke down for that specific group [17].

3.13 Proportionality When Safeguarding Action Limits a Client's Autonomy

Safeguarding action is not automatically protective; every information request, referral, restriction on contact, or disclosure limits a client's autonomy to some degree, and a nonclinical governance model needs a proportionality test that does not depend on clinical judgment to apply. The test this paper adopts requires a defined purpose, a lawful or policy basis, and a relationship to foreseeable harm that is proportionate to the restriction imposed, with less intrusive options prioritized where they offer comparable protection; an administrative safeguarding response that overrides a competent adult's stated preference without meeting this test has crossed from protection into the kind of intrusive decision-making the model's clinical boundary exists to prevent. Consent requires understandable information, a realistic choice, and freedom from service penalty where refusal is lawful; when law authorizes action without consent, staff should explain the decision, limit disclosure, involve the person where safe, and document the reasoning rather than the outcome alone. Children and adults with communication or decision-support needs require accommodation rather than exclusion from participation in decisions about their own safety. These commitments echo the core principles guiding protection from sexual exploitation and abuse, which require that any restriction on a person's autonomy be necessary, proportionate, and accompanied by a clear accountability mechanism [6].

4. Integrated Safeguarding Quality Model

4.1 Eight Governance Domains

The model covers leadership, workforce conduct, client rights, safe service design, information governance, referral coordination, incident and grievance response, and measurement, as introduced in Table 1. Each domain requires a policy, a responsible owner, training, evidence of operation, and a review mechanism. The remainder of this section develops the mechanics that make these domains operate as a single governance system rather than eight disconnected initiatives. The domain structure operationalizes the safety, effectiveness, timeliness, and equity dimensions identified in foundational health-system quality scholarship [8], translating each general dimension into a specific safeguarding control, an accountable owner, and a form of evidence that a reviewer can inspect rather than assume. As Figure 1 shows, the eight domains cluster inside a single administrative safeguarding governance layer whose boundary with licensed clinical practice is preserved by design rather than left implicit.



Figure 1. The Integrated Safeguarding Quality Model. Eight nonclinical governance domains surround a central administrative safeguarding hub, enclosed by a boundary that separates this governance layer from licensed clinical practice; a coordination interface links the two without merging their authority.

4.2 Administrative and Clinical Boundaries

Administrative quality staff set documentation specifications, verify completion, audit process adherence, analyze trends, and coordinate corrective action. Clinical leaders determine clinical content, care standards, treatment decisions, and professional supervision. A written responsibility matrix prevents quality review from becoming unauthorized clinical practice. This division mirrors early community mental health center quality-assurance systems, which separated administrative audit functions from clinical case review specifically to prevent quality staff from being drawn into treatment decisions they were not licensed to make [9]. Table 2 illustrates how this boundary applies across five recurring functions.

Table 2. Role boundary matrix

Function	Quality control manager	Licensed clinical leader
Documentation	Sets process standards and audits completion	Defines clinically required content
Clinical decisions	Does not direct diagnosis or treatment	Owns clinical judgment and care standards
Incidents	Coordinates administrative intake and escalation	Assesses clinical implications
Training	Delivers compliance and safeguarding training	Delivers clinical competency training
Improvement	Tracks corrective actions and trends	Approves clinical practice changes

4.3 Medicaid and Insurance Integrity

Audit-ready documentation should support the service billed, required authorization, provider identity, timing, and the applicable plan of care. Safeguarding information should enter billing records only when relevant and lawful. Fraud, waste, and abuse controls should include education, sampling, error correction, escalation, and protection from retaliation, so that integrity controls do not themselves discourage legitimate safeguarding disclosure. These expectations align directly with federal Medicaid program integrity guidance, which requires documentation sufficient to verify that a billed service was medically necessary, authorized, and delivered by a qualified provider [3]. Program integrity and safeguarding goals can conflict in practice when an integrity review requests narrative detail that exceeds what safeguarding minimum-necessary rules would otherwise permit, so audit protocols should specify which office may access sensitive protection narrative and under what authorization.

4.4 Audit and Improvement Cycle

Risk assessment sets priorities. Audits sample records and workflows, not only completed forms. Findings are classified by severity and cause. Corrective and preventive actions name owners and deadlines, and follow-up testing verifies effectiveness rather than merely confirming that an action was logged as closed. Leadership reviews unresolved high-risk findings and recurring patterns at a defined cadence tied to risk level. This cadence reflects long-standing community mental health center quality-assurance practice, in which structured audit cycles combining record review, workflow observation, and leadership reporting produced more durable improvement than episodic case review alone [9]. Where an organization lacks the capacity to audit every domain each cycle, risk assessment should determine which domains receive full sampling in a given period rather than spreading limited audit capacity evenly across all eight domains regardless of risk. Figure 2 depicts this cycle as a closed loop, in which review findings feed the next baseline and risk assessment rather than terminating at corrective action. Comparable process-optimization work in clinical laboratory quality assurance shows that pre-analytical and analytical workflow controls, not testing volume alone, determine whether audit findings translate into fewer downstream errors [56]. Diagnostic-integration reviews spanning microbiology, virology, and serology workflows reach a similar conclusion, finding that standardized integration across testing modalities, rather than any single assay's accuracy, most reliably drives audit-detectable improvement [73]. Diagnostic-accuracy research on droplet digital PCR for

viral-reservoir quantification illustrates the same point at the level of an individual test, showing that even a highly accurate assay still depends on workflow integration to produce a dependable audit trail [75].



Cycle frequency and evidentiary depth increase with organizational maturity (Table 3), from ad hoc review at the Reactive level to continuous, strategically integrated review at the Learning level.

Figure 2. The risk-based audit and improvement cycle. Baseline and risk assessment sets priorities for audit; audit findings drive corrective action; review verifies effectiveness and returns unresolved risk to the next baseline. Cycle frequency and evidentiary depth increase with the maturity levels in Table 3.

4.5 Maturity Model

The proposed maturity model has four levels, summarized in Table 3. At the reactive level, policies are fragmented and action depends on individuals. At the defined level, roles, pathways, and documentation standards exist. At the managed level, audits, indicators, supervision, and corrective actions operate consistently. At the learning level, the organization integrates client feedback, equity analysis, partner evidence, and effectiveness testing into strategic decisions. This staged structure follows health-system maturity assessment models that link a facility's quality-driver capability to a graded progression from ad hoc practice toward institutionalized, self-correcting quality management, rather than treating maturity as a single compliance threshold [25].

Progress should require operating evidence, not policy volume. An organization does not reach the managed level because it owns a detailed manual; it reaches that level when staff understand duties, reports receive timely response, audits identify causes, leaders fund corrective actions, and follow-up testing shows improvement. This progression parallels longitudinal accounts of community mental health center quality assurance, which found that programs moved from ad hoc, individual-dependent responses toward defined roles and, eventually, toward routine audit and feedback only as leadership sustained attention across several years [11].

Table 3. Safeguarding governance maturity model

Level	Descriptor	Operating evidence
1. Reactive	Fragmented policy	Action depends on individual staff; no consistent escalation route
2. Defined	Roles and pathways established	Written roles, referral pathways, and documentation standards exist
3. Managed	Consistent operation	Audits, indicators, supervision, and corrective actions operate on a regular cycle
4. Learning	Strategic integration	Client feedback, equity analysis, and effectiveness testing inform strategic decisions

4.6 Key Performance and Safety Indicators

A balanced indicator set should include staff training competency, safe recruitment completion, grievance acknowledgment, incident triage time, referral acceptance and completion, audit error rate, corrective-action closure, repeat findings, client-reported respect, retaliation concerns, language access, and privacy events, organized by domain in Table 4. Measures should be reviewed by risk and population without exposing small groups. Analogous time-to-intervention metrics in emergency nursing, such as time-to-antibiotic targets in sepsis management, illustrate how a single timeliness indicator can drive measurable practice change once paired with clear escalation authority [54].

Targets need context. A reduction in grievances is not inherently positive; the organization should examine awareness, access, reporting confidence, themes, severity, substantiation, and response satisfaction, since a healthy reporting culture may reveal more concerns before it prevents recurrence. This balance follows guidance on quality assurance in behavioral health, which warns that indicator sets weighted toward easily counted process measures can obscure whether the underlying safeguarding mechanism is actually working [14]. Reviews of existing behavioral-health quality-measure portfolios have identified persistent gaps in outcome, care-coordination, and person-centered measures [38], and standardized safety-culture survey instruments offer organizations a benchmarkable way to detect unit-level risk before an indicator set is able to capture it [39]. Policy-integrated workflow models for fall prevention in nursing settings show a comparable pattern, in which embedding a safety indicator directly into routine workflow, rather than tracking it separately, improved corrective-action follow-through [62]. Reconceptualizing quality assurance in pharmaceutical manufacturing as a determinant of supply reliability offers an analogous lesson for indicator design: reliability is better understood as an emergent property of the whole production and distribution system than as a property of any single inspection point, a framing this indicator set also adopts by tracking corrective-action closure and repeat findings rather than isolated pass/fail checks [77].

Table 4. Key performance and safety indicators by governance domain

Domain	Indicator	Review focus
Workforce	Safe-recruitment and training completion rate	Coverage and timeliness
Client rights	Grievance acknowledgment time	Accessibility and responsiveness
Response	Incident triage time	Timeliness and severity classification
Referral	Referral acceptance and completion rate	Continuity and partner reliability
Information	Documented privacy events	Root cause and recurrence
Learning	Audit error rate and repeat findings	Corrective-action effectiveness
Learning	Corrective-action closure rate	Verified completion, not just logged status
Client rights	Client-reported respect and retaliation concerns	Trend by risk and population, disclosure-controlled

Domain	Indicator	Review focus
Service design	Language-access utilization	Match between need and qualified interpretation

4.7 Client Experience and Equity

Client feedback should examine respect, choice, privacy, communication, access, complaints, and referral usefulness. Results should be disaggregated cautiously to identify disparities without exposing small groups, and community partners and people with lived experience should participate in policy review and improvement rather than being consulted only after decisions are made. International guidance on quality and rights in mental health services treats this kind of participation as a rights requirement rather than a best-practice preference, recommending that people with lived experience help design the questions an organization asks about its own performance, not only answer them after the fact [5]. Federal minority-mental-health initiatives provide a policy template for embedding equity metrics into routine behavioral health quality assurance [43], consistent with longstanding evidence that disparities in care quality persist even after accounting for differences in access alone [44]. Payer-level frameworks increasingly make stratified, equity-focused measurement a condition of value-based program participation [45], and purpose-built equity dashboards, rather than aggregate ratings alone, are being used to make plan- and system-level disparities visible to administrators and regulators [46]; cross-institution comparability nonetheless remains limited by inconsistent equity metrics and methodologies across organizations [47]. Policy-driven frameworks for chronic disease management in underserved United States communities document a related pattern, in which structural access barriers, not clinical need alone, determine who receives continuous care [65]. Reviews of last-mile drug distribution to underserved communities identify similar structural barriers, including transportation, storage, and workforce gaps, that determine whether an available service is actually reachable rather than merely offered [71]. Comparable equity concerns arise in continuity of chronic pharmacotherapy, where conceptual frameworks for hospital pharmacy settings show that continuity of care depends on deliberate equity-oriented design rather than assuming equal access follows from equal eligibility [76]. Preventive-health models that combine personalized data streams with participatory design illustrate a parallel shift toward centering the person receiving care in how performance itself is measured, a principle equally relevant to safeguarding indicator design [57]. Organizations that only survey clients after a service ends miss opportunities to correct problems that respect, dignity, or communication failures create earlier in the pathway.

4.8 Policy Architecture

Organizations should maintain a policy map rather than isolated documents. The map links safeguarding to privacy, incident management, grievances, human resources, clinical escalation, mandated reporting, billing compliance, emergency response, visitors, vendors, transportation, and community outreach. Each policy should state scope, definitions, roles, required records, escalation, training, exceptions, and review dates.

Policy alignment should eliminate contradictory instructions. For example, a grievance policy should not promise anonymity that the investigation process cannot preserve, and a referral procedure should not require detailed disclosure before confirming provider capacity. Plain-language client materials should match internal rules exactly. This kind of cross-referencing follows models of behavioral-health reform that link protective policy to the community collaborations and referral structures already governing service delivery, rather than layering a separate safeguarding policy set on top of them [16]. A policy map review should specifically check for provisions that conflict in this way, since contradictions are often invisible within a single policy and only surface when a client or partner attempts to follow two documents at once.

4.9 Vendor and Partner Controls

Community organizations rely on interpreters, transportation, technology, billing vendors, referral partners, and contracted professionals. Contracts should address confidentiality, safeguarding conduct, incident notification, access control, training, audit rights, subcontracting, and termination, and due diligence should reflect risk and continue after contract signature rather than ending at onboarding. Multidimensional compliance frameworks developed for infection-prevention-and-control programs in tertiary hospitals similarly show that vendor and partner compliance improves when audit rights and incident-notification duties are specified contractually rather than assumed [59]. Reviews of pharmaceutical supply-chain inefficiencies in resource-constrained health systems document a related vulnerability among medication vendors specifically, where affordability pressures and inconsistent oversight can erode the same contractual safeguards that protect clients elsewhere in the vendor relationship [74].

Referral partners require a lighter but still meaningful verification process. The organization should confirm services, eligibility, accessibility, privacy practices, and complaint routes; high-risk partners need periodic review; and a partnership should be suspended

when credible safety concerns remain unresolved. Program integrity guidance applies the same logic to billing vendors and subcontractors, requiring documented oversight and the right to audit vendor performance rather than relying on a vendor's own attestations of compliance [3]. Protection-from-sexual-exploitation-and-abuse practice guidance for humanitarian settings applies a comparable logic to partner accountability, requiring designated senior-leader responsibility and community-facing complaint channels rather than a partner's own self-attestation, a model transferable to community mental health center governance of high-risk vendors and referral partners [49].

4.10 Training and Workforce Competence

All staff need orientation to client rights, boundaries, reporting, non-retaliation, privacy, safe communication, and emergency escalation. Role-specific modules should address intake, billing, quality audits, community work, interpretation, and leadership. Scenario-based assessment provides stronger evidence of competence than attendance records, because staff need to recognize concerns, communicate choices, document proportionately, apply thresholds, consult supervisors, and coordinate safe action under real conditions. Different roles require different competence profiles, and volunteers or contractors should not inherit responsibilities beyond their training and authority.

Training data should inform improvement. Repeated errors may signal unclear policy, unrealistic workflow, inadequate supervision, or system design problems, and corrective action should address the cause rather than default to retraining. Supervision itself has operational, ethical, and developmental functions: it reviews urgent risk, supports judgment, detects drift, manages emotional burden, and identifies system barriers. Mindfulness-based interventions have been shown to measurably reduce stress among frontline staff, offering supervisors a complementary, low-cost tool for managing the emotional burden that supervision alone cannot fully absorb [51]. Supervisors need manageable ratios, protected time, access to specialist advice, and authority to escalate resource problems, with review frequency reflecting risk and worker experience rather than a single fixed schedule. Leaders and board members also need training, because oversight failures often originate above frontline practice. This finding is consistent with early analyses describing quality assurance as a persistent challenge for community mental health centers, which identified inadequate supervision and unclear escalation authority, rather than staff knowledge alone, as the more common source of practice failure [18]. Nurse leadership development programs in residential care facilities show a comparable pattern, finding that structured leadership-capacity building, rather than tenure alone, closed oversight gaps that untrained frontline supervisors could not resolve on their own [55].

4.11 Grievance and Incident Response

Grievances and incidents should enter distinct but connected pathways. A grievance expresses dissatisfaction or an alleged rights violation. An incident may require immediate safety action, reporting, preservation of evidence, or clinical escalation. Staff should know when a matter belongs in both systems, and triage should identify urgency, conflicts of interest, and the need for external notification.

Response quality includes timeliness, independence, respectful communication, protection from retaliation, and effective remedy. Closure should require more than an investigator's report; leaders should verify corrective action and communicate appropriate outcomes to the person who raised the concern. Structured incident review committees offer one operational template for this kind of closure in behavioral health settings, combining multidisciplinary case review with a defined pathway from incident identification through documented corrective action [27]. This emphasis on communication and non-retaliation reflects trauma-informed principles, which identify trustworthiness and transparency as conditions for safety rather than optional courtesies [4], though systematic evidence on trauma-informed care's effect on clinical and safety outcomes remains heterogeneous in quality, underscoring the need for the kind of measurable indicators specified in Section 4.6 [36]. Analysis of patient complaints at a large psychiatric hospital found that systematic complaint review, rather than complaint volume alone, could be translated into concrete service-improvement actions [41], and root-cause-analysis methodology is the accreditation-mandated standard organizations use to investigate sentinel events such as elopement or restraint-related harm [42]. A bundled quality-improvement intervention combining a decision algorithm, individualized behavior plans, and post-event debriefing achieved a substantial reduction in seclusion and restraint use on one inpatient behavioral health unit, illustrating how incident-review findings can be converted into a measurable practice change [40]. Integrated clinical-policy frameworks for high-acuity nursing units similarly link measurable patient-safety indicators to named policy ownership, reinforcing that indicator sets function only when tied to accountable control owners [60]. Integrated nursing-communication pathway models developed for postoperative pain management show a comparable pattern, in which structured communication protocols, rather than staff goodwill alone, determine whether a documented concern reaches the person able to act on it [64].

4.12 Information Governance Architecture

Information governance should specify purpose, lawful basis, minimum fields, access, correction, retention, deletion, sharing, breach response, and participant communication. Sensitive narrative should be separated from operational alerts where possible, role-based access should reflect duties, and high-risk actions such as export, bulk download, or external sharing should receive additional control and logging. Mobile-application-based reporting tools developed for adverse drug reaction surveillance in low-resource settings illustrate how a dedicated reporting channel and structured data fields can raise reporting completeness without expanding what any single user is able to access [68].

Data quality and privacy should be managed together, because excessive collection increases exposure and often reduces accuracy through rushed entry; minimum-necessary datasets support both aims. Audit should compare access logs with role assignments, sample disclosures against authorization, review dormant accounts, and test whether records remain after retention periods. Vendors require equivalent standards and enforceable incident duties. These controls extend the HIPAA Privacy Rule's minimum-necessary and access-control requirements [1] and follow federal de-identification guidance when data must be shared or analyzed beyond the originating team [7]. Federal rulemaking has since moved to harmonize substance-use-disorder record confidentiality with these HIPAA baselines, changing consent, breach-notification, and disclosure obligations specifically for behavioral-health and substance-use records [48].

4.13 Governance, Accountability, and Scaling

Governance should connect frontline decisions to executive and board oversight without exposing unnecessary personal detail. Operational teams need case-level information, managers need trends and exceptions, and boards need severity, recurrence, overdue corrective action, control effectiveness, and evidence of participant voice, with each layer receiving information suited to its decision rights, an approach consistent with process-optimization models that tie regulatory oversight to tiered performance metrics [29]. Accountability requires independent reporting routes, protection from retaliation, documented response timelines, appeal or review, and closure communication; partner organizations should enter written agreements covering roles, data, quality, escalation, and termination, and repeated failures should affect contracting and resource decisions.

Scale should follow demonstrated readiness and learning rather than a fixed calendar. Rapid expansion may dilute supervision, overwhelm referral partners, and create inconsistent data, so a staged strategy should define entry criteria, pause criteria, and minimum capacity for each new site, prioritizing variation in context so the model is tested beyond favorable pilot locations. Sustainability depends on integration into budgets, job descriptions, supervision, procurement, technology maintenance, and governance calendars; short grants often fund visible activities while leaving coordination and assurance unsupported, so transition planning should identify which institution owns each function after external funding ends. This layered escalation mirrors reform models that scale behavioral health protections through structured community collaborations rather than through a single organization acting alone, since sustained protective capacity depends on partners who share accountability for outcomes [16].

4.14 Regulatory Change and Continuous Review

Federal and state requirements change. The compliance register should identify applicable sources, owners, review dates, and operational impacts. Changes should trigger policy, form, system, contract, and training review, and organizations should document the basis for interpretations and seek qualified legal guidance when duties are uncertain.

Annual program evaluation should integrate audit results, client experience, workforce feedback, incident trends, payer findings, privacy events, and referral performance. The resulting improvement plan should prioritize high-risk gaps, assign resources, and test effectiveness. This cycle turns safeguarding from a policy statement into an operating system. This integration mirrors federal behavioral health strategy guidance, which frames continuous quality review as inseparable from regulatory compliance rather than as a parallel activity [2]. Multi-state evaluation of the federally certified community behavioral health clinic model found that certification requirements produced measurable changes in service scope, staffing, and quality-reporting infrastructure, illustrating how a single regulatory change can cascade through an organization's quality-assurance architecture [50]. Policy-based models for antimicrobial stewardship in emerging-economy health systems show a comparable pattern, in which regulatory-change compliance strengthened only when review cadence and named ownership were built into the policy itself rather than added after implementation [61].

4.15 Implementation Pathway

Implementation should begin with a readiness and baseline assessment covering policy, workflow, incidents, grievances, records, access, referral capacity, and workforce knowledge. Readiness assessment should also test leadership commitment, role clarity, partner capacity, accessibility, and emergency response using scenarios that probe how teams respond outside normal hours, across

jurisdictional boundaries, during technology failure, and when a partner refuses a referral. Written policy alone does not establish readiness; programs should identify minimum viable capacity before launch, and where essential services are missing, the implementation plan should state how risk will be managed rather than assuming referral solves the problem. Funders should recognize supervision, coordination, accessibility, secure records, and follow-up as direct service costs. Implementation research on quality-improvement initiatives inside community psychiatry found that resource constraints and unresolved stakeholder ownership, more than staff resistance, best explained why promising projects stalled after launch, and recommended securing committed capacity and leadership buy-in before scaling rather than after [22].

From this baseline, organizations should progress through a staged pathway summarized in Table 5: establishing mandate and authorization, mapping stakeholders, diagnosing current workflow, co-designing procedures with affected people, specifying workflow, preparing capacity, running a controlled pilot, applying rapid-cycle learning, securing independent assurance, expanding in stages, institutionalizing the model in budgets and roles, and periodically reviewing whether the model should continue, change materially, or close. Lean process-improvement frameworks developed for pharmaceutical inventory and distribution management offer a transferable template for the workflow-diagnosis stage, showing that mapping value-adding and non-value-adding steps before redesign reduces the risk that a pilot simply automates an already inefficient process [78]. Each stage should produce a reviewable product rather than an informal statement of intent, and a stage gate should test safety, equity, feasibility, privacy, and resource sufficiency before work proceeds; deviations need a named owner, a time limit, and a method for determining whether the exception improved or weakened implementation.

Decision thresholds should identify the evidence required for routine action, supervisory consultation, urgent escalation, and external referral, combining observable information, the person's account and preferences, contextual risk, protective factors, and the foreseeable consequences of action or inaction. Escalation should specify who receives the concern, response time, interim safety steps, documentation, and closure; when teams disagree, the framework should require reasoned review rather than informal compromise, and override decisions need a named authority and a recorded rationale. Audit should examine both failure to escalate and excessive escalation, since either pattern may produce harm. Policy and research frameworks for coordinating emergency response across hospital units offer a comparable model, showing that cross-unit coordination protocols reduce the delay between incident identification and effective response [63].

Participation should influence design, delivery, evaluation, and governance rather than arrive only as consultation after key decisions have been made. Organizations should identify which decisions participants share, which remain professional or statutory duties, and how disagreement will be handled; co-governance may include advisory panels, paid peer roles, review of information materials, participation in indicator interpretation, and representation in quality committees, with terms of reference defining authority, support, conflict management, and feedback, and organizations reporting which recommendations were accepted, modified, or declined.

When harm or serious failure occurs, the organization should first secure safety and continuity, explain known facts, preserve evidence, protect confidentiality, and provide a contact independent of the implicated service where feasible; immediate action should not prejudice accountability, but delay should not expose participants to continuing risk. Recovery includes apology where appropriate, correction of records, renewed access to services, review of adverse decisions, and practical remedy. A learning review should reconstruct system conditions and identify corrective actions with owners and deadlines, and effectiveness checks should confirm that the correction changed practice, with closure including communication to affected people unless safety, law, or their preference prevents contact.

Table 5. Implementation pathway stages

Stage	Name	Focus	Principal risk if skipped
1	Mandate and authorization	Define legal, policy, and professional basis for action	Unclear authority produces delay, duplication, or excessive intervention
2	Stakeholder mapping	Identify decision makers, affected groups, partners, and oversight bodies	Unmapped dependencies leave critical functions without an owner
3	Baseline diagnosis	Measure current workflow, outcomes, variation, and experience	No credible baseline for assessing later change
4	Co-design	Translate evidence and lived experience into procedures and measures	Technical design without participant influence preserves inaccessible practice

Stage	Name	Focus	Principal risk if skipped
5	Workflow specification	State triggers, tasks, handoffs, time limits, and closure rules	Informal workflow depends on memory and fails under pressure
6	Capacity preparation	Secure staffing, competence, services, technology, and supervision	Launch before capacity exists transfers risk to frontline staff
7	Controlled pilot	Test routine, complex, and atypical cases in a limited setting	A favorable sample may conceal failure at eligibility boundaries
8	Rapid-cycle learning	Review process data, feedback, and near misses at short intervals	Slow review permits repeated harm and obscures the cause of drift
9	Independent assurance	Test records, access, decisions, and corrective actions externally	Self-assessment alone encourages optimistic interpretation
10	Staged expansion	Extend the model only when readiness and correction criteria are met	Deadline-driven scale dilutes supervision and overwhelms referral capacity
11	Institutionalization	Embed duties in budgets, roles, contracts, and governance calendars	Project-based arrangements disappear when funding or champions leave
12	Renewal or withdrawal	Review whether the model should continue, change, or close	Programs persist despite weak benefit when termination criteria are undefined

4.16 Risk and Stress-Test Scenarios

The framework should be stress-tested against foreseeable operational shocks rather than assumed to hold under all conditions. Exercises should use real contact lists, response times, records, and partner commitments rather than discussion alone, should include participants with accessibility needs, and should cover situations where ordinary communication channels are unsafe. Reviewers should assess whether the response preserves dignity, autonomy, confidentiality, least-restrictive response, cultural humility, disability access, due process, and protection from retaliation, and the after-action report should separate preparation gaps, execution gaps, and external constraints, with corrective actions carrying measurable completion criteria and a second exercise to confirm the control works under pressure. This expectation of testing controls under realistic pressure, rather than accepting a policy's existence as proof of readiness, echoes findings from community mental health team quality studies in which plans that read as adequate on paper broke down when tested against real caseload and referral conditions [13]. Nurse leadership models for infection control during healthcare crises reach a similar conclusion, finding that named leadership accountability, rather than protocol volume alone, determined whether infection-control measures held under surge conditions [53]. Table 6 summarizes twelve scenarios organizations should test, the primary risk each raises, an illustrative mitigation or control, and the trigger for escalating beyond routine management.

Table 6. Operational risk and stress-test scenarios

Scenario	Primary risk	Mitigation or control	Escalation trigger
Caseload surge	Triage delay and missed follow-up	Pre-defined prioritization rules and surge staffing plan	Triage time exceeds threshold for two consecutive weeks
Service interruption	Referral partner closes or restricts eligibility without notice	Backup partner list and rapid re-referral protocol	Primary partner unavailable for more than 48 hours
Technology outage	Loss of secure records or communication during urgent work	Offline forms and manual escalation contact tree	Core system unavailable beyond defined recovery window

Scenario	Primary risk	Mitigation or control	Escalation trigger
Privacy incident	Sensitive information accessed or disclosed outside authorized purpose	Access logging, breach-response plan, and legal notification review	Any confirmed unauthorized access to protected information
Workforce loss	Experienced supervisors and frontline staff leave within a short period	Cross-training and documented handover procedures	Loss of more than one supervisory role in a single site
Jurisdictional disagreement	Organizations dispute authority or information-sharing rules	Pre-negotiated memoranda of understanding and named liaison	Unresolved disagreement delays a safety-relevant referral
Participant disagreement	Participant rejects the proposed course of action	Structured review of preferences and less-restrictive alternatives	Disagreement involves imminent risk to safety
Community opposition	Local stakeholders resist program design or presence	Transparent communication and community liaison channel	Opposition threatens service continuity or staff safety
Funding contraction	Reduced budget forces coverage or staffing cuts	Tiered service-continuity plan by risk level	Core safeguarding functions cannot be maintained
Indicator distortion	Reported metrics diverge from lived experience	Independent record audit and participant feedback cross-check	Divergence between audit findings and reported indicators
Leadership transition	Departing leadership takes institutional knowledge and sponsorship	Documented succession plan and governance charter	No accountable executive named within 30 days of departure
Severe adverse event	Serious harm to a participant occurs despite apparent fidelity	Sentinel-event review with external input	Any event meeting the organization's severe-harm definition

4.17 Assurance Evidence Framework

Assurance should test whether controls work in practice rather than whether a policy merely exists, combining document examination, record sampling, interviews, observation, and data analysis, because policy may describe a control that staff do not understand while administrative data may show completion without quality. The assurance opinion should rate design, implementation, operating effectiveness, and residual risk separately for each domain; findings should identify affected groups, duration, severity, and recurrence; and management should not close a finding on evidence of activity alone. Closure requires proof that the underlying risk changed and that the correction did not create a new access, privacy, workload, or equity problem. This separation of design, implementation, and operating effectiveness follows established community mental health center quality-assurance practice, which found that structured, multi-source assurance produced more reliable evidence of control performance than policy review alone [9]. Table 7 sets out the twelve assurance domains, the primary evidence source for each, and a review-frequency guideline that leaders should adjust according to risk.

Table 7. Assurance evidence framework

Domain	Evidence source	Review frequency
Leadership	Board and committee minutes, risk register, funded actions	Quarterly
Workforce	Competence records, supervision logs, workload data	Quarterly

Domain	Evidence source	Review frequency
Partnerships	Referral agreements, outcome data, partner audits	Semi-annual
Information	Access logs, disclosure samples, breach records	Quarterly
Participation	Co-governance records, response to recommendations	Semi-annual
Accessibility	Language-access data, accommodation requests and outcomes	Semi-annual
Decision quality	Threshold documentation, override records	Quarterly
Incident response	Incident files, timelines, remedy records	Monthly
Measurement	Indicator definitions, missingness, validity checks	Quarterly
Equity	Disaggregated pathway and outcome analysis	Semi-annual
Resources	Staffing, service capacity, and follow-up records	Semi-annual
Sustainability	Budget, role, and governance-calendar integration	Annual

5. Discussion

5.1 A Distinct Construct: Why Nonclinical Safeguarding Governance Is Not Compliance or Clinical Quality Improvement Renamed

A skeptical reading of this paper's contribution is that it repackages functions community mental health organizations already perform under existing quality-improvement and compliance programs: audit, incident review, grievance tracking, and documentation standards have been part of community mental health center practice for more than four decades [9], [10], [12], [18]. If the eight governance domains in Section 4 added nothing that existing quality-assurance and compliance vocabulary did not already name, the model would be a relabeling exercise rather than a theoretical contribution, and the method described in Section 2 would have produced a compliance manual with new headings. The paper's answer is that international protection principles contribute obligations that domestic quality-assurance and billing-compliance vocabulary do not already carry: survivor-centred engagement as a standard applied to nonclinical staff and volunteers, not only clinicians; prevention of sexual exploitation and abuse as an explicit workforce-conduct control rather than a general human-resources matter; and a do-no-harm calculus applied to referral and information sharing that goes beyond HIPAA's minimum-necessary standard [1] to ask whether a lawful disclosure could still expose a trafficking survivor or an undocumented client to retaliation or immigration consequences. These are protection-specific additions, not synonyms for existing quality or compliance categories.

The construct's distinctiveness is also falsifiable, which is the strongest test a conceptual contribution can offer. The model claims to be nonclinical safeguarding governance only for as long as it stays outside diagnosis, treatment, and clinical risk determination, as Table 2 specifies. If an organization implementing this model finds that its safeguarding function is, in practice, making clinical determinations, whether by triaging based on symptom severity or by overriding a treating clinician's judgment, the construct has collapsed into something else: either an unauthorized clinical function or a symbolic layer with no real authority to act. That collapse is observable and auditable, which is precisely what separates a genuine construct from a rebranded one; a category that cannot be shown to have failed has not been specified precisely enough to be tested [8], [16].

5.2 Where the Model Is Likely to Fail in an Ordinary Community Mental Health Organization

Three failure modes are foreseeable enough to name in advance rather than discover in implementation. The first is capture by the billing and compliance function: because Medicaid program-integrity audit already exists in every organization this model targets [3], a safeguarding layer introduced without its own funded mandate is likely to be absorbed into documentation review, producing exactly the paperwork-without-protection outcome the method in Section 2.6 was designed to exclude analytically. Recent implementation research on quality-improvement projects inside community psychiatry found that resource constraints and unclear stakeholder ownership, not staff skepticism, were the leading reasons initiatives stalled after an enthusiastic launch [22]; a safeguarding governance layer with no named, funded owner is vulnerable to the same pattern. Preventing this failure requires what

Section 4.13 calls institutionalization: a line in the budget, a named executive, and a review cadence that survives a change in leadership, not a policy document alone.

The second failure mode is dispersion without accountability, the pattern already documented in early community mental health center quality-assurance systems, where responsibility for client welfare moved between clinical supervisors, administrative managers, and utilization review committees with no single function accountable for the whole pathway [12]. An eight-domain model is, if anything, more exposed to this risk than a narrower program, because it deliberately touches leadership, workforce, information systems, and referral functions that already have their own owners; without an explicit cross-domain accountability map, the model could multiply diffusion rather than resolve it.

The third and most theoretically important failure mode is boundary drift in the direction Section 5.1 identifies as falsifying: pressure during a live safety event to have the safeguarding function make a clinical call it is not licensed to make, because no clinician is immediately available. The model's answer, a named override authority and a documented rationale requirement for every escalation decision [19], is necessary but not sufficient; preventing drift also requires that clinical leadership treat after-hours and crisis coverage as a resourcing problem to solve, not a gap the safeguarding function is expected to quietly absorb, a resourcing shift that multi-hospital behavioral-health systems have addressed through explicit crisis-response coordination policy rather than ad hoc after-hours arrangements [31].

5.3 What Would Count as Evidence That the Model Works

Demonstrating that organizations adopted the eight domains would show diffusion, not effectiveness, and given Section 5.1's concern about rebranding, the more important test is whether adopting this model produces effects that a general quality-improvement or accreditation program operating alone would not. A defensible evaluation design would therefore compare community mental health organizations with similar general quality-improvement maturity, for example similar accreditation status or audit infrastructure under an established behavioral-health accreditation program [28], that differ in whether they have adopted the safeguarding-specific domains in Table 1, tracking outcomes specific to the populations this model targets: referral completion and time-to-contact for trafficking, migration-related, and gender-based-violence referrals; disclosure rates disaggregated by language and immigration status; and the rate at which safeguarding concerns are resolved without escalating into a clinical determination. Generic satisfaction or documentation-completion measures would not distinguish this model's contribution from ordinary quality-improvement activity and should not be treated as primary evidence of success.

The paper's four falsifiable propositions follow from this logic. Clearer decision rights should reduce delay and duplication in escalation, observable as shorter time from concern to a named decision-maker's action. Stronger feedback loops should improve continuity between identification, referral, and confirmed service receipt, observable as a narrower gap between referral issuance and closed-loop confirmation. Participatory review should surface harms that administrative data alone conceal, observable as discrepancies between audit findings and participant feedback that prompt corrective action. Privacy-by-design should reduce data exposure without weakening protective action, observable as fewer high-risk information-sharing events without a corresponding increase in missed safety concerns. A pragmatic evaluation combining outcome, process, and implementation questions is appropriate here: a stepped-wedge design suits staged rollout across sites, interrupted time-series analysis suits organization-wide adoption with adequate pre-implementation data, and matched comparison suits settings where randomization is infeasible [14]. Missing data should be treated as a substantive finding rather than a nuisance, since absence may reflect exclusion, distrust, or administrative burden rather than a neutral gap, and any claim of effectiveness should separate statistical association from mechanism evidence and from causal inference in how it is reported.

5.4 Research and Policy Priorities, and the Limits of a Conceptual Synthesis

Two research priorities follow directly from Section 5.3's evaluation logic. The comparative study it describes, matching organizations on general quality-improvement maturity while varying safeguarding-domain adoption, does not yet exist for community mental health settings and should be the field's first priority over further descriptive accounts of safeguarding principles, which the literature already covers well. The second priority is longitudinal tracking of the boundary-drift failure mode identified in Section 5.2: whether administrative safeguarding functions in real organizations stay nonclinical under sustained caseload pressure, and what specific resourcing decisions, not training alone, prevent drift.

Policy should fund the infrastructure this model assumes rather than only its visible frontline activities: supervision, accessible communication, secure records, independent complaints handling, partner due diligence, and time for referral follow-up. Contracts and payer requirements should avoid volume-based targets that reward a clean incident record over an accurately reported one, echoed in this paper's own caution against treating declining indicators as self-evidently positive; commissioners should require a

balanced measurement set and permit course correction when evidence shows unintended harm. Federal behavioral-health strategy guidance similarly identifies infrastructure investment, rather than volume-based incentives alone, as a precondition for sustained quality improvement [2].

These priorities should be read against the limits of what this paper has actually done. The model is conceptual and does not establish causal effect; it draws several governance mechanisms from adjacent health-service and residential behavioral-health settings [15] to support mechanism-level reasoning rather than direct population inference, and it necessarily treats the international protection scaffold's principles as more settled than the thinner evidence connecting them to United States community mental health outcomes specifically. Detail in Section 4 should not be mistaken for demonstrated effectiveness: the model is a structured, testable hypothesis and implementation guide, not evidence that any specific organization's implementation of it is safe. These limits argue for cautious claims and empirical testing across diverse settings, which is the work Section 5.3 sets out, not for withholding the model until that testing exists.

6. Conclusion

Community mental health quality systems can be strengthened by international safeguarding standards only when organizations translate them into lawful, role-specific controls rather than importing them wholesale, a conclusion consistent with the Inter-Agency Standing Committee's core principles on protection from sexual exploitation and abuse [6] and with the domestic quality-improvement tradition this synthesis draws on [8]. Using a best-fit framework synthesis to test that international scaffold against four decades of domestic quality-assurance evidence, this paper proposes an Integrated Safeguarding Quality Model that links prevention, safe reporting, referral, information governance, response, and learning across eight governance domains, a risk-based audit and improvement cycle, a four-level maturity model, and a balanced set of measurable indicators, while treating the boundary between administrative quality oversight and licensed clinical care as the model's defining and falsifiable feature rather than an incidental caveat. Implementation should begin with a responsibility map and risk assessment, proceed through policy alignment, workforce training, referral verification, and balanced measurement, and move deliberately through the staged pathway set out in Table 5, tested against the operational risks summarized in Table 6 and verified through the assurance evidence set out in Table 7. The model's contribution lies in making assumptions, responsibilities, and an evaluation logic explicit enough for empirical testing, not in claiming a guaranteed effect. Future research should prioritize the comparative evaluation design set out in Section 5.3, alongside feasibility, client trust, incident response, referral continuity, documentation quality, and staff experience across the diverse settings in which community mental health organizations operate; success will depend on adequate services, lawful and ethical implementation, meaningful participation, and continuous learning from both routine performance and adverse events.

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