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FEATURE ARTICLE

There is more to risk and safety planning than dramatic risks: Mental health nurses' risk assessment and safety-management practice

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ABSTRACT: *Risk assessment and safety planning are considered a cornerstone of mental health practice, yet limited research exists into how mental health nurses conceptualize 'risk' and how they engage with risk assessment and safety planning. The aim of the present study was to explore mental health nurses' practices and confidence in risk assessment and safety planning. A self-completed survey was administered to 381 mental health nurses in Ireland. The findings indicate that nurses focus on risk to self and risk to others, with the risk of suicide, self-harm, substance abuse, and violence being most frequently assessed. Risk from others and 'iatrogenic' risk were less frequently considered. Overall, there was limited evidence of recovery-oriented practice in relation to risk. The results demonstrate a lack of meaningful engagement with respect to collaborative safety planning, the identification and inclusion of protective factors, and the inclusion of positive risk-taking opportunities. In addition, respondents report a lack of confidence working with positive risk taking and involving family/carers in the risk-assessment and safety-planning process. Gaps in knowledge about risk-assessment and safety-planning practice, which could be addressed through education, are identified, as are the implications of the findings for practice and research.*

KEY WORDS: *Ireland, nursing practice, risk assessment, risk management, safety planning mental health.*

INTRODUCTION

Risk assessment and safety planning, or what some people term 'risk management', are considered the 'highest profile tasks of mental health practitioners' (Woods 2013, p. 807) and a central component of mental health nursing. The manner in which risk is assessed and safety assured in mental health services are issues of concern to all stakeholders, including people who use services, family members, practitioners, the general public, and policy makers (Higgins *et al.* 2015). Historically, risk assessment and management within mental health have been viewed primarily from the perspective of assuring public safety (Rose 1996). Consequently, emphasis was on 'dangerousness' and 'dramatic risks', which in recent years has been fuelled by high-profile cases of homicide involving people with a history of mental health problems (Muir-Cochrane *et al.* 2011), the growth in literature that perpetuated the idea that all risks can and should be identified and prevented (Higgins *et al.* 2015), and the development of the availability of actuarially-based risk-assessment tools, which attempt to identify individuals' potential for violence or the risk of

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suicide (Doyle & Dolan 2002; Godin 2004). However, it is acknowledged that screening and prediction are very much an inexact science beset with false positives and negatives (Woods 2013).

Similar to international policy, in recent years, Irish health policy has positioned mental health within a recovery-oriented framework (Department of Health and Children 2006; Mental Health Commission (MHC) 2007; Mental Health Reform (MHR) 2012; Health Service Executive 2014), reflecting an intention to include recovery-oriented care as a key component of clinical nursing practice. The concept of recovery is not without debate, with authors differentiating between clinical recovery and personal recovery. Clinical recovery frequently refers to a reduction or elimination of clinical symptoms, and is defined and measured by health professionals using objective criteria or tools developed by researchers or clinicians (Higgins & McGowan 2014). In contrast, personal recovery is 'a journey of discovery', where the person develops 'personal resourcefulness…control, a positive sense of self… and rediscovers their voice and a belief in their ability to live a meaningful life, despite the presence of challenges' (Higgins 2008, p. 7). While recovery is a personal process that belongs to the service user, practitioners can facilitate that process by providing a recovery-oriented approach to care.

One aspect of a recovery-oriented approach is the ability to engage with therapeutic or positive risk taking, which might 'involve the person taking on new challenges leading to personal growth and development' (Slade 2009, p. 177). At the same time, positive risk taking must be balanced with the service users' and wider public's right to be guarded from unwanted negative outcomes (Morgan 2000). Best-practice guidance around a recovery-oriented approach to risk identifies a number of key factors for effective assessment and safety-planning processes. These include widening of the risk construct beyond 'dramatic risk' to include positive or therapeutic risk, promoting the person's autonomy and control (Boardman & Roberts 2013; Slade 2009), collaborating with service users in the assessment and safety-planning process (Department of Health UK (2007); Health Service Executive (HSE) 2009; Boardman & Roberts 2013), building on strengths and protective factors, using a combination of clinical judgment and actuarial methods (tools) to assess an individual's risk, taking a multidisciplinary and multiagency approach towards risk, and recognising the dynamic and fluid nature of risk (Muir-Cochrane *et al.* 2011; Department of Health and Children 2006; Department of Health UK 2007; Health Service Executive (HSE) 2009).

Risk and mental health nursing

A comprehensive search of peer-reviewed published works indexed in the databases CINAHL, Medline, PsychInfo, PubMed, Wiley, Academic Search Complete, and ProQuest Nursing & Allied Health Source, as well as the *Social Science and Medicine* journal was conducted. The search key words used in various combinations were 'risk assessment', 'risk management", 'safety planning', 'mental health', 'mental illness', 'psychiatric', 'nursing', 'self-harm', 'suicide', 'self-neglect', 'exploitation', 'forensic', 'violence', 'aggression', 'substance misuse', 'clinical decision-making', 'decision-making', 'confidence', 'attitude', 'knowledge', and 'practice'. This was supplemented by a search of Google Scholar in order to identify relevant grey literature on the topic.

Despite academics' repeated claims that risk assessment and safety planning are core aspects of mental health nurses' role (Crowe & Carlyle 2003; Cusack & Killoury 2012; Woods & Kettles 2009), limited research exists into how nurses conceptualize 'risk', or how they engage with assessment or safety planning, or include the promotion of safe and positive risk-taking opportunities in the context of the shift towards recovery-oriented care. Research that is available suggests that mental health nurses continue to define risk as a negative and harmful phenomenon located within the individual, and one which needs to be assessed, managed, and prevented (Clancy *et al.* 2014; Woods 2013). In terms of assessment practices, studies describe nurses' reliance on informal unstructured processes, intuition, and 'gut feelings' to guide their assessment. One study was located that reported nurses using validated tools or derivatives to guide their practice (Godin 2004). While some of the community mental health nurses ($n = 20$) in Godin's study reported using tools, they still favoured clinical judgment and 'interpretative' approaches, and relied heavily on their own 'instinct' to guide assessment. In addition, ineffective safety-planning practices were also found, with studies highlighting the dissociation between risk-assessment and safety-management plans (Gilbert *et al.* 2011; Langan & Lindow 2004; Woods 2013). In particular, little evidence of proactive safety planning and therapeutic risk taking was located, with a focus instead on crisis intervention (Delaney *et al.* 2001; Muir-Cochrane *et al.* 2011; Murphy 2004; Raven & Rix 1999; Trenoweth 2003; Woods 2013). Reports of other disconnections between the risk-assessment process and the formulation of a safety plan included some studies reporting that risk-assessment and safety-planning practices were characterized by incomplete and inconsistent assessments, safety plans that were not informed by assessments, inconsistent documentation of risk,

and a lack of ongoing review of risk and safety plans (Delaney *et al.* 2001; Gilbert *et al.* 2011; Godin 2004; Woods 2013). In the absence of research in this area, and in an attempt to inform the development of an education programme and best-practice guide on risk and safety planning within a recovery ethos, a study was conducted into the risk-assessment and safety-planning practices of mental health nurses within a number of mental health services in Ireland.

Objectives

The objectives of the present study were to:

- Explore mental health nurses' practices in relation to risk assessment and safety planning
- Identify mental health nurses' confidence in relation to risk assessment and safety planning
- Identify to what extent mental health nurses adopted the principles of recovery in their practice in relation to risk
- Identify mental health nurses' training needs in relation to risk assessment and management.

RESEARCH DESIGN

In the absence of a validated instrument, a self-completed, anonymous survey was developed by the research team to collect the data. The structured format of the survey allowed a large amount of baseline information about mental health nurses' risk-assessment and safety-planning practice to be collected. This approach also ensured the anonymity of respondents, which is important for reducing the likelihood of socially-desirable responding (de Vaus 2013).

The first section of the survey collected demographic information on respondents, including age, sex, highest level of education, nursing role, area of work, number of years qualified as a mental health nurse, and prior education in relation to risk assessment and safety planning. Practices in relation to risk assessment were examined by asking respondents how often they consider a range of issues from a list of 28 items when they completed a risk assessment. The response category options were 'never', 'rarely', 'frequently', and 'always'.

Practices in relation to safety planning were similarly examined by asking respondents how often they engaged in a range of actions from a list of 21 items when they developed a safety plan. The response category options were 'never', 'rarely', 'frequently', and 'always'. Respondents' confidence in relation to risk assessment and management were also explored. Confidence was measured using a 12-item Likert scale developed by the research team, which asked respondents how confident they perceived themselves to be on a scale of one (no confidence) to five (very confident). In addition, respondents were asked some questions about personal views, policies and procedures, education provided, and their training priorities (tool available on request).

The face validity of the survey was established by asking four qualified mental health nurses employed as clinical nurse specialists in the area of suicide and self-harm to review the survey and provide feedback in relation to its relevance and appropriateness, as well as to identify any gaps in the survey. The internal reliability analysis of the confidence scale resulted in a Cronbach's alpha level of 0.948, which indicated a highly-reliable scale.

Ethical issues

Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College, Dublin, Ireland, while area directors of nursing from the seven Health Service Executive (HSE) regions participating in the study granted permission to recruit registered mental health nurses from within their respective regions. Each respondent received a pack containing an information leaflet, survey, and a prepaid envelope for return of the survey. Respondents were assured anonymity, and voluntary participation was emphasized through the study information. Completed surveys could be returned directly to the research team in the envelope supplied, or returned centrally to the gatekeeper who forwarded them on to the team. Return of the survey was taken as consent.

Inclusion and exclusion criteria

Mental health nurses registered with the Nursing and Midwifery Board of Ireland, and employed either full time or part time in adult mental health services in one of the participating sites, were eligible to participate in the study. Mental health nurses working as agency staff or nursing students were excluded from the study, as were mental health nurses working in child and adolescent services or in old-age psychiatry.

Recruitment and data collection

The study was conducted in seven HSE regions in Ireland with wide geographical coverage. Key stakeholders in each region facilitated the recruitment of nurses to the study by distributing hard-copy study information packs to all potentially-eligible respondents. It was estimated that there were approximately 1320 eligible mental health nurses to whom the survey could be distributed. A total of 381 eligible surveys were returned, representing an approximate response rate of 28.9%.

Data analysis

Statistical analysis of responses to the survey was performed using the Statistical Package for the Social Sciences (SPSS), version 21 (International Business Machines 2011). Descriptive statistics, including frequency distributions, means, and standard deviations (SD), were generated to describe the data. Bivariate analysis was also conducted to highlight patterns in variable means or proportions broken down by key demographic variables of interest. The types of parametric or non-parametric inferential tests used were determined by level of measurement and assumptions of normality tests. Parametrical statistical tests conducted included independent sample *t*-tests, one-way ANOVA, cross-tabulation χ^2-tests, and Pearson product moment correlation co-efficient tests. Non-parametric statistical tests conducted included the Mann–Whitney and Kruskal–Wallis tests. The response options 'never' and 'rarely' were combined for the purpose of analysis due to the small number of responses in these categories. The qualitative comments on training priorities were analysed by grouping similar training content into broader areas.

TABLE 1: *Respondents' demographic profile*

Sex (*n* = 374)	**% (*n*)**
Male	30.1 (112)
Female	69.9 (260)
Age (*n* = 379)	
20–24	3.7 (14)
25–34	32.2 (122)
35–44	22.1 (84)
45–54	34.1 (129)
55+	7.9 (30)
Current grade (*n* = 362)	
Staff nurse	51.1 (185)
Clinical nurse manager	22.7 (82)
Clinical nurse specialist/advanced nurse practitioner	10.5 (38)
Community mental health nurse	15.7 (57)
Highest education (*n* = 376)	
Certificate/diploma	21.0 (79)
Degree	38.3 (144)
Postgraduate/Master/PhD	40.7 (153)
Years qualified as mental health nurse (*n* = 380)	
0–10	41.3 (157)
11–20	22.9 (87)
21–30	22.9 (87)
31–40	12.9 (49)

RESULTS

The majority of respondents were female (69.9%), aged 45–54 years, staff nurse grade, and qualified to degree level. The average number of years qualified was 16.25 (SD = 11.28), with the majority qualified less than 10 years. The majority of the sample worked in community settings (47.3%), followed by acute inpatient services (42.1%), with approximately one-tenth identified as working in residential rehabilitation settings (10.6%).

A full breakdown of the demographic characteristics of respondents is presented in Table 1. Nearly four-fifths of respondents (78.9%) reported receiving education on risk assessment (78.9%), while just under half (49.9%) received education on safety planning. Over half (58.2%) received education during attendance at a short course or study day, and just under half (48.5%) received education as part of their preregistration nurse-education programme, which was many years previously.

Risk-assessment practice

Most respondents (95.7%) reported conducting risk assessments in their clinical practice. In relation to the 28 risk-assessment practices examined, the risk categories considered most often by nurses were risk to self and risk to others. Within these categories, risks related to suicide, self, harm, violence, forensic history, and substance abuse were considered most often. Risks related to exploitation and social exclusion were not routinely addressed in the risk assessment. Approximately one-third of respondents reported always considering the risk of sexual vulnerability (34%), homelessness (31.2%), intimate partner violence (31%), and financial exploitation (30.7%), while approximately one-fifth reported always considering the risk of losing contact with family (20.6%) and social networks (21.8%), losing custody of children (21.5%), disclosing mental health issues to others (20.5%), and victimization in the community (19.2%). Although just one item addressed risk from services, it showed that less than half of those conducting risk assessments always consider the risk of developing adverse drug reactions (45.7%). Conversely, approximately two-thirds of respondents reported always considering the risk of non-adherence to prescribed medication (66.6%) (Fig. 1).

When considering contextual factors that impact a person's risk factors, the person's past history or aspects of mental state was considered by over 70% of respondents. However, just over half of respondents (52%) reported always considering a person's protective factors when completing a risk assessment (Fig. 2).

Impact of area of practice on risk assessment practice

When the analysis is stratified by area of work (i.e. acute inpatient/community settings/residential rehabilitation), there were clear differences in the frequency with which

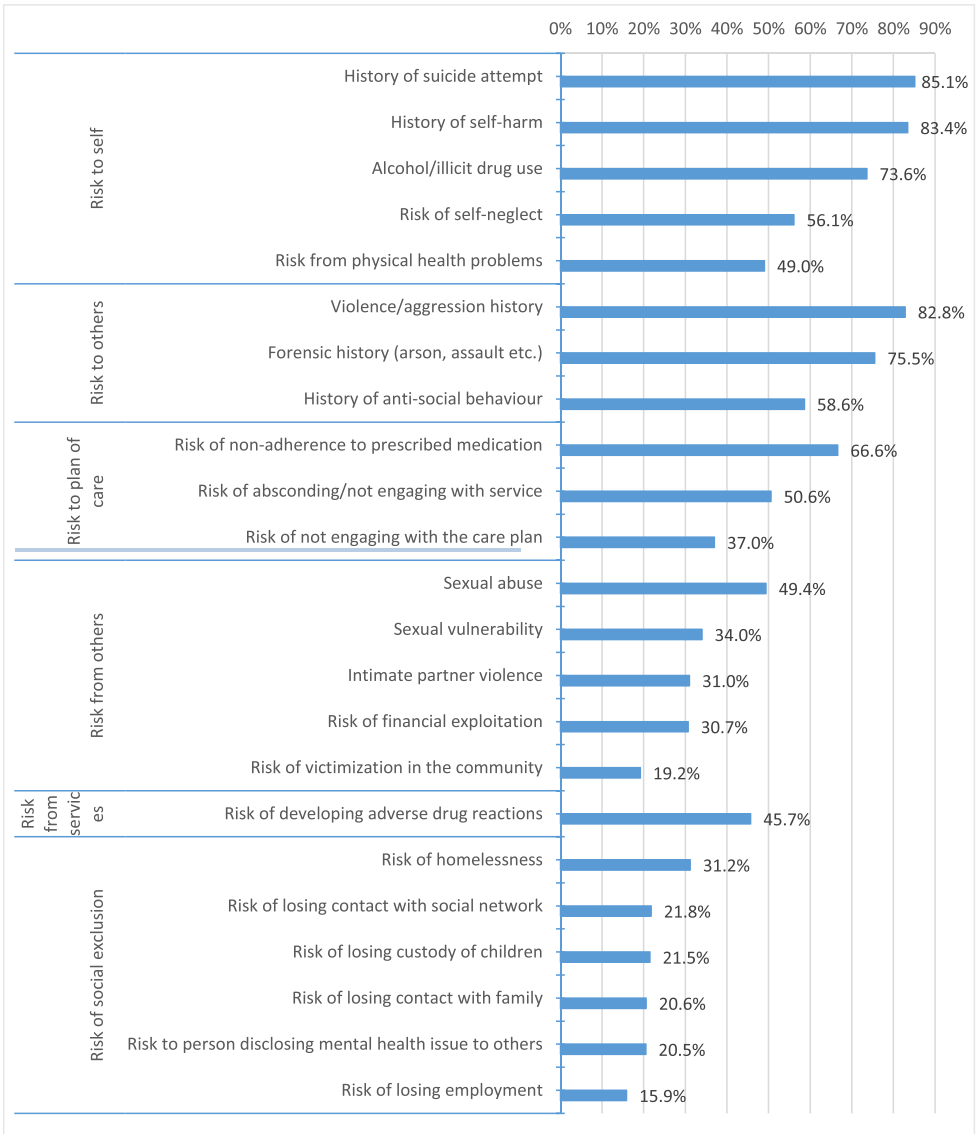

FIG. 1: *Risk factors 'always' considered by risk category.*

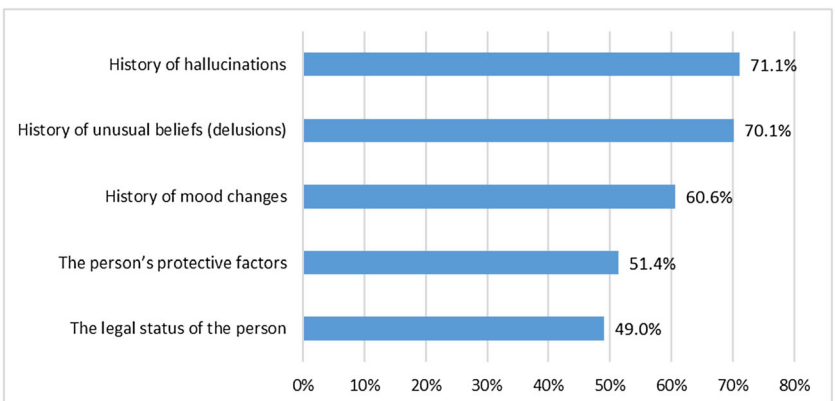

FIG. 2: *Contextual risk factors 'always' considered.*

some risks were assessed, which were statistically significant. Those working in community settings had higher proportions of respondents who 'always' considered the risk of victimization in the community (18.1%) (χ^2 (2) 12.123, $P = 0.016$), the risk of losing contact with social network (22.9%) (χ^2 (2) = 9.883, $P = 0.042$), and the persons' protective factors (59.5%) (χ^2 (2) = 10.447, $P = 0.034$), compared to those working in acute settings (13.4%, 16.1%, 48.6%). Higher proportions of those working in acute settings 'always' considered a person's legal status (60.7%) and the risk of absconding/not engaging with the care plan (59.5%) compared to staff in community settings (37.4%, 44.2%).

Safety-planning practice

Although over 95% reported completing risk assessments, only four-fifths of respondents (83.2%) reported having developed a safety plan, and this practice was not routine, with more than half of these reporting doing so only sometimes (43.7%), as opposed to always (39.5%).

In relation to the 21 items on safety planning, the five highest-ranked actions 'always' followed when developing a safety plan included asking the person what they need to do to stay safe (65.6%); identifying harm-minimization strategies (60.4%); recording a short-term safety plan (59.5%); giving risk-reduction advice (57.5%); and removing items of risk, such as razors and lighters (55%). Half of the sample reported always communicating risk level to the person, while less than half reported always identifying how the person's strengths can support the safety plan (43.4%). With regards to positive risk taking, approximately one-fifth of respondents reported always including it in the safety plan, while approximately half reported its inclusion 'sometimes' (52.2%) (Fig. 3).

Impact of area of practice on safety-planning practices

There were some statistically-significant differences in safety-planning practices depending on respondents' areas of work. The results indicate that a higher proportion of respondents working in acute inpatient services 'always' put the person on a level of observation (54.7%) (χ^2 (2) = 25.318, $P < 0.000$), remove items of risk (75.6%) (χ^2 (2) = 47.498, $P<0.000$), identify anti-absconding strategies (32.6%) (χ^2 (2) = 42.727, $P < 0.000$), and identify de-escalation strategies (54.9%) (χ^2 (2) = 19.096, $P < 0.001$), compared to those working in the community (23.7%, 30.2%, 8.4%, 27.9%).

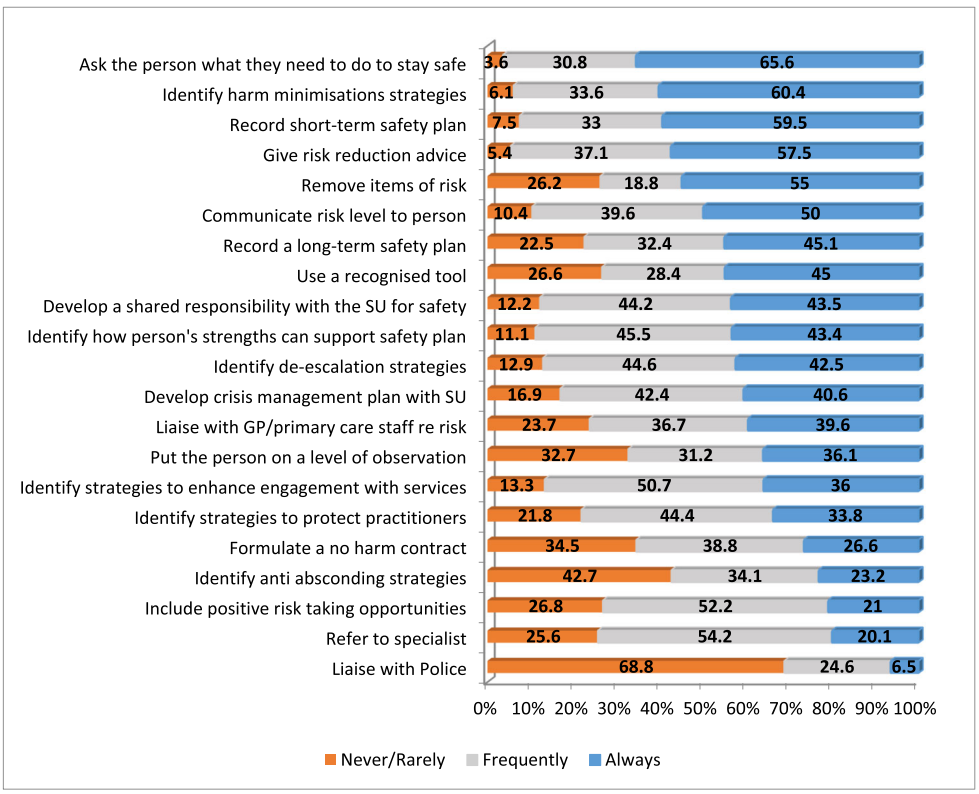

FIG. 3: *Frequency of actions taken when developing a personal safety plan. GP, general practitioner; SU, service user.*

Involving stakeholders

More than three-quarters of respondents reported always involving service users in risk assessment and safety planning (77.8% and 78.4%, respectively), while approximately three-quarters of respondents reported always involving the psychiatrist (77% and 74.2%, respectively). Just less than two-thirds of respondents reported always involving other nurses (62.5% and 63.3%, respectively). A higher proportion of respondents reported sometimes involving members of the multidisciplinary team than always involving them in assessment (47.9% compared to 43.6%) and safety planning (49.6% compared to 47.5%). Families and carers were the least-consulted stakeholder group, with approximately one-quarter of respondents reporting always involving them in risk-assessment (24.9%) and safety-planning processes (25.4%).

Confidence

The overall mean score for the 12-item confidence in risk assessment and safety planning scale was 3.85 (SD =0.79). While respondents reported a high mean level of confidence in relation to risk assessment and safety planning, the results confirmed that nurses are less confident involving family members in safety planning, formulating a risk-assessment profile, developing a safety-management plan, liaising with police, and working with positive risk-taking opportunities, with below-average confidence being reported in these areas (Fig. 4).

Impact of training and confidence

Statistically-significant differences were found in relation to training in risk assessment and self-reported confidence in conducting risk assessments. A higher proportion of those with training in risk assessment were conducting risk assessments compared to those without training (98% *vs* 85.3%) ($P = 0.000$, Fisher's exact test). Higher mean confidence scores were also found among those conducting risk assessments (mean =3.88, SD =0.761) compared to those who did not conduct risk assessments ((mean =3.18, SD =1.13) (t (15.632) = 2.473, $P = 0.025$).

Statistically-significant differences in developing safety plans were found in relation to training and self-reported confidence, with a higher proportion of those with training developing safety plans compared to those without (87.3% *vs* 65.1%) (χ^2 (1) = 18.137, $P = 0.000$), and higher mean confidence scores among those developing safety plans (mean =3.97, SD =0.705) compared to those who did not ((mean =3.11, SD =0.808) (t (337) =8.170, $P = 0.000$)).

Training needs

Most respondents expressed a need for education about the processes, strategies, and skills involved in assessing risk ($n = 212$) and managing risk ($n = 204$). Risk areas cited as

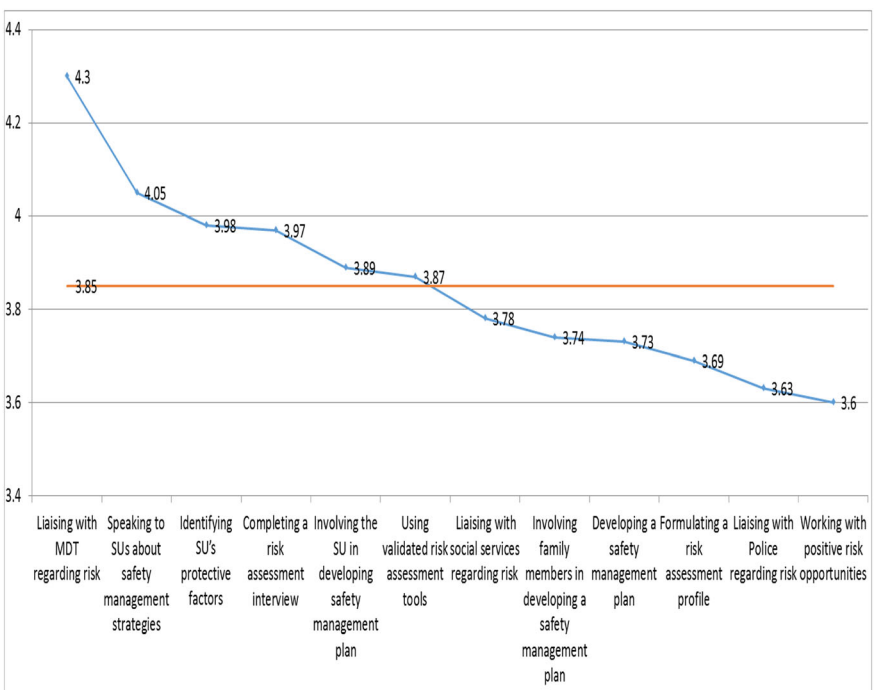

FIG. 4: *Respondents' mean confidence with risk assessment and safety planning. MDT, multidisciplinary team; SU, service user.*

requiring education included the risk of suicide, self-harm, violence and aggression, forensic risk, and the side-effects of medication ($n = 58$). The use of assessment tools, as well as how to work with and involve service users and others in the risk-assessment and management process, were also identified as a high priority for training. As well as identifying training needs in relation to organizational policies, procedures, and guidelines, respondents were of the view that organizational issues, such as the culture of an organization and interagency working, could be addressed through training ($n = 73$). Finally, a small number of responses identified training needs in relation to national policy and law in this area ($n = 12$). Many respondents ($n = 113$) also articulated a desire for training to be ongoing, mandatory, service-wide, locally available, and informed by best practice.

DISCUSSION

How people conceptualize and classify risk, as well as how they engage in what Kelly and McKenna (2004:379) term 'risk selection', is a crucial issue for mental health nursing. The findings from the present study suggest that nurses continue to concentrate on what Ryan (1998) describes as the high-consequence/low-frequency end of the risk spectrum, with the emphasis being on risk to self (suicide and self-harm) and risk to others (violence). Respondents cited that they required more education in these risk areas, which again highlights the focus with which nurses in this study approach risk assessment and safety planning.

Notwithstanding the importance of issues, such as suicide, self-harm, and violence, an approach that is centred on such events creates a dominant discourse in relation to 'extreme' risk, which might not be applicable to the majority of service users (Morgan 2007). In addition, other important risks, such as risks from others and 'iatrogenic' risks, are ignored. In order to capture a balanced and comprehensive assessment of risk, assessments should include consideration of risks posed by service users to themselves, risks posed by service users to others, risks posed by others to service users, and 'iatrogenic risks' or risks posed to service users as a result of their engagement with the mental health services. Within this study there was little emphasis on risk posed by others, with only approximately one-third of respondents always considering sexual vulnerability or the risk of intimate partner violence. Yet research has consistently reported high levels of sexual victimization and sexual abuse, including intimate partner violence among mental health service users (Allen 2001; Mullen *et al.* 1993). Indeed, guidelines issued by the Department of Health (Victoria, Australia) (Department of Health 2012) for acute inpatient units emphasize the importance of including the assessment of a person's sexual vulnerability as a component of risk assessment because of the well-established link between past sexual abuse and the development of mental health problems. Similarly, despite the problems that people with mental health problems encounter in their daily lives in relation to employment and housing, and the difficulties that these pose for social inclusion and recovery (MacGabhann *et al.* 2010), the trend within this study was to miss out on these issues. The narrow perspective on risk is also reflected in the fact that the risk of people being victimized and abused by others (Goodman *et al.* 2001) was missed by the majority of respondents. Yet research over the past 20 years indicates that people with mental health problems experience high levels of financial exploitation, victimization, and harassment from the general public, both in their own home and on the street (Kelly & McKenna 2004; MacGabhann *et al.* 2010).

Another issue that is certainly a priority area within mental health is physical health, with high prevalence rates of poor physical health (Phelan *et al.* 2001), type 2 diabetes (Bushe & Holt 2004), and obesity (Citrome & Vreeland 2009) reported. However, only 49% of respondents reported that they always consider physical health issues as part of their risk assessment. This might be due to nurses not equating the term 'physical health' with the concept of risk. Similarly, the area of self-neglect, an underresearched area in risk assessment and management, was not seen as integral to risk and safety planning. Despite the growing evidence of the negative impact of side-effects of psychotropic medication on people's quality of life and physical health (Higgins 2007; Moncrieff 2009), just 45% of the respondents reported always considering the risk of the person developing an adverse drug reaction. However, 66% reported always assessing the risk of the person not adhering to the medication prescribed, which suggests that compliance with medication is still seen as the priority, as opposed to the iatrogenic risks associated with prescribed medication. Greater emphasis on symptom management and compliance with treatment was also found in another study of mental health nurses in Ireland (Cleary & Dowling 2009).

The purpose of conducting a risk assessment is to gather information to form an overall picture of the person, place the person on a continuum of risk, and inform a plan that supports the person and practitioner to maintain safety. In terms of safety planning, similar to other studies (Delaney *et al.* 2001; Gilbert *et al.* 2011; Godin 2004), there appears to be the presence of what Woods (2013) terms a 'fragmentation' between risk assessment and the safety-planning process. While the majority (95.7%) of respondents reported completing a risk assessment, approximately 17%

did not develop safety plans, and another 43.7% reported only 'sometimes' following through with a safety plan. While assessment is an important cornerstone of safety planning, it is of limited utility for service users and practitioners if practitioners simply conduct a risk assessment as a data-collection exercise and do not follow through with a safety plan.

Notable differences emerged between respondents working in acute inpatient settings compared to those working in community. Risk-assessment and safety-management practices of those working in acute settings tended to concentrate on absconsion, de-escalation, and observation, with less attention paid to the person's family and social context. Reasons for these differences could not be explored, although, speculatively, it could reflect the different stages of people's recovery or the level of expertise of respondents, as recently-qualified staff and younger respondents were more likely to be working in acute inpatient settings.

A secondary objective of the study was to identify to what extent mental health nurses adopted the core principles of recovery in their practice in relation to risk. A recovery-oriented approach to care has implications for risk-assessment and safety-management practices (Muir-Cochrane *et al.* 2011). Boardman and Roberts (2013) describe recovery and risk management as 'uneasy bedfellows'. While recovery is orientated towards the development of hope and the provision of opportunities to foster control, choice, autonomy, and growth, in contrast, risk management is frequently concerned with 'avoiding danger, restrictions, containment, protection and staff control' (Boardman & Roberts 2013, p. 4). Overall, nurses' risk- and safety-management practice in this study was characterized by taking actions to minimize potential risk, including giving the person advice and strategies to reduce risk, removing items that pose a risk, and focusing on the risk of non-adherence to prescribed medication. This suggests that the nursing practice of a large number of practitioners in this study is leaning more towards the risk averse end of the continuum. Recovery-oriented safety planning focuses on the person's strengths, resources, and capabilities, as well as fostering engagement and a shared responsibility for safety and planning among service users to enhance 'their capacity to develop self-directed plans to manage risk in the pursuit of valued life goals' (Boardman & Roberts 2013, p. 18). In addition, the wider context of people's lives and commonly-encountered risks of everyday living, such as risks of doing a new course, engaging in a new relationship, or disclosing a mental health issue to employers, which are all aspects of life that have the potential to be sources of positive risk taking and learning, are missed.

Despite the high level of self-reported involvement of service users in risk-assessment and safety-management processes, other indicators of involvement suggest a lack of meaningful engagement with services users in planning their care. On the basis of the evidence reported in the present study, over 25% of respondents 'never/rarely' considered positive risk-taking opportunities in safety planning. In addition, less than half of the respondents always engaged in recovery practices, such as developing a shared responsibility with the person for safety (43%), identifying how the person's strengths can support safety (43%), developing a crisis-management plan (40%), and including positive risk-taking opportunities (21%). Evidence also illustrates a lack of confidence in regards to positive risk taking, with respondents reporting being least confident in working with positive risk-taking opportunities. While respondents reported a relatively high level of confidence in speaking to service users about safety management strategies, just half (50%) reported 'always' communicating risk level to the service user. The literature cites numerous barriers to communication with service users about risk, including dissonance between professionals and service users' language and perceptions of risk; fears about negative adverse reactions from services users, such as violence or disengagement from the therapeutic relationship; as well as concerns about stigmatization and disempowerment of service users by applying the discourse of risk (Clancy *et al.* 2014; Langan 2008).

Family members can be pivotal in people's recovery journeys, and can support people to successfully manage or reduce risk behaviours. In addition to emotional support, family members provide practical and other ongoing support, such as housing and financial assistance, that acts as protective factors in the person's life (Boardman & Roberts 2013). Yet family members frequently report that their concerns about safety go unheeded (Royal College of Psychiatrists 2008), and that they often find themselves on the outside of discussions about medical diagnosis, treatment, and recovery (McDaid & Higgins 2014). While family/carer involvement needs to occur within the context of service user-informed consent, within this study, family members/carers were the least-consulted stakeholder group, with approximately one-quarter of respondents reporting always involving them in risk-assessment (24.9%) and safety-planning processes (25.4%). Involving family members was also one of the areas where respondents reported a lack of confidence.

The emphasis by respondents on extreme risk or 'harmful risks' to be avoided or prevented is no doubt related to the manner in which risk is researched and taught, as both research and education tend not to focus on risk as an

everyday part of life. The literature also suggests that the dominant risk discourse, which frames risk in negative terms and views service users as 'risk-laden objects', precludes the adoption of a positive approach to risk (Clancy *et al.* 2014; Morgan 2007; Slade 2009). Others argue that the narrow conceptualization of risk within mental health policy has contributed to a focus on risks related to potential harm to oneself and to others (Busfield 2004; Ryan 1998; Stickley & Felton 2006). Furthermore, concerns about clinical responsibility and professional accountability, and the fear of litigation, can contribute to a risk-averse culture (Boardman & Roberts 2013; Higgins 2008; Raven & Rix 1999; Stickley & Felton 2006). It has also been noted that positive or therapeutic approaches to risk are difficult to implement in practice, because the values underpinning them are often in stark contrast to organizational risk-management policies, which focus on avoidance of risk and reinforce professional control (Boardman & Roberts 2013).

Finally, similar to previous research, the respondents articulated a need for education about the skills and strategies for effective safety planning; in particular, education in the use of risk-assessment tools and positive risk (Cleary & Dowling 2009; Cusack & Killoury 2012; Jelinek *et al.* 2013). While a significant correlation between education in risk assessment and safety planning, and the subsequent undertaking of risk assessments and the development of safety plans was found, findings from this study also identified gaps in how risk is conceptualized and discussed, and how collaborative safety planning is operationalized with service users and family members.

LIMITATIONS

The findings need to be considered in the context of the following limitations. First, nurses' practices and behaviours are self-reported and not observed; therefore, it is impossible to determine whether the nurses' behaviour is the same and/or different in clinical practice. Second, nurses might have interpreted questions differently, with some responding to questions based on assessing risk on all service users as part of routine care planning, whereas other might have interpreted the questions in relation to particular risk events only. Third, there is potential for a response bias with those more positively disposed to risk assessment and safety planning completing the survey.

IMPLICATIONS OF STUDY

The findings from the present study have important implications for practice, education, and research. Mental health service providers, in conjunction with service users, need to review policies on risk assessment and safety planning to ensure that they encompass a comprehensive definition of risk and are underpinned by recovery and positive risk principles. Risk-assessment and safety-planning education should be developed and delivered at undergraduate and postgraduate levels to mental health nurses to enable them to work with risk within a collaborative recovery ethos, and build positive risk-taking opportunities into everyday practice. In addition, education should include information on approaches to risk assessment, the use of risk-assessment tools, and risk and protective factors, as well as the skills necessary to engage service users and family members in the risk-assessment and safety-planning process. There are considerable gaps in our knowledge on all aspects of risk assessment and safety planning, with further research warranted in areas, such as service users' perspectives of risk and the strategies they use to maintain safety, multidisciplinary working in risk assessment and safety planning, organizational practices that foster or hinder nurse's safety planning, as well as how nurses resolve tensions between working in a recovery-oriented manner within a risk-averse culture.

CONCLUSION

Risk assessment and safety planning are central components of mental health nursing, with mental health nurses acting as key agents in transforming services to a recovery orientation. If in mental health the emphasis continues to be on high impact or dramatic risks that occur for a few, the opportunity to think about risk in a positive manner and explore the idea of risk being part and parcel of the growth and development of all individuals who use mental health services will be missed (Slade 2009). From the service users' perspective the right to coproduce safety plans and be supported to make challenging and difficult choices, even if they are not in agreement with professional opinion, is a key variable underpinning recovery (Higgins & McGowan 2014; Watts 2014). However, what is evident from this study is the need for education to enable nurses to adopt a much more holistic conceptualization of risk and truly embrace the concept of coproduced safety plans, as well as the concept of 'dignity of risk, and the right to failure' (Deegan 1996, p. 28).

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