This article explores the conceptual framework of the Safety Triad, originally applied in secure psychiatric settings. The framework can be utilised beyond that of secure services and seek to aid our thinking and reflection about safer systems in safeguarding.

The Safety Triad

Initially developed to understand the core security components in secure mental health hospitals in the UK, the safety triad can be applied to most services/systems in which practitioner psychologists work, albeit to varying degrees (See Think Act, 2015). The strength and safety of a system (for those accessing or working within) can depend on how well each organisation implements three components: (1) Physical Security (e.g. environmental factors such as locked doors), (2) Procedural Security (e.g. policies, procedures or rules such as steps to take for safe visitation) and (3) Relational Security (e.g. how we relate or interact with our patients/clients in a way that is safe).

Inevitably there are some organisations that rely less on certain components of the safety triad. For example, community-based services will not be able to have an emphasis on physical security given the nature of the work, however they perhaps rely most heavily on the procedural and relational security. Conversely, settings such as prisons or high secure psychiatric hospitals have high levels of physical security that outweighs the emphasis on relational and procedural security (although these components are still implemented and incredibly important).

Nevertheless, the triad works like a three-legged stool, if one leg is significantly weaker than the others, the stool becomes wobbly, unbalanced and subsequently the organisation or system becomes more prone to safeguarding matters arising.

Impact of COVID-19 on the Safety Triad

Taking the three-legged stool metaphor further, the rapid and necessary adaptations during COVID-19 have forced changes to the way Practitioner Psychologists and other mental health professionals work, in order to prevent COVID infection spreading rapidly. These changes have inevitably caused initial instability, some of which are continuing. It has changed the entire systems in which we work.
There have been changes to the **physical security**. For example, we have been working remotely, attending virtual meetings, and using different methods to interact with our patients/clients.

The changes during the pandemic can be argued to have weakened the **procedural security** put in place by organisations due to the need, particularly in the beginning, to rapidly adapt to the growing crisis. For example, the implications of visitor restrictions in secure hospitals leading to the implementation of smartphones for service users to access within their bedrooms to ensure they have remained in contact with family and friends. Equally, community-based services changing to making initial appointments via telephone call instead of making home visits and relying on telephone calls to judge and assess risk (without sight of the dynamics of the household).

In respect to **relational security**, the COVID-19 pandemic has increased staff burnout, sickness and attrition rates. This has left organisations short of staffing and with increased usage of bank workers and less experienced staff such as student nurses. Whilst this helps to support the service and add resource to an already dwindling and burnt-out workforce, this also impacts the strength of the relational security in the workplace. For example, less experienced and/or unfamiliar staff may be less attuned to the need for boundaries in order to maintain a safe environment. Additionally, they may be less aware of the risks associated with those clients or patients they are working with. Clearly there are caveats associated with these organisational shifts during the COVID-19 pandemic.

Essentially, these changes in working practices, have shifted the dynamic in the Safety Triad and this can make safeguarding amidst a pandemic more nuanced and complex. Although, decision-makers (i.e. government officials, service and operational managers etc.) had good intentions in making organisational and system-based changes, as many of the decisions were either forced or based on necessity, it is fair to say that some of these impacts have made the systems in which we work potentially less safe.

**What does this mean for safeguarding?**
Taking into consideration the model for decision-making in safeguarding practice for psychologists, below are some examples of how safeguarding has been affected by COVID-19 and led to changes in the systems (layers) in which we operate more widely. This can be seen to have impacted on procedural, physical and relational security too:

- **The removal of protective factors that may have mitigated risk of harm towards self or others.** For example, community-based projects shutting down due to governmental/societal factors (i.e. lockdown measures, self-isolation).
- **COVID-19 has acted as a catalyst for organisational change,** decision makers have seen this as an opportunity to make significant transformations to how services are run. For example, in response to the crisis, the risk criteria of community-based services may have changed to manage the demand, adding another barrier for those to access services that were previously deemed appropriate. Organisational changes have occurred not just in response to the crisis, unrelated changes have been made too. This has taxed professionals who are already overladen with changes and increased pressure due to the pandemic.
- **Professionals** have found themselves expecting to continue with ‘business as usual’ after the initial anticipatory anxiety prior to and at the start of the pandemic. Already large caseloads were increased and there have been unrealistic expectations placed upon those still working throughout the pandemic. The importance of reducing arousal levels and the need for thinking space seemingly deprioritised. Stress, burnout and low morale has been a common feature in those who provide frontline care for those in need. This has inadvertently impacted on the care received by patients/clients and can lead to higher attrition rates of staff, with those who know their patients/clients well leaving the workforce. This can impact the robustness of relational security.
- **Supportive networks for families and carers** have significantly reduced due to lockdown measures. Local infrastructures that individuals and families relied upon have been limited and/or have operated at a reduced capacity. These community and social factors impact safeguarding in multiple ways for example preventing people from accessing respite (such as sports clubs, education, activities, and employment away from those perpetrating abuse) and reducing the ability to monitor individuals’ mental state and risk.
- **Peer relationships** have changed during COVID-19. For some virtual or phone contact has enhanced people’s experiences. However, for the digitally excluded or low-income households which are not blessed with high-speed internet (or inpatient services with a lack of Wi-Fi connectivity) this has posed problems in keeping people connected. This can negatively impact the individual’s mental state, and lead them to feel isolated from those who enhance their life. It could also render them vulnerable to more online abuse on social media or successful phishing attempts (i.e. due to others taking advantage of their lack of confidence in using technology). The latter could indicate weaker physical security due to a lack of security measures on their devices. Within inpatient settings, procedural security would also be compromised due to it being impossible to employ robust monitoring of individuals’ devices.
- **Education** is an environment in which children can thrive, where they can feel safe and build trusting relationships with professionals. Moving to online based classroom learning can create barriers which reduce disclosures made to professionals. Teachers and other
professionals working in schools are less able to make detailed observations of children as their interactions are limited through online classrooms. Although schools remained open for children of keyworkers or at-risk children, many remained at home. Safeguarding issues may have been missed due to this.

- The impact of COVID-19 on mental health has been significant, it is likely that this could impact negatively upon parenting capacity, particularly if the relied upon support is less available than usual. The pandemic, lockdown measures, furlough pay, and increased use of food banks have inevitably placed strains upon those looking after children or vulnerable adults. Parents/carers and family have found providing the basic needs for their dependant harder than ever. The utilisation of less helpful coping strategies may have increased as a result (i.e. substance misuse and problematic alcohol use).

- Children or adults need to be at the centre of assessment and procedures regarding safeguarding. Professionals work with some of the if not the most disadvantaged members of society. The COVID-19 pandemic has affected these individuals the most. For some they are living in abusive environments and lack opportunity to escape. Protective factors that were present before, could have been compromised or inhibited through lockdown measures or self-isolation/shielding. For example, an elderly service user who has been asked to shield within the confines of his bedroom yet doing so would impact his mental state and subsequent risk. It can lead individuals to feel stuck between a rock and a hard place.

This article highlights some of the issues and pitfalls when it comes to safeguarding matters amidst a global pandemic, with the additional lens of the Safety Triad, most commonly used in secure settings.

The Safety Triad adds another dimension to enrich how we can think about safeguarding. Physical, procedural and relational security can influence each layer of the safeguarding model and flavour our safeguarding discussions. There are opportunities for learning and reflection upon the many layers of systems. Lessons learnt can help drive forward change which create safer systems and trauma informed organisations. Hopefully, this article sparks further thought about the situation we find ourselves in 2021. Professionals are likely to have experienced some, if not all, of the situations described above, despite the type of service or client/patient group they work with. Positively, lockdown measures have eased and there appears to be a return to some form of normality on the horizon. This may bring about a shift in the Safety Triad and along with it, a new homeostasis.

References: