British Journal of Social Work (2025) **00**, 1–19
https://doi.org/10.1093/bjsw/bcaf094

'A broken system'? Service user definitions of avoidable social and psychological harm in mental health social care and recommendations for its minimization in England

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Abstract

Mental health social care (MHSC) is an under-researched area, with little investigation of avoidable social and psychological harm. Understanding this type of harm from service user perspectives is critical for identifying effective strategies for harm minimization. This survivor-controlled research aimed to generate a service user-defined model of avoidable social and psychological harm in community-based MHSC in England, and gather recommendations for its minimization. We first conducted an evidence synthesis to generate an initial model. To refined and finalize the model and explore recommendations, we held two focus groups and carried out a survey with MHSC service users. The final model includes seven sources of avoidable social and psychological harm: barriers or burdens caused by systems/bureaucracy; stigma and discrimination; fragmented services; disruption to or lack of appropriate support; oppressive, controlling, or defensive organizational cultures and systems; serious misconduct or sexual abuse by staff; and neglectful, defensive, or controlling frontline practice. Nine recommendations for harm minimization are made, including: practice improvements; recruitment, education and training; monitoring and regulation; complaints processes; and independent advocacy. Further research is needed to investigate the scale of these harms, who is at particular risk, and the implementation of service user-generated harm minimization recommendations.

Keywords: avoidable harm; co-production; mental health; qualitative; service users; social care; social work.

Accepted: November 2024

Introduction

Mental health social care (MHSC) largely provides community-based support to people who have mental health and social care needs. It is an under-researched area, with little investigation of avoidable harm: harm caused by interventions or services. This contrasts with physical healthcare (e.g. Panagioti et al., 2019).

The Care Quality Commission (CQC) reports avoidable harm in certain mental health settings and their 2020/21 State of Care report showed that people in 'high-risk mental health services' are put at risk by closed cultures, problems with staff competence and training, abuse, and lack of external oversight (CQC 2022). They examined reported incidents on mental health wards from fifty-four NHS Trusts in a single three-month period in 2017 and found a lack of sexual safety (CQC, 2018). Within social care, they concluded, 'not being able to access the right care and support when needed increases the risk of individuals' mental health deteriorating' (CQC 2022:18).

CQC mental health service inspections focus on inpatient environments, with avoidable harm in community-based mental health settings under-investigated. This is arguably influenced by social care often remaining 'invisible' in mental health policy (Trewin 2017) and under-recognized in mental health services (Allen 2014), highlighted by the withdrawal of social workers from community mental health teams (BASW 2016; Abendstern et al., 2022).

Service user testimony suggests that mental health services can be psychologically and socially damaging (Sweeney et al., 2015; Markham 2018; Langley and Price 2022; Lomani 2022; Faulkner et al., 2023). For example, assessments can result in various harms (Shardlow et al., 2005; Faulkner et al., 2023) and social care service users can experience stress and deteriorating mental health when using services (Holmes 2022).

There is some understanding of avoidable harm in mental health and social care separately, but little is known about avoidable social and psychological harm in MHSC specifically. Whilst legislation and service standards aim to mitigate harms, these are not informed by experiential knowledge (Lomani 2022). Service user feedback on mental health social work practice is not systematically sought (Allen et al., 2016). Related concepts, such as risk and safety, are typically defined by professionals, with service user perspectives again underexplored (e.g. Mitchell, Baxter, and Glendinning 2012; Veale et al., 2023).

Conceptualizations of avoidable social and psychological harm may not reflect the ways service users understand and *experience* such harms. Berzins et al. (2018) found that service user conceptualizations of patient safety in inpatient mental health settings were broader than official definitions. Conceptualizing avoidable social and psychological harm in-line with service user experiences and perspectives could generate effective strategies to minimize and prevent such harm.

Our research aimed to generate and refine a service user-defined model of avoidable social and psychological harm in community-based MHSC in England, and to gather recommendations for its minimization. We did so through survivor-controlled research (Russo 2012), with the core research team identifying as service user/survivor researchers.

We have used the terms 'mental distress' and 'mental health', acknowledging that no term can convey the meaning of each person's experience. We note that service users often reject the term 'care' in favour of 'support'.

Methods

Survivor research values and theory

Our multistage study used the ethics and practice of survivor research (Faulkner 2004; Beresford and Croft 2012). Survivor research ethics are complex, and relate to minimizing power differentials between participants and researchers in order to harness collective power and generate research that positively impacts people's lives (see, for instance, the Survivor Research Framework survivorresearch.org). This is founded on a belief in the role and value of experiential knowledge in understanding phenomena, consistent with interpretive/qualitative research paradigms (e.g. Braun and Clarke 2019). The methods drew on previous survivor-controlled studies, including a multistage process for developing user-defined outcome measures (Rose et al., 2011).

Advisory group

The study was guided by an Advisory Group of practitioners, service users and researchers, often with dual identities. They advised at key study stages, helping ground the research in lived experience and social care practice and policy.

Ethical considerations

Ethical approval was obtained from the Social Care Research Ethics Committee (ref: 20/IEC08/0010, July 2020); this is the national ethics committee for social care research in England. We were guided by an ethical framework for trauma-related research (Newman, Risch, and Kassam-Adams 2006) and the 'Ethics of Survivor Research' (Faulkner 2004). We anticipated potential research governance, ethical and safeguarding issues, including through scenario planning and a distress protocol. We held regular reflective team sessions, reviewing ethical conduct iteratively.

Data collection and analysis

Generating an initial service user-defined model of avoidable social and psychological harm in MHSC

Stage 1: evidence synthesis

We conducted a scoping review of peer-reviewed literature on adult service users' experiences of MHSC in England using a detailed review protocol (Carr et al., 2023). We also identified 'grey literature', searching for literature published 2008–20. We undertook targeted searches of relevant websites including of user-led organizations, charities and social work regulators and organizations. Service user blogs, articles and reports were identified using specialist search engines. Search terms included 'mental health', 'social care', 'social work', 'harm', 'service user' and 'experience'. Searches were supplemented through Advisory Group consultation and a social media (then Twitter) call.

Identified literature was systematically screened using inclusion and exclusion criteria. Two authors (SC, TC) familiarized themselves with the literature and extracted the relevant data using prespecified tables. The data was then coded and thematically analysed guided by Braun and Clarke's (2006) framework. The resulting themes were then reviewed using the scoping review findings (Carr et al., 2023) to guide comparison and integration of findings from both reviews (Christensen, Todić, and McMahon 2022). The evidence synthesis was finalized through team-based discussion, leading to an initial working model of avoidable social and psychological harm in MHSC. This model contained seven sources of this harm, as detailed in the evidence synthesis results below.

Details of the grey literature search strategy and results, and inclusion and exclusion criteria, can be found in Supplementary File 1.

Refining the service user-defined model of avoidable social and psychological harm in MHSC and generating preliminary prevalence data

Stage 2: focus groups

Two focus groups were held virtually via Zoom to refine the working model. Focus groups allow data to be generated through participant interaction, and it has been argued that this results in an enhanced understanding of participants' experiences, language, and concepts (Wilkinson 1998). Online focus groups were selected because the anonymity of online spaces can be suitable for sensitive topics, with the lack of a physical setting removing geographical barriers to participation, allowing more diverse contributions (Reisner et al., 2018). Participants were recruited through networks, adverts in service user organization newsletters/e-bulletins, Twitter calls, and posters in relevant organizations. Eligibility criteria included: aged 18–65 and used MHSC in the past seven years.

The first group discussed general experiences of avoidable social and psychological harm, including intersectional experiences, while the second group additionally focused on experiences of discrimination within MHSC in response to significant issues raised by group members. The working model of avoidable social and psychological harm and harm mitigation recommendations were discussed.

Focus groups were recorded, transcribed, and analysed thematically. Three researchers (AS, NA, and SC) analysed transcripts independently, applying a deductive framework from stage 1, and coding inductively for additional harms and mitigators. Data were used to revise the model, which was then commented on by Advisory Group members.

Stage 3: survey

The model was further refined through an online, anonymous survey which ran for three weeks. The survey was split into several sections: harmful experiences; ranking the importance of addressing sources of harm; minimizing harm; and participants' sociodemographics. It was disseminated in England through Advisory Group and researcher networks, service-user organization e-bulletins, and social media (Facebook pages and Twitter). Inclusion criteria matched that for focus groups. Questions included tick-boxes, Likert rankings and free-text.

Quantitative data were analysed to generate average rankings and overall prevalence rates for each source of avoidable harm. Free-text qualitative data was thematically analysed by each researcher, before being discussed, leading to a final version (AS, GH, and SC).

Final model of user-defined avoidable social and psychological harm in MHSC and recommendations for harm minimization

The survey findings were integrated into the final model. Researchers compared independent analyses and agreed final changes through discussion. The model and recommendations for minimizing harm were discussed and finalized with the Advisory Group.

Results

Generating an initial service user-defined model of avoidable social and psychological harm in MHSC

Stage 1: evidence synthesis

The scoping review identified twenty-two peer-reviewed papers that explored service user experiences of MHSC (Carr et al., 2023). After systematically screening 122 grey literature items (AS, NA, and SC), twenty-seven met the inclusion criteria.

The scoping review set out six key themes relating to experiences of avoidable social and psychological harm in MHSC: poor relationships and communication with practitioners; lack of information, involvement and decision-making; lack of support or support that fails to meet needs; inflexible, bureaucratic systems; fragmented services and discontinuity; and 'power over' and discriminatory cultures (Carr et al., 2023). The grey literature review results consolidated and expanded these findings, additionally providing evidence on serious misconduct or sexual abuse by staff. The evidence synthesis led to an initial working model of avoidable social and psychological harm in MHSC that contained seven sources of avoidable social and psychological harm ordered according to their frequency in the literature: Disruption to or lack of support; Neglectful or controlling frontline practice; Stigma and discrimination; Oppressive or controlling organizational cultures; Fragmented services; Barriers or burdens by systems or bureaucracy; Serious misconduct or sexual abuse by staff. A detailed account of the findings is available in Supplementary File 2.

Refining the service user-defined model of avoidable social and psychological harm in MHSC and generating preliminary prevalence data

Stage 2: focus groups

Thirteen people participated in focus groups, with another submitting an email response. Participant socio-demographics are outlined in Table 1.

The seven sources of avoidable social and psychological harm resonated with participants. People additionally highlighted personal budget ‘top up’ fees where service users must partially self-fund; discrimination due to mental health diagnoses, disability, ethnicity, culture or religion; damaging complaints processes and outcomes; organizations and/or staff not accepting responsibility for failings; closed cultures and service users not being believed or having needs taken seriously. These findings extended and developed the model.

> ‘I’ve been really harmed by the process (of applying for social care), I would compare it to a PIP [Personal Independence Payment] assessment, that level of animosity and not being believed … your integrity, your account questioned as to, you know, you must be faking’.
>
> ‘… this is actually […] a system problem, because the system itself hasn’t got the cost and the money, it then provides you with a broken system.’

Stage 3: survey

There were forty-four survey participants, with twenty-seven completing the whole survey. See Table 1 for participant socio-demographics.

Qualitative data were used to develop the model. Participants highlighted further sources of harm: a lack of appropriately trained staff; stigma due to diagnoses, disability, or neurodiversity; having to repeat one’s history; gatekeeping in services; staff coercion; physical and sexual abuse; and abuse of position and trust.

Serious misconduct or sexual abuse by staff was reported by over half of the participants. Neglectful, defensive, or controlling frontline practice

Table 1. Focus group and survey participant characteristics.

Characteristic	Focus group participants ($n = 14$)	Survey participants ($n = 27$)
Gender (n, %)		
Male	6 (43)	6 (23)
Female	7 (50)	16 (59)
Nonbinary	—	3 (11)
Agender	—	1 (4)
Prefer not to say	—	1 (4)
Other—'Binary'	1 (7)	—
Age (mean, standard deviation)	40.6 (SD = 10.3)	46.2 (SD = 12.2)
Range	19-52	23-65
Ethnicity (n, %)		
Asian	3 (21)	2 (7)
Black	1 (7)	—
Mixed	3 (21)	3 (11)
White	7 (50)	17 (63)
Other	—	2 (7)
Prefer not to say	—	3 (11)
Sexuality (n, %)		
Heterosexual	10 (71)	17 (63)
Gay/lesbian	1 (7)	3 (11)
Bisexual	1 (7)	3 (11)
Queer	—	2 (7)
I don't know/Prefer not to say	2 (14)	2 (7)
Disability (n, %)		
Yes	14 (100)	26 (96)
Prefer not to say	—	1 (4)
Parent (n, %)	4 (29)	10 (37)

was the most frequently experienced harm, with 86 percent reporting these experiences. No participants reported that they had experienced none of the avoidable harms. Participants had experienced harm from five sources on average, ranging from one to all seven. Four participants had experienced harm from one category and fourteen had harmful experiences from all seven categories. Participants ratings of the most urgent harms to address revealed little variation between harms, ranging from 4.1 for the barriers or burdens caused by systems and bureaucracy to 4.68 for neglectful, defensive, or controlling frontline practice (see Table 2). Survey participants also ranked focus group suggestions for social and psychological harm minimization (see Table 3) revealing greater variation, with restorative instead of defensive practice the most recommended and risk adversity the least recommended.

Final service user-defined model of avoidable social and psychological harm in MHSC and recommendations for harm minimization

Table 4 presents the final model based on combined findings from the evidence review, focus groups, and survey. The seven sources of

Table 2. Rankings of socially and psychologically harmful experiences to address by order of urgency.

	Barriers or burdens caused by systems and bureaucracy	Stigma and discrimination	Fragmented services and lack of joined-up working	Disruption to or lack of support	Serious misconduct or abuse by staff	Oppressive, controlling or defensive organizational cultures and systems	Neglectful, defensive or controlling frontline practice
Average ranking	4.1	4.17	4.24	4.39	4.41	4.56	4.68
Overall ranking	1	2	3	4	5	6	7

avoidable harm are ordered according to survey respondent rankings of urgency to address, with the most urgent first.

Harm minimization recommendations

Table 5 outlines MHSC service user recommendations for minimizing social and psychological harms, generated in the focus groups and ordered by survey ranking results.

Discussion

This survivor-controlled study aimed to create a service user-defined model of avoidable social and psychological harm in adult MHSC and generate recommendations for harm minimization. Our final model includes seven sources of avoidable social and psychological harm which represent a comprehensive understanding of the manifestation of this type of avoidable harm in MHSC from service user experience. Our findings are reflected in later consultations with all social care service users (Holmes 2022).

Our research found that avoidable social and psychological harm can manifest at relational, systemic, organizational, and cultural levels within MHSC, which reflect Preston-Shoot's (2018) recommendations for creating whole system alignment to ensure effective safeguarding where harms at the frontline often have their origins at systemic or organizational levels (Preston-Shoot 2018; Preston-Shoot and Lawson 2019). We found that avoidable social and psychological harm can be enacted at multiple levels simultaneously which suggests the need to address issues at multiple levels through multiagency working and strong leadership (Lawson 2017) that centres service user experience.

Avoidable social and psychological harm was a common experience amongst survey respondents. Over half the survey respondents had

Table 3. Social and psychological harm minimization recommendation ranking by order of importance.

	Restorative instead of defensive practice	Improved assessment processes and practice	Improving frontline practice	Practice principles	Service user involvement in recruitment, education and training	Better monitoring and regulation	Complaints processes and outcomes	Access to independent advocacy services	Risk aversity
Average ranking	3.64	3.73	3.77	3.86	4.41	5.14	5.14	6.32	6.95
Overall ranking	1	2	3	4	5	6	6	8	9

Table 4. Service user-defined model of avoidable social and psychological harm in MHSC.

Source of avoidable social and/or psychological harm	Specific factors	Percentage of survey respondents ($n = 27$) experiencing this source of avoidable harm
Barriers or burdens caused by systems and bureaucracy	1. Inaccessible, inflexible decision-making. 2. Unclear assessment processes. 3. Insufficient information about entitlements, support options and staff roles. 4. Burdensome personal budget administration. 5. Inaccessible or intimidating complaints processes. 6. Lack of access to, or awareness of, care plans. 7. Unreasonable pressure to prove need. 8. Bureaucratic delays to support planning and budget decisions. 9. Administrative errors. 10. Systemic failure to address multiple needs. 11. Poor working conditions and high staff turnover. 12. Shortage of qualified and trained staff.	61%
Stigma and discrimination	1. Mental health stigma and discriminatory assumptions about risk. 2. Negative views on capacity and ability. 3. Institutional racism, homophobia, and transphobia. 4. Discrimination against parents, individuals with learning disabilities, homeless people and substance users. 5. Detrimental impacts of discriminatory cultures on front-line work.	80%
Fragmented services and lack of joined-up working	1. Ineffective collaboration between systems and agencies. 2. Funding disputes between health and social care services. 3. Lack of integrated mental health and social care assessments. 4. Forced choice between mental and physical health support, with the risk of being denied both. 5. Insufficient social care support post-hospital discharge. 6. Service users having to repeat their story, risking re-traumatization.	68%
Disruption to or lack of appropriate support	1. Impact of government and local authority funding cuts. 2. Reduction in social care services and support packages. 3. Loss of benefits, housing advice, user-led organizations, and independent advocacy. 4. Delays in decision-making. 5. Needs being ignored, unmet, or deemed ineligible. 6. Inaccurate assessments and records. 7. Frequent practitioner changes. 8. Variable or inadequate personal budgets and additional ‘top up’ charges. 9. Limited support for social activities. 10. Negative experiences leading to disengagement. 11. Restricted access to services and resources (‘gatekeeping’). 12. Adverse impacts of diagnostic labelling. 13. Disruptions related to the COVID-19 pandemic.	82%

(continued)

Table 4. (continued)

Source of avoidable social and/or psychological harm	Specific factors	Percentage of survey respondents ($n = 27$) experiencing this source of avoidable harm
Oppressive, controlling, or defensive organizational cultures and systems	1. Risk-averse practices. 2. Power dynamics negatively affecting service delivery. 3. Discriminatory and stigmatizing organizational cultures. 4. Systems and processes experienced as impersonal and uncaring. 5. The systemic undermining of personhood. 6. Damaging ‘us vs. them’ cultures. 7. Promotion of ‘tick-box’ approaches. 8. Closed, opaque decision-making processes. 9. Ineffective or damaging complaints processes and outcomes. 10. Coercion and fear of hospitalization. 11. Access to advocates controlled by services. 12. Service users being silenced or not believed. 13. Lack of accountability for errors or harms (‘staff closing ranks’). 14. Service users positioned for failure. 15. Resistance to change and service user participation. 16. Negative organizational culture affecting frontline practice. 17. Organizational breaches of law, regulations, or rights.	73%
Serious misconduct or sexual abuse by staff	1. Issues of sexual harassment and assault, physical abuse, abuse of trust and power, record falsification, false accusations, dishonesty, intimidation and breaches of confidentiality.	52%
Neglectful, defensive, or controlling frontline practice	1. Inflexibility and judgmental attitudes, including discrimination based on diagnosis, assumptions of dishonesty, and discrimination relating to ethnicity, culture, religion, disability, and neurodiversity. 2. Poor communication skills, controlling behaviours, misuse of power, exclusionary decision-making, and restrictive practices. 3. Not listening, failing to provide information or explanations, employing ‘tick-box’ methods, not taking responsibility for errors and fostering adversarial relationships.	86%

experienced serious misconduct or sexual abuse by staff that was disbelieved and unaddressed. Failures to address abuse occurred despite this meeting the three statutory criteria in Section 42 of the Care Act 2014, which states that local authorities have a duty to make enquiries and decide what multiagency action needs to be taken. Additionally, Article 15 of the UNCRPD states that people should be free from cruel, inhuman or degrading treatment and the incidents described in the survey were in breach of this.

Table 5. Social and psychological harm minimization recommendations.

Recommendation	Description	Ranking
Restorative practice	Practitioners and organizations should adopt a restorative rather a defensive approach, taking responsibility for harm and working with service users to repair it while acting on lessons and making changes collaboratively and transparently.	1
Improved assessment and care planning	Assessment and care planning processes should be person-focused, with transparent decision-making, involving service users throughout and ensuring their needs are not dismissed.	2
Better front-line practice	Practitioners need advanced communication and listening skills, empathy, respect, and an understanding of trauma-informed approaches, avoiding discriminatory judgments. More and better trained frontline MHSC practitioners are needed.	3
A set of service user-defined practice principles	Individual and organizational practice should be underpinned by the principles of honesty, openness, transparency, empathy, and humanity.	4
Improvements in practitioner recruitment, education, and training	Service users should be involved in the selection, education, and training of all social work practitioners. Introduce a 'buddy system' where trained, paid service users work with practitioners to assess their practice. All practitioners should receive regular training in communication, human skills and trauma-informed approaches.	5
Better monitoring and regulation	Independent monitoring and regulation should be strengthened with influential service user involvement to ensure robust oversight. Well-resourced user-led organizations should promote awareness of standards, legislation and rights.	6
Accessible and responsive complaints processes	Complaints processes must be accessible, clear, and not cause further harm, with an emphasis on believing complainants and avoiding defensive responses. An independent complaints mediation organization for service users is needed along with an independent, confidential service user helpline for incident reporting and support.	6
Independent advocacy and user-led support	Service users should be able to self-refer to fully independently funded advocacy to support their rights, navigate systems and processes, and provide support to those who have been harmed.	7
Enhanced understanding of risk	Organizational cultures should avoid controlling practices and discriminatory assumptions about 'riskiness', promoting less restrictive approaches.	8

The Care Act 2014 guidance on adult safeguarding defines different types of abuse (DHSC 2022) and several of the harms described in our research map onto these. The same Act identifies six statutory safeguarding principles that apply to all sectors and settings, including community-based MHSC services (Lawson 2017): these are, empowerment, prevention, proportionality, protection, partnership, and accountability. However, our study participants did not suggest adult safeguarding as a route for addressing or minimizing social and psychological harm. Participants and Advisory Group members suggested that independent advocacy and user-led organizations could support awareness-raising and service users to access and navigate complex safeguarding and complaints systems.

In their systematic review of avoidable harm in medical care settings, Panagioti and colleagues (2019) found that, ‘harm is preventable … (ii) when the prevention of future recurrence of harm is possible with reasonable adaptation to a process and adherence to guidelines’ (p. 14). The harms described in our model could be reduced through adherence to existing legislation such as the Care Act 2014, standards, codes of conduct. Advisory Group members also highlighted the need for more fundamental change through UK implementation of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD 2017). This would foster a voluntary (rather than coercive) and rights-based system backed by law that could *prevent* the social and psychological harms associated with certain organizational cultures.

‘Closed cultures’ in ‘high-risk mental health services’ put service users at risk of harm (CQC 2022) and are defined as ‘a poor culture that can lead to harm’, including where ‘staff and/or management no longer see people using the service as people’ (CQC [n.d.]: 4). Searle’s (2019) investigation into sexual misconduct in health and social care found a correlation between sexual misconduct and the imbalance of power between service providers and users, with some providers dehumanizing service users. Our findings suggest the possibility of problematic ‘closed cultures’ in community-based MHSC. Again, implementation of the UNCPRD could address the social and psychological harms caused by such cultures.

Harmful organizational cultures can cause practitioner ‘moral injury’ from ‘sustained ethical stress: the stress experienced when workers cannot base their practice on their values’ (Fenton and Kelly 2017: 461). ‘Moral injury’ has been highlighted for social workers (Rutter and Banks 2021) and is associated with several other harmful factors identified by service users in this study including insufficient resourcing (Mänttäri-van der Kuip 2016) and defensive practice cultures (Fenton and Kelly 2017). Addressing harmful and dehumanizing organizational cultures would also benefit practitioners.

Mental health service users generated nine recommendations for minimizing social and psychological harms. The recommendation concerning restorative practice was considered the most important to address by survey respondents, and is reflected in UNCRPD guidelines on deinstitutionalization (UNCRPD 2022). Our Advisory Group stressed the need to establish an independent organization to provide legal and emotional support to people who experience sexual and other abuse within MHSC (and other mental health settings). Our study recommendations echo with social care service users who emphasize the importance of independent advocacy, peer support and advice on rights and entitlements (Holmes 2022). In the UNCRPD rights monitoring includes disabled people's organizations having a role in setting laws, policies and strategies (UN Office of the High Commissioner for Human Rights 2010).

Our Advisory Group observed that the need for enhanced practice principles and improved frontline practice has been repeatedly emphasized in survivor research (e.g. Gould 2012; Sweeney et al., 2015; Carr et al., 2017, 2019). We argue for further work to underpin and promote the implementation of the recommendations.

Strengths, limitations, and research gaps

Strengths of this study include its status as survivor-controlled research with ethical integrity, potentially enhanced ecological validity, and increased credibility and trust with participants (Faulkner et al., 2019). Our model and recommendations are grounded in the knowledge of those who are directly affected by avoidable social and psychological harms in MHSC.

Limitations include the small number of survey respondents. Survey participants were self-selecting and so may overrepresent people with poor experiences. The focus groups and survey were conducted online and so did not capture the perspectives of those without full online access. Our survey respondents included a high proportion of white and female participants. However, the focus groups were more balanced, with one group focusing on the experiences of racialized people and LGBTQ people.

We found that avoidable social and psychological harm in MHSC is significantly under-investigated when compared to preventable harm in medical practice (e.g. Panagioti et al., 2019; Hodkinson et al., 2020; Quinlivan et al., 2020). This raises the possibility that people receiving MHSC may be experiencing avoidable harms that the sector is not aware of and therefore not working to minimize. Further research is needed to quantify social and psychological harms and to understand who is most at risk of this type of harm and the relationship to broader intersectional systems of oppression.

The high prevalence of social and psychological harm among survey respondents provides further evidence—along with Safeguarding Adults Reviews, personal testimonies and media reports—that the Care Act 2014 is not preventing MHSC service users from being exposed to avoidable social and psychological harm. Our results are preliminary and further research directly exploring mental health service users' experiences of this type of avoidable harm in practice is required to further test the model and gain a wider perspective on prevalence, impacts, and harm minimization.

Conclusion

As the first significant study in this area, we have demonstrated the importance of survivor-controlled research in identifying and investigating issues of importance to MHSC service users, who provide a perspective that may be overlooked by or inaccessible to mainstream researchers. We highlight that avoidable social and psychological harm in MHSC appears to be cultural, systemic, and relational, with cultural and systemic issues influencing frontline practice. This type of avoidable harm was commonplace amongst our participants, with survey respondents experiencing neglect, discrimination, and serious misconduct including sexual abuse by frontline practitioners. Given existing legislation and policy, this suggests a significant policy-practice gap. MHSC service user recommendations for minimizing these harms included independent advocacy, improved assessments and practitioner training, and changes in organizational culture. Recommendations around safeguarding were notably absent. To prevent social and psychological harms, our Advisory Group suggested UK implementation of the UNCRPD. Further research is needed to quantify the scale of social and psychological harm, understand who is most at risk and under what circumstances, and to implement and evaluate service user-generated recommendations for minimizing avoidable harm of this nature.

Acknowledgements

The authors would like to thank everyone who contributed to this study. A.S. would like to acknowledge the support of the Economic and Social Research Council (ESRC) Centre for Society and Mental Health at King's College London [ES/S012567/1]; and the National Institute for Health Research (NIHR) Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care, ESRC or King's College London.

Supplementary data

Supplementary data is available at *British Journal of Social Work* online.

Conflict of interest. The authors declare that they have no conflicts of interest.

Funding

This article reports on independent research funded by the National Institute for Health Research School for Social Care Research (NIHR SSCR, grant number C969/CM/UBCN-P137). The views expressed are those of the author(s) and not necessarily those of the NIHR SSCR, the National Health Service, the National Institute for Health Research or the Department of Health and Social Care.

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British Journal of Social Work, 2025, 00, 1–19
https://doi.org/10.1093/bjsw/bcaf094
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