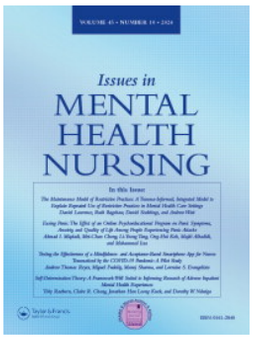

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Mental Health Risk Assessment and Safety Planning During UK Covid-19 Pandemic Lockdown: Mixed Methods Survey and Interview Study

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ABSTRACT

Risk assessment and safety planning are central to mental health nursing practice but were seriously affected by the Covid-19 pandemic and associated lockdowns. In this study, we aimed to explore how the UK pandemic lockdowns affected risk assessment and safety planning from the perspective of mental health practitioners. A sequential, mixed methods study design was used. A link to an online survey questionnaire was distributed and semi-structured interviews with a subset of respondents were conducted. Survey data were analysed to describe perceived changes in the frequency and nature of risk assessment and safety planning during the pandemic lockdowns. This was supplemented by thematic analysis of qualitative interview data. In total, 106 practitioners were surveyed and 10 participated in semi-structured interviews. More respondents increased than decreased risk assessment frequency but there was no significant overall change. Remote contact was more common in community settings and largely involved telephone appointments. Participants did not wish to continue with remote working following the pandemic. Risk assessment practice changed in UK mental health services as a result of COVID-19 lockdowns.

Introduction

Risk assessment is integral to the process of risk management whereby potential adverse outcomes are identified, evaluated, and mitigated; it features significantly in the daily work of mental health professionals, and some consider it to be one of the highest profile components of mental health practice (Department of Health, 2006; Healthcare Quality Improvement Partnership, 2018; Woods, 2013). Risk assessment and management has been described as a mechanism to enhance care quality (Flintoff et al., 2019) and to assure the safety of patients and staff (Rimondini et al., 2019). In the UK, the Department of Health (2007, p. 61) has defined risk as 'the nature, severity, imminence, frequency/duration and likelihood of harm to self or others'. Risk assessment in mental health practice can be focused on preventing adverse outcomes including aggression and violence, self-harm and suicide, self-neglect, and victimisation (Gunenc et al., 2018).

Appropriate risk assessment in mental health practice requires careful consideration of biopsychosocial factors using multiple information sources (Deering et al., 2019). It involves interpersonal, technical, philosophical, and intuitive aspects (Dickens et al., 2023). In addition to harm amelioration and improved mental health care, risk assessment and management are associated with increased quality of life (Vorstenbosch & Castelletti, 2020), proactive practice (Roberts, 2019), health professional collaboration (O'Rourke et al., 2018), autonomy and empowerment (Rimondini et al., 2019), and positive risk-taking (Reddington, 2017). Further, when conducted collaboratively, risk assessment has been linked with person-centred approaches (Markham, 2020) and shared responsibility (Slemon et al., 2017). A systematic review (Deering et al., 2019) investigated patients' perspectives on risk management practice and found that, when they felt involved, it was considered beneficial in terms of open communication and interpersonal relationships with healthcare practitioners. Despite the increasing acknowledgment of the importance of risk assessment in mental health practice, evidence about how consistently it is used is mixed (Markham, 2020). In one study just 10% of patients were involved in discussions about the risk assessment and management plans (Coffey et al., 2019) which may suggest a lack of shared understanding among mental health professionals.

Within this context, from March 2020 the Covid-19 pandemic created a situation in which mental health practitioners (MHPs) were required to maintain their responsibilities for care and assessment but in circumstances much removed from their hitherto usual practice. In the case of those working in the community this involved, to some extent, remote working. Given the importance of observation in risk assessment (Ayhan & Üstün, 2021; Muir-Cochrane et al., 2011; Woods, 2013) this had potentially major implications. For those based in inpatient units, the rules of lockdown also

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heightened potential risks to service users through isolation, loneliness, and the removal or other radical alteration of their regular support mechanisms. This study investigated the experience of risk assessment and management among mental health practitioners during the COVID-19 pandemic.

Methods

Aim and objectives

The overall aim was to better understand the risk assessment and safety-management planning-related experiences of mental health practitioners during and following the 2020 Covid-19 lockdown to inform future delivery. Specific objectives were to quantify the extent to which risk assessment and safety planning practice were perceived to have changed during the lockdown periods and to explore more deeply practitioners' personal experiences of conducting risk assessment during the lockdown periods.

Design

Northumbria University Ethics Committee approved the study protocol (Ref:34508). A mixed methods sequential design was selected to explore mental health practitioners' perspectives about risk assessment and safety planning during the UK COVID-19 pandemic lockdowns. Mixed methods studies are appropriate when researchers aim to gather a range of perspectives (O'Cathain et al., 2007). In this study we aimed to explore our literature-informed agenda about risk assessment during the pandemic lockdown using a cross-sectional survey and participants' lived experience using semi-structured online video or telephone interviews. The two methods were used sequentially, survey then interviews; the latter were informed by results from the former. The two methods were treated with equal weight and results were combined to explore convergence, divergence, and complementarity. The study is reported with adherence to the checklist for reporting of survey studies (CROSS; Sharma et al., 2021), the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007), and the good reporting of a mixed methods study checklist (GRAMMS; O'Cathain et al., 2008).

Setting and sampling

JISC© online survey data collection was conducted from June 2021 to September 2021 (opt in Geo-locking positive) and interviews in January and February 2022. The study setting was essentially the entire system of mental health services in the UK. This is largely a publicly funded service comprising primary, secondary, tertiary, and highly specialist services provided free at the point of need. Almost all services are delivered by the National Health Service with a small proportion delivered by for-profit and not-for-profit independent sector providers who nevertheless are funded direct from public monies. Inclusion criteria for the survey were: all care staff working in mental health services in the UK including in the NHS, social care, independent sector, and voluntary services. The exclusion criterion was working outside the UK. Survey recruitment was opportunistic via a hyperlink posted in relevant internet forums including the mental health nurse academics forum (www.mhnauk.org), the National Elf Service (www.nationalelfservice.net/forums) and a request to NHS Research & Development Departments to circulate study information including the hyperlink. Target sample size was predicated on a mental health professionally qualified clinical staff population of 115,300 (Health Education England, 2017). A sample size of 383 would allow population estimates with 95% confidence level (5% margin of error). JISC© online surveys does not as standard prevent multiple completions from the same computer or IP address. Survey participants were asked to provide email contact details if they were willing to participate in a one-to-one interview; all those who did were invited.

Data collection

Survey participants indicated informed consent through the survey platform. Those interested in interview participation were provided with an information sheet and individual, informed consent was taken by the researcher before conducting an audio-recorded interview via telephone or Microsoft Teams. Recordings were transcribed, pseudonymized and then wiped. No individual identifying details linked participants with their interviews. Recordings were supplemented with field notes made during or immediately following interviews.

An online questionnaire (available on request) was developed drawing on an extensive literature review (Dickens et al., 2023). We based some items on a survey instrument developed in Ireland (Downes et al., 2016; Higgins et al., 2016) for which permission was granted to modify for use in the current study (Higgins, personal communication). The questionnaire requested personal demographic and professional characteristics; information about frequency of risk assessment for specific outcomes during the pandemic lockdown (8 items); change in frequency from before the lockdowns (8 items); risk assessment practice during lockdown and change in practices from before lockdown for both existing and new cases (both 7 items); use of digital technology during lockdown (5 items); safety planning practice during lockdown and change in safety planning practice from before lockdown (16 items each); and perceptions about risk assessment and safety planning during the pandemic lockdowns (9 items). Data were collected on a series of unipolar (0 = Never/Hardly ever, 1 = Occasionally, 2 = About half the time, 3 = Usually, 4 = Always/almost always) scales for items related to frequency and Likert scales for data about change in frequency (-2 = Much less frequently than before the lockdown; −1 = Less frequently than before the lockdown; 0 = About the same as before the lockdown; 1 = More frequently than before the lockdown; 2= Much more frequently than before the lockdown). Data about perceptions was also collected on 5-point Likert scales (-2 = Strongly Disagree to 2 Strongly Agree). In phase two,

individual interviews were conducted by RI (male) and FW (female), both experienced qualitative mental health nurse academic researchers with a PhD, using a semi-structured questionnaire (available on request). Questionnaires were pilot tested with $n=3$ mental health nurses enrolled on a Masters level degree programme and amended based on feedback. Interview items built on issues investigated in the questionnaire survey and were designed to explore risk assessment practice during the lockdown in greater detail including any difficulties, challenges or perceived benefits of remote or otherwise changed practice, the impact of those changes, the support and development that may be needed should those practices continue or be implemented again, and the response of service users to changes to risk assessment practices during lockdown. Interviewers used prompts to elicit detailed information. There was no a priori relationship between the interviewer and the participant and the interaction between them was limited to a maximum of two sessions. Interviewers were clear about their own status as academics with no clinical role and therefore their experience of the phenomenon under investigation was limited to their contact with nursing students on practice placement and health service employees on educational programmes. In line with the study protocol interviewers were clear about their position as broadly supportive of risk assessment and safety planning practices. Interview transcripts were not returned to participants for member checking.

Data analysis

Survey data were exported from JISC© into the Statistical Package for Social Science (SPSS) version 26.0. Descriptive statistics (Mean, 95% CI) were calculated for frequency, change and perception variables; no weighting or adjustment of variables was conducted. Mean reported change in practice from before the lockdown period was interpreted via inspection of 95% CIs. For frequency of assessment for specific risks and for risk and safety planning perceptions we also calculated the proportion of respondents reporting indicating more, less or about the same frequency of assessment and agreement/disagreement or neutrality with statements about practice in the lockdown. Repeated measures t-tests were used to examine differences between how participants undertook practice with newly referred cases compared with existing cases. Independent t-tests were conducted to examine differences between those working in inpatient versus all other settings. Quantitative analysis was conducted by GLD and MAM. Qualitative analysis was informed by Braun and Clarke (2006) six-phase thematic analysis: i) familiarisation with data through reading and re-reading transcriptions of interviews; ii) initial coding of data; iii) tentatively generated initial themes encompassing codes; iv) review of themes; v) definition of themes; vi) writing of thematic analysis. Initial qualitative coding was conducted by FW with a sample independently coded by GLD. Coding was inductive and was initially conducted in Microsoft Word. Initial codes were assigned to blocks of text; codes were organised into loose collections of seemingly related themes and interview text transferred into tables reflecting initial themes. There was an iterative process of discussion and reorganisation of themes and quotes representing themes conducted by GLD, FW and RI. Final themes were agreed by the entire research team. Integration of qualitative and quantitative findings involved comparison of quantitative results with qualitative themes to highlight areas of convergence, divergence, and complementarity. This was done by three of the researchers (GLD, FW, RI) and then circulated among the research team for comment and amendment.

Results

Sample

A total of 140 mental health professionals responded to the survey; of these, 138 (98.6%) provided valid responses to all non-demographic questionnaire items. This represents a response rate of 0.12% of NHS professional staff employed in mental health services (Health Education England, 2017). $N=106$ of these individuals (76.8%) responded 'yes' to the question: "Do you conduct risk assessments and/or safety planning arising from risk assessments as part of your role? (By risk assessment we refer to the estimation of the likelihood, nature, severity, frequency or circumstances of behaviour with adverse consequences" and we did not use their responses about risk assessment during the pandemic. This is the sample described in this paper. Nurses comprised 59.4% of the sample compared with 58.9% of the national total; other professionals included psychiatrists and psychologists (7.5% and 8.5% respectively), managers (4.7%) and allied healthcare professionals (19.8%). Most worked in the UK National Health Service (93.4%). Thirty-two respondents were invited into the interview phase of the study and ten subsequently participated (see Table 1). Non-participation was due to failure to respond to follow-up communication offering an interview date and time and failure to establish a suitable time for an interview. Interviews lasted from 23 to 58 min (mean = 35 min).

Survey results

Assessment for specific risk outcomes

Participants reported conducting risk assessment for eight outcomes prior to the pandemic lockdown and change in frequency during lockdown. Mean frequency prior to lockdown ranged from 2.82 (other forensic issues; mean in the range 'about half the time' to 'usually') to 4.03 (suicide; mean in the range 'always/almost always), representing, for the other six outcomes (self-harm, violence, victimisation, self-neglect, physical health, non-adherence), a mean frequency between in the range 'usually' and 'always/almost always'. During the pandemic lockdown period the mean change was, for all but one outcome, between 1.12 (victimisation) and 1.47 (self-neglect) representing average change between 'more frequently and 'much more frequently'. For the assessment of 'other forensic' issues there was an increase in mean frequency of 0.91. However, 95% CIs for change in

Table 1. Interview study participant characteristics.

	Age Group	Gender	Education	Years of Experience	Profession	Community/ Inpatient role	Had RA, RM Training	Using RA	Interview mode
Sam	26–35	Female	Bachelor	5	Registered Nursing Associate	Community	Yes	Yes	Audio/Visual
Kendra	46–55	Female	Postgraduate	17	Psychological Therapist	Community	Yes	Yes	Audio/Visual
Justine	46–55	Female	Bachelor	20	Team leader Nursing	Community	Yes	Yes	Mixed
Carole	36–45	Female	Postgraduate	26	Nurse consultant	Inpatient	Yes	Yes	Face-to-Face
Alia	36–45	Female	Bachelor	5	Nurse	Community	Yes	Yes	Audio/Visual
Naz	26–35	Female	Postgraduate	3	Assistant Psychologist	Inpatient	Yes	Yes	Mixed
Richard	46–55	Male	Bachelor	26	Nurse	Inpatient	Yes	Yes	Mixed
Maisie	26–35	Female	Bachelor	5	Nurse	Inpatient	No	Yes	Face-to-Face
Stella	18–25	Female	Bachelor	2	Student nurse	Inpatient	Yes	Yes	Mixed
Rod	36–45	Male	Bachelor	10	Mental health practitioner	Community	Yes	Yes	Mixed

Type of Patients Contact.
- Face-to-face in-person.
- Audio/Visual via telephone and/or web-based.
- Mixed (Face to Face/ Audio/Visual).

assessment frequency all included zero indicating no significant overall change. Inpatient-located and other staff did not differ in change in frequency of any specific risk assessment.

Risk assessment practice and process

Inspection of 95% CIs indicated that, overall, respondents reported no significant changes in their risk assessment practice: for their existing caseload or for new referrals. However, new referrals were more likely to be seen on online platforms during the pandemic lockdowns ($t = 2.93$, df = 105, $p = 0.004$). Inpatient-located staff were less likely to have shifted to remote delivery of risk assessment ($t = 2.58$, df = 104, $p = 0.011$) and to telephone delivery specifically ($t = 3.04$, df = 104, $p = 0.001$).

Access to technology

Mean ratings of statements about use of digital technology represented for all items indicated overall responses in the 'neither agree nor disagree' to 'agree' range (0.62 to 0.94). Items related to service users' level of access to suitable technology for web-based communication, suitability of web-based consultation per se, confidence with web-based consultation, technical problems during web-based consultations, and confidentiality issues during such consultations. There were no significant differences between inpatient-located respondents and others on any measure related to access to technology.

Safety planning practice

Respondents' Mean (95% CI) frequency of use of and pre-post pandemic change in use of safety planning practices were examined. Compared with ward-based staff, community-located respondents 'asked service users what they need to do to keep safe' (Mean 3.35 [0.71] vs. 2.99 [0.76], $t = 2.04$, df = 104, $p < 0.05$); and would liaise with the service user's general practitioner (3.35 [0.93] vs. 2.94 [0.75], $t = 2.18$, df = 104, $p < 0.05$). There were no significant pre-post lockdown change in practice. The most commonly reported practices were 'including positive risk-taking opportunities' and 'record a long term safety plan' while less commonly reported ones were police referral and increased frequency of contact.

Risk assessment and safety planning perceptions

There was majority disagreement that organising risk assessments had been easier during the lockdown (84% disagree or strongly disagree); that the accuracy of practitioners' risk assessments had improved in the period (92.5%); that stress and anxiety specifically about risk assessment had increased (75.4%); that remote risk assessment would be preferred going forward (88.7%); that service users preferred remote arrangements in the lockdown period (70.8%); that safety planning had been easier in the lockdown (67.9%). On the other hand, there was majority agreement that practitioners' confidence in their risk assessments had agreed during the lockdown (61.3% agree or strongly agree); and that risk and safety planning outcomes had improved during the lockdown (84.9%). There was no overall majority in respect of whether risk assessment-related practice had been easier during the lockdown (47.2% neither agree nor disagree).

Interview results

The six-stage analysis revealed two themes: i) change and continuation in practice; ii) impact on people and relationships.

Change and continuation in practice

Participants described an almost complete hiatus on assessment related to community leave from hospital due to widespread curtailment of leave during this period:

> in terms of the standard risk assessments we do around leave, they all came to a halt during the pandemic because there was no leave. [Naz]

This reportedly impacted on service user progress due to their inability to demonstrate advancement through graded exposure to the community, a situation described by Naz as

regressive in which risk assessment became "… just very much managing the risks within the inpatient setting due to boredom, agitation, and just being stuck…".

Participants said the pandemic itself forced them to consider new elements of risk including the spread of the infection, how and whether they could mandate mask-wearing, handwashing, social distancing measures, Covid-related vulnerabilities of individuals, ward environments, and new community circumstances. Working in the community, Justine described "just being very careful about the screening process" and identified a new layer of risk assessment involving a brief telephone conversation with service users to inform whether to ask them to attend an online session or a face-to-face clinic. For new referrals, more information than before was sought from referrers to inform a decision about need for in-person or online assessment.

Some participants noted that higher echelons of management became involved in clinical decision-making around risk in a way that was not part of pre-pandemic practice. Maisie described how clinical decisions taken were subject to unprecedented scrutiny:

> the main difference that we had is that the service manager for our site had to coordinate and discuss things with our chief operating officer. So things that we would never normally discuss… with our service manager let alone the chief operating officer, but because the default was no one has leave… we had to ramp up the scrutiny really, the levels of authorization. [Maisie]

Interview data revealed little about changes to the frequency of risk assessment during lockdown; however, for Alia and her community-based colleagues, the pandemic lockdown facilitated an additional multidisciplinary (MDT) team meeting to be held each week:

> We used to have one MDT a week where we've discussed referrals, assessments, and… cases for concern… now we have a meeting on a Tuesday afternoon, which is our main MDT. We'll have a little catch up on a Thursday afternoon where we discuss any cases for concern and any other assessment feedbacks. So, we're doing it twice a week now. [Alia]

For some participants, risk assessment practice remained unchanged despite new modes of delivery:

> that's one thing that's been good. We've definitely continued with asking our typical risk assessment, no matter what sort of method we've switched to. [Kendra]

Participants described benefits and drawbacks of the shift to remote delivery of risk assessment. Reported benefits included efficiency and, paradoxically, the time to spend more time in contact with service users. Speaking about her community-based colleagues, Justine said:

> [they] feel there's less time spent out on the road. There's less travel time. Because we have a vast area. We can actually see more people… people can work remotely and still keep in touch with patients. [Justine]

Similarly, Alia found the transition to remote working encouraged diligence in maintaining regular contact:

> as you progress through, you start to look at risk very differently. maybe that time working from home gave me [the opportunity] to do that, because I had more time. I had more contact with my patients actually because I was ringing them every week just to check in because I didn't want anybody to relapse or struggle. So there was… maybe people felt more contained and that managed risk. [Alia]

Despite this there was a reported sense of 'not getting the full picture' from remote working:

> I found when I was trying to navigate managing risk in a community placement and asking those questions around people's risk quite difficult. Trying to do that over the phone with people because people can mask things, people can say 'yeah, yeah, everything's alright'. I did find it difficult and there were certain times where I thought, what if somebody was in crisis? Body language I count a lot… somebody might say they're not suicidal, but you could maybe tell from their body language the way they communicate or their eye contact, you might think this is not adding up… you can detect, but over the phone, I would say it's a change. [Justine]

There was little apparent dissatisfaction with the technology available or the support from managers to use web-based and telecoms-based communications. However, even with video link appointments, concerns were expressed about not getting the full picture from remote assessment. One problematic example was highlighted by Justine, a team leader in a community eating disorder service,

> We had been encouraged to do video link appointments, telephone appointments, and on one occasion with a young person we had used that. And then when we actually saw him face to face, his weight had gone down dramatically. [Justine]

Impact on people and relationships

There was a shift in perception, particularly among nursing staff, about the weight of individual responsibility for risk assessment during the lockdown period. This was most apparent in inpatient settings where the physical absence of other multidisciplinary team members left nurses feeling the weight of potential consequences of risk-related decisions:

> but in reality, and it happened to me on many occasions, would be you'd speak to [a service user] they'd be in a risky situation., you can't leave someone if they're in danger… so the reality was that the risk sat with myself… whereas previously it had been an MDT decision and it'd be shared responsibility. I did make the phone calls and I did try to pass the responsibility and share that around, but then they [team members off the ward] were like, you are there… we support you in that. I found that quite difficult. [Maisie]

Respondents described considerable levels of uncertainty. For Naz, working in an in-patient setting, this was exacerbated by a perceived lack of detail in official messaging:

> I've never seen a situation like this and it was very much going off pure hypotheticals. We didn't really have a lot of communication from the government. We just got told you're not allowed out. And that's how it's got to be. [Naz]

This led to frustration for staff who could offer no firm timescales to service users regarding restrictions on leaving

the unit. This reportedly impacted on service users themselves and would "increase the frustration, which would increase the difficult dynamics on the ward, which would increase the agitation… they were very fixated on dates in terms of how long discharge will be, how long all these assessments take… no one had any answers for them and it made it incredibly difficult" [Naz].

Concurrently, respondents recalled boredom and some distress among service users due to loss of family and other social contacts, and routines:

> I found during COVID, I' had to provide a lot more reassurance. That is because family and things weren't able to come in. There's a lot of restrictions on who can and who can't come. So, for instance, I've had to provide a lot of reassurance… to the patient. [Carole]

There was a perceived change in risk behaviours, in part due to increased difficulty in moving or transferring service users during the pandemic: "We've got people who really should be in seclusion on a PICU who are getting placed in acute admissions, just because there are no beds, not even in the private sector" [Carole]. But some of the change in service user behaviour was linked to measures introduced to manage the spread of Coronavirus: "So we did see a massive increase in them pulling the face masks off our face, spitting at us, punching, assaulting" [Maisie].

Integration of quantitative and qualitative findings

Quantitative and qualitative findings were largely complementary. Survey results indicated increased vigilance around a number of specific risks during lockdown. Interviews suggested nuances around specific issues, most notably for leave of absence which, for inpatients, mostly ended for large periods of the lockdown. We did not ask about risk assessment for COVID-19 in the survey, however it was highlighted in qualitative interviews as a prominent risk concern. Survey results indicated little change in practices and processes related to risk assessment beyond the actual shift to remote modes of delivery and this was supported in interview data. Access to suitable technology was not rated an issue in either survey or interview data. Interviews indicated some wholly new aspects including the self-insertion of senior managers in the clinical decision-making process. Reflecting the demands on services, survey results indicated that, where there was change, safety planning practice became more conservative with respondents reporting greater inclination to ask service users if they would like them to remove items of risk or to call in the police for support. Qualitative interviews highlighted the difficulty of making plans during the lockdown period. Survey results suggested the period was not experienced by respondents as easier than pre-lockdown, but most also said it had not caused more stress and anxiety than before, and there was no apparent desire to continue new practices in the future. In contrast, qualitative data picked up some nuances around increased stress and anxiety, particularly for inpatient staff, linked to increased risk of patient aggression, patient-patient conflict, and increased responsibility on nurses to make decisions. Interviews highlighted a range of other issues linked to uncertainty, poor communication, and lack of clarity about COVID-19 messaging.

Discussion

The Covid-19 pandemic lockdowns necessitated rapid changes to mental health practitioners' working lives. We conducted a sequential mixed methods study about their experiences of risk assessment and safety planning practice during this time. There were two main insights drawn from mixing survey and interview data. First, survey data suggested that more respondents had become more conservative in their practice than had become less so during the lockdown period. This may not be surprising given that stressful life events, like the COVID-19 pandemic, are associated with more risk averse behaviours (Cerami et al., 2021). However, most respondents reported that their risk assessment practice remained about the same as pre-lockdown. While respondents had adapted to the changes necessitated by lockdown, and could even see some benefits, there was no quantifiable demand for new working practices to remain in place once restrictions were lifted. Interview data added nuances about specific difficulties associated with risk assessment practice in the lockdowns that we were not able to anticipate when devising questionnaire items. These included risks arising from the pandemic lockdown itself including risk of infection in the inpatient environment, and the added jeopardy of increased boredom and social friction brought about by changes to leave and visiting arrangements.

Some experiences were shared irrespective of whether respondents worked in inpatient or community settings. For inpatient staff, the focus of risk assessment activity changed significantly because service users were subject to restrictions on off-ward activity including leave of absence. Similarly to Johnson et al. (2021), practitioners described having to manage strained inter-patient relationships and patient boredom due to restricted activities as emerging challenges for risk assessment and safety management. It would be wise for managers and clinicians in inpatient services in particular to consider contingencies in the event that future lockdowns occur. This could include building capacity and infrastructure for digital communication in services.

The need to work remotely impacted on both inpatient and community-based staff risk assessment activity. For inpatient staff, online platforms were essential in maintaining contact with the multidisciplinary team as most non-nursing professionals were working from home during lockdowns. Multi-disciplinary working is a key aspect of mental health practice, with professionals adopting a shared approach to decision making and planning where possible (Reeves & Fletcher, 2018). However, participants' experiences suggest professionals may have difficulty engaging in this when not actually in the physical care environment, with reports that decisions were left predominantly with on-ward nursing staff with responsibility for 24-h face to face care. In contrast, for community staff, there was a sense that the shift to remote working, particularly online platforms like

Teams and Zoom, had transformed the team working aspect of their role, facilitating better contact and more frequent meetings to support risk assessment and management. This supportive multi-disciplinary context to individual practice is required across all services if options to work from home are maintained post pandemic (Johnson et al., 2021). Therefore, clear agreements need to be in place regarding shared decision making and team responsibility and these will need to consider the needs of all staff in inpatient and community roles.

There were limited concerns about deleterious aspects of the shift to remote working. This might have been an acceptance that there was no choice. Importantly, most responses about continuing the practice post-lockdown were negative suggesting no enthusiasm for a protraction. Participants identified being able to ask the same questions of service users, to continue with the use of risk assessment tools, and, once the initial change was accepted, they felt confident in the outcome of risk assessments undertaken. This confidence in the ability to undertake remote contact suggests standards of risk assessment can be maintained and is an important consideration should future circumstances demand a return to working in this way. Perhaps counter to expectations, remote risk assessment practices in relation to service users most commonly involved telephone rather than online contact, but it was unclear whether this reflected practitioner or user preference, or a lack of access to essential technologies among users. In identifying suicide risk, Simon et al. (2021) suggest the concerns about remote assessment are linked to institutional liability issues rather than true patient safety concerns. However, we found, the lack of physical face-to-face contact was a real concern for community practitioners. Observation of the person's verbal and non-verbal behaviours is an important component of mental state examination (Huggins et al., 2019) and the lack of in-person contact raised the potential for important and pertinent information to be missed. The loss of observational opportunities places an onus on practitioners to rely on listening skills to notice speech content, clarity, tone, intonation and flow. Balanced against this were reports that remote working meant that practitioners contacted more people more frequently. Significant time was saved by not travelling, particularly by those working in rural areas. This may be an advantage given the current workforce crisis in health care, with over 13,000 registered mental health nursing vacancies in England (Royal College of Nursing, 2022); any strategy that offers more efficient means of care delivery will appeal to service providers. Should remote appointments continue in the future then risk assessment practices and training will need to reflect this. Such changes could offer more flexibility for service users, but the implications should be examined thoroughly.

We investigated risk assessment practice during a very difficult period and caveats about the validity of comparability should be observed when examining results in the context of previous research. We used a tool similar to that developed by Higgins et al. (2016). One section required participants to estimate the frequency with which they carried out various safety planning practices. Respondents in Higgins et al. (2016) survey ranked 'include positive risk-taking activities' 14/16 in terms of frequency while those in our sample ranked it as 1/16. Participants in Higgins et al. (2016) ranked 'ask the person what they need to do to feel safe' 1/16 while our sample rated it 7/16. Other divergences related to 'identify harm minimisation strategies' (2/16 in Higgins et al., 2016 vs. 6/16 in current sample) and 'develop a long-term safety plan' (7/16 in Higgins et al., 2016 vs. 2/16 in current sample). These differences may reflect different practice during Covid-19, or reflect different practices in Ireland and the UK. There is a need for valid measures of risk assessment practice and attitudes to facilitate longitudinal and comparative research.

Limitations

The main limitation of the survey was the low participation rate. This may reflect a sense of research fatigue that has been noted to have grown during the Covid-19 pandemic (Patel et al., 2020), or may be related to high workload during the survey period. As a result the margin of error for 95% confidence level in our sample is 8%. Further, we have previously noted a lack of valid instrumentation to capture attitudes about risk assessment (Dickens et al., 2023) and the survey instrument used here was devised for the study based on existing non-validated tools (e.g. Downes et al., 2016). It was also disappointing that of 32 participants who indicated an interest in participating in supplementary interviews, only 10 did eventually accept the offer. This could have contributed to suboptimal variability in the sample and may indicate that data nay not have been maximally rich.

Implications for practice

The Covid-19 pandemic lockdowns are over but there should be proactive planning for future scenarios to support service users and staff. The lockdowns may have catalysed inevitable changes to practice including remote working that may otherwise have unfolded over years rather than months (Phillips, 2020). It is important that those changes are carefully evaluated to ensure that only the valuable ones are retained. Central to this should be to ascertain their impact on service users. At a time when there is a recognised need to improve shared decision making (Markham, 2020) with service users and carers then they must also be involved in this process. As in wider society, Covid-19 and the subsequent lockdowns had a considerable impact with services users and staff deeply affected both practically and personally. There was uncertainty for service users, particularly those in inpatient services, regarding their status, their recovery, and their progress to discharge. The pandemic initiated a major change in how healthcare staff use remote communication; considerable and rapid changes to practices were required. Whilst face to face contacts have increased significantly post pandemic, it is likely that some aspects of remote working will continue at a higher level than before (Simon et al., 2021). Therefore, it is important that risk assessment and

management practices are developed to reflect this change. Staff must feel supported within a multi-disciplinary decision-making process to deliver this aspect of practice. Assessment tools need to be reviewed to consider the changed context of remote contact and procedural issues should be addressed. The pandemic brought about an enforced change and our findings indicated little enthusiasm for continued use of remote working. Its practice therefore needs to be carefully considered in relation to service user, staff and organisational need.

Ethics statement

The study was approved by Northumbria University Faculty of Health and Life Sciences Research Ethics Committee

All authors declare they have no conflict of interest.

Authorship statement

Study conception: GLD, FW
Study design: GLD, NH, RI, CK, MS, FW
Data collection and extraction: MAM, FW, RI
Data analysis: GLD, MAM, FW, RI, FW
Drafting the study: All
Approval of the final version: All

The following are available on reasonable request from the corresponding author: anonymised raw survey and interview data.

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