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Risk Assessment and Safety Planning in Mental Health Nursing Services

An exploration of practices, policies and processes

Trinity College Dublin
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The University of Dublin

Tús Áite do Shábháilteacht Othar
Patient Safety First

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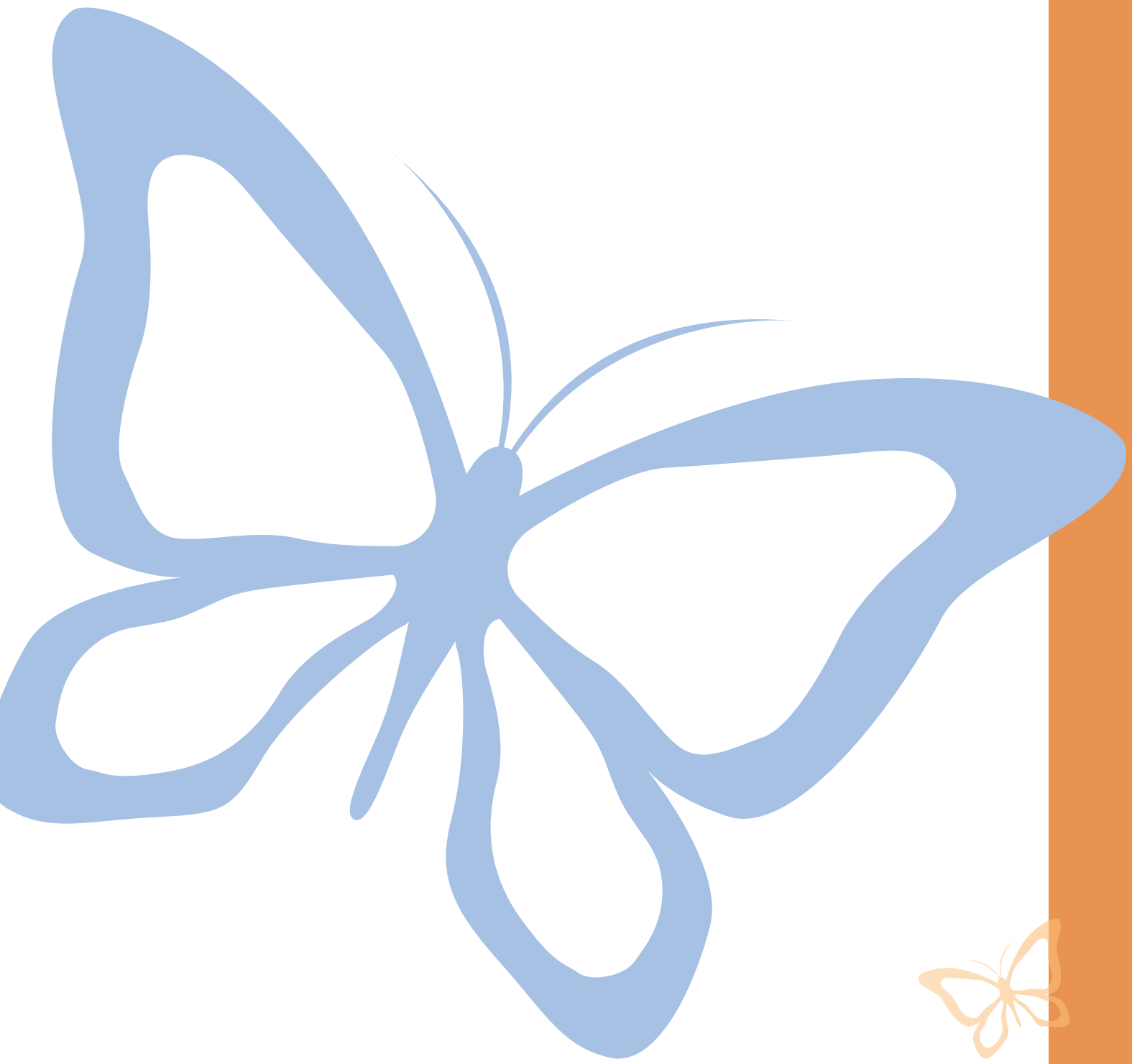
Risk Assessment and Safety Planning in Mental Health Nursing Services:

- An exploration of practices, policies and processes



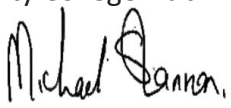
Foreword

The Office of the Nursing & Midwifery Services Director (ONMSD) is delighted to present this research report into current practices, policies and processes around Risk Assessment and Safety Planning within mental health nursing in our Irish mental health services. This work was commissioned to provide an evidence base to inform recommendations for the profession on nursing policy, practice guidelines and education programmes in this area of Risk Assessment and Safety Planning and is the first of its kind for nursing internationally.

Contemporary international and national health policies all articulate the need for services to be driven by principles of quality and safety, with particular emphasis being placed on increased safety of service users, carers, families, staff and the community. Irish mental health policy is no different with an increasing emphasis being placed on the need for services to be driven by a quality and safety agenda. Within this agenda issues of risk have become increasingly dominant and this increased consciousness is equally true within mental health services. Policy and guidance documents emphasise the importance of partnership and collaboration between professionals, service users and families/carers when carrying out Risk Assessment and Safety Planning in mental health. Within mental health nursing, how risk is defined and classified needs to be evidence-based and responded to in a consistent way across all clinical settings and locations where care is delivered.

Over the past decade the clinical role and responsibilities of the nurse working in mental health services has developed significantly in order to provide responsive care. The on-going developments and expansion of the scope of nursing practice at all levels including Specialist and Advanced practice in areas such as Liaison, Self-Harm, Suicide Crisis Assessment and Community Mental Health provides a complex and changing environment in which nurses' work. The ONMSD commissioned this report to support nurses working within their professional roles. This report will provide an evidence base to inform recommendations on nursing policy, practice guidelines and education programmes in this area of Risk Assessment and Safety Planning.

This report is the result of extensive consultation with nursing services nationally and provides evidence for the profession to inform the development of best practice principles and an elearning education programme on Risk Assessment and Safety Planning for all nurses working within Mental Health services nationally. We would like to thank the service users, nursing staff and Area Directors of Nursing who contributed to this groundbreaking work, and extend our appreciation to Professor Agnes Higgins and her team who carried out this work in the School of Nursing & Midwifery, Trinity College Dublin.



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GLOSSARY OF ABBREVIATIONS

APN – Advanced Nurse Practitioner

CMHN – Community Mental Health Nurse

CNM – Clinical Nurse Manager

CNS – Clinical Nurse Specialist

DoH – Department of Health

DoH&C – Department of Health and Children

HSE – Health Service Executive

MDT – Multidisciplinary Team

MHC – Mental Health Commission

MHR – Mental Health Reform

NICE – National Institute for Health and Care Excellence

NMBI – Nursing and Midwifery Board of Ireland

WRAP – Wellness Recovery Action Planning

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EXECUTIVE SUMMARY

Despite the current emphasis on safety planning and positive risk, limited research exists into how mental health nurses conceptualise 'risk' and how they engage with risk assessment and safety planning within an organisational context. This report presents the findings of a study undertaken that explored practices, policies and processes around risk assessment and safety management within mental health nursing in a number of mental health services in Ireland, with a view to informing recommendations on policy, practice and education in the area of risk assessment and safety planning.

Methodology

A mixed methods research design was employed to meet the overall aim of the study. The study comprised two components. Module one involved an anonymous, self-completed survey of mental health nurses risk assessment and safety management practices, and module two comprised a documentary analysis of mental health services' risk assessment and safety policies, procedures and guidelines. Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin.

Key gatekeepers within the seven participating HSE sites distributed a study pack containing information about the study and survey to all mental health nurses meeting the inclusion criteria in their area. In total, 381 adult mental health nurses from the seven sites completed the survey. Documentation in the form of policies, guidelines and tools on risk assessment and safety management were received from 23 Directors or Acting Directors of Nursing.

Results

The results indicate that respondents' risk assessment practice is heavily orientated towards consideration of the risk to self and the risk to others with less emphasis on other risk categories including risk from others, iatrogenic risks, risk from services and contextual issues that influence risk. Acute inpatient setting workers' risk assessment practice appeared to be guided by safety and security priorities while greater emphasis was placed on risks related to social exclusion in risk assessment and management practices in community mental health settings. While the value of positive risk taking was acknowledged by around two thirds of the sample, respondents reported least confidence in working with positive risk taking opportunities in their risk assessment and safety management practice. Less than half of respondents perceived that there was an emphasis on positive risk taking in their organisations.

Fragmentation in the risk assessment and safety planning process was indicated by the finding that approximately 15% of those who conduct risk assessments did not also develop safety plans. There was limited evidence of the recovery ethos being implemented in risk assessment practices. A persons' strengths and protective factors were not routinely considered by nurses, while service users' family or carers were the stakeholder groups consulted least by nurses. While respondents reported a relatively high level of confidence in speaking to service users about safety management strategies, just half reported 'always' communicating risk level to the service user. Those who had training were more confident in practicing risk assessment and safety planning and more likely to 'always' consider some risk factors and perform some safety management practices more often than those without training. However, ongoing education in risk assessment and management was available to less than a third of respondents within their organisations. These findings together with the finding of relatively low self-reported confidence with developing a safety management plan, reinforce the need for training to address this practice deficit. Respondents in this study identified a range of educational needs related to the skills and strategies for effective risk assessment and safety planning particularly training in the use of risk assessment tools and working within an ethos of positive risk. Responses underlined the importance of training which is on-going, mandatory, locally available, inclusive and informed by best practice.

Overall, the documentary analysis revealed heterogeneity of risk practice within HSE mental health services with disparities in risk policies, procedures and practices. There was variation in how risk, risk assessment and risk management were defined. Emphasis within documentation was on risks related to self and others, with several risk categories absent, including risk from others, risk of social exclusion and iatrogenic risk. In addition, evidence of positive risk taking language and guidance on positive risk within risk-related documentation was also found to be largely absent. Many of the risk assessment tools which exist in mental health services in Ireland have not been validated. Furthermore, the validated screening tools used lacked consistency or guidance in relation to how screening tools were selected or applied. An acknowledgement of the dynamic nature of risk was largely absent within most documentation as there was a notable absence of space for ongoing review of the persons' situation and safety plan.

The following recommendations are proposed:

Recommendations for policy

- National guidelines or recommendations are required to inform the development of evidence based policies and strategies for risk assessment and safety planning at organizational and clinical practice levels.

Recommendations for practice

- A HSE wide mental health service approach to risk assessment and safety planning is required which incorporates recovery and positive risk principles. Managers within local service, in conjunction with service user panels, need to review their policies on risk and safety to ensure that they have a recovery and positive risk focus, as well as ensuring that the policies reflect a comprehensive definition of risk.
- A common language of risk is developed so that both professionals and service users have at least a common understanding of what is meant by terms such as risk assessment, risk management, safety planning and positive risk. This might be underpinned by the adoption of a best practice guide to assist nurses to work with risk and safety in a recovery oriented manner, and a risk glossary that can be given to clinicians, service users, families and carers.
- A coherent approach to the development of documentation, including risk screening and other risk tools is required. This may involve the selection and adoption of named, validated instruments throughout HSE mental health services which will require detailed discussion to arrive at a consensus on which tools should be employed.
- A standardized risk screening tool and care plan template should be developed that can be used across all services and evaluated from all stakeholder perspectives. Any tool/template should be multi-disciplinary in nature, as many of the issues will require multidisciplinary input, and incorporate a space for service users to sign off on the plan.

Recommendations for education

- Risk assessment and safety planning education and training should be developed and delivered to mental health practitioners to enable them to develop skills to work with and respond to service users presenting with risk issues in a competent, creative and compassionate manner including the knowledge, skills, and attitudes to discuss protective factors and positive risk taking opportunities.
- Service user and family/carer input should be incorporated into such training in order for professionals to see the potential impact on service users and family members of decisions made regarding risk and safety planning.
- Service users' capacity to formulate self-directed plans should be built-up through educational interventions as well as ensuring training focuses on the requisite knowledge and skills practitioners need to engage in the process of person-centred planning.

Recommendations for research

- There is considerable gaps in our knowledge on all aspects of risk and safety therefore we recommend that further studies are undertaken to explore service

users', family members' and other practitioners' perspectives on and practices in risk assessment and safety planning.

1. Literature Review

Introduction

According to Beck (1992) issues of risk have become increasingly dominant in recent decades with the emergence of a new society - a 'risk society', characterized by a greater consciousness of risk. This increased consciousness around risk is equally true within mental health services, with writers noting that over the past 20 years the term 'danger and dangerousness' has gradually been replaced by the term risk (Cordall 2009:11). Woods (2013:807) also notes that today risk assessment and risk management is one of the 'highest profile tasks of mental health practitioners'. Muir-Cochrane *et al.* (2011) posit that within the mental health context the risk adverse culture is fuelled by high profile cases of homicide involving people with a history of mental health problems. The media attention surrounding these cases also resulted in an increase in public concern around the dangerousness of people experiencing mental health problems (Murphy 2004). Furthermore in response to both the media and inquires that followed these incidents, risk assessment became the new technology of psychiatry to assure the general public of their safety and replaced the institutional walls of the past (Rose 1996). The risk culture within mental health was further fuelled by the growth in literature that perpetuated the idea that all risks can and should be identified and prevented and the development of actuarially based risk assessment tools to determine peoples' potential to violence or risk of suicide (Doyle and Dolan 2002; Godin 2004). As it is beyond this report to present all debates and evidence, the issues selected and presented are conducted with a view to setting the study in an International and National context. The first part of the review deals with some of the core issues around defining risk, risk assessment and management practices, and risk in the context of recovery principles. The second part reviews the research into nurses' practices around risk assessment and safety planning.

The overall aim of the study is to explore practices, policies and processes around risk and safety management within mental health nursing and within a number of mental health services in the Republic of Ireland to inform future developments in the area of risk assessment and safety management for mental health services.

Prior to presenting the literature it is important to note that language is not neutral (Foucault 1975). Language is both a product of a system and that which helps shape the system. The language of risk is no different; it is both a product of the institution of psychiatry and also a key player in shaping values and practices, be it at the level of policy or the individual practitioner. Today the language of risk (risk assessment, risk management, risk formulation) is embedded within mental health. However, there is a growing awareness that service users do not frame their lives within a 'risk' discourse (Clancy *et al.* 2014), and with a greater acceptance of recovery and the principles of recovery there are more voices

emerging that are challenging the language and the ideologies embedded within the current risk discourse. As far back as 2005 Barker and Buchanan-Barker discussed within the Tidal Model the importance of language and the need to move to a language of safety as opposed to risk. The language of safety and safety planning albeit at an embryonic stage of development is now beginning to grow and take hold (Langan 2008; Slade 2009; Boardman and Roberts 2013).

Irish mental health policy and risk

Contemporary international health policies all articulate the need for services to be driven by principles of quality and safety, with particular emphasis being placed on increased safety of service users, carers and families, staff and the community (Department of Health UK 2007; Department of Health WA 2008). Irish mental health policy is no different with an increasing emphasis being placed on the need for services to be driven by a quality and safety agenda. The mental health policy *Vision for Change* clearly articulated the need for a focus on 'risk' stating that 'the development of clinical risk-management and risk-assessment approaches within mental health settings is essential' (DoH&C 2006:102). In 2007 the HSE issued a *Quality and Risk Management Standard* aimed at effectively managing quality and risk by implementing an integrated quality and risk management framework across all service providers. The standard states that '*Healthcare quality and risk are effectively managed through implementation of an integrated quality and risk management system that ensures continuous quality improvement*' (HSE 2007:5). While this standard does not apply specifically to mental health services, there are specific legal and regulatory requirements that are specific to the mental health service. From a legal perspective Article 32 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 (Government of Ireland 2006) provides the statutory requirements for approved centres in relation to risk management procedures. In addition, the *Quality Framework, Mental Health Services in Ireland* (MHC 2007) lays out other standards in relation to safe and effective care within the mental health service, arguing for the adoption of a whole-systems approach towards safety and quality. More recently the Health Service Executive (HSE) produced a guidance document on risk management in the mental health service that acknowledges that while risk can never be eliminated completely, safety is everyone's responsibility and risk can be minimized by good processes and procedures (HSE 2009).

Defining and categorizing risk

The concept of risk is a complex issue which can (and does) mean different things to different people. From a mental health perspective, how risk is defined and classified not only shapes the nature of the discourse but it influences the practice priorities that arise from definition and classification. Within the literature the term risk is frequently used to refer to the 'probability of a particular adverse event occurring within a stated period, or resulting from a particular hazard' (Cordall 2009:11). Morgan (2004:18) defines risk as *'the*

likelihood of an event happening with potentially harmful or beneficial outcomes for self or others', thus creating the possibility for risk to be re-framed as being about possibility rather than just probability and being beneficial rather than entirely negative. The recently published HSE document defines risk as *'the culture, processes and structures that are directed towards realizing potential opportunities whilst managing adverse effects'* (HSE 2009:5), thus acknowledging that all actions and decisions have both potential harmful and beneficial outcomes. Given this perspective on risk the practitioners' role is not just about 'eliminating risk' but about 'ensuring the potential benefits identified are increased and the likelihood of harms occurring as a result of risks are reduced' (HSE 2009:11).

Others define risk by classifying and ordering risks into categories, thus performing what Lupton (1999:131) calls 'tasks of inclusion and exclusion'. The New Zealand Mental Health Commission (1998) classifies risk in the following way: risk of progression of illness; risk of self-harm and unintentional self-harm to self; and risk of intentional or unintentional harm to others. The Department of Health Western Australia (2008) adds to what is considered as risk to self (due to self-harm, self-neglect, wandering and use of substances) and risk to others (violence and aggression including sexual assault and abuse, harassment, stalking, property damage including arson, and reckless behaviour e.g. drink driving) by adding the category of risk by others (physical, sexual and emotional abuse by others; social or financial abuse or neglect by others). Within the HSE (2009:9) document an organisational approach to risk classification is taken, with a recognition of the interdependent nature of safety of the individual and environment wherein care is delivered. Consequently, risk is classified into eight broad areas: risks of injury to patient, staff and public; risks to service user experience; risk to the compliance with standards; risk to objectives and projects; risk to business continuity; risk to reputation; risk to finances and risk to the environment. Within this document four areas of risk are identified that are considered relevant when working with people experiencing mental health difficulties: namely vulnerability; self-harm/suicide; mental instability and risk to others (see table 1.1).

Table 1.1 Area of risk considered when working with people with mental health problems

Vulnerability	Exposed to damage or harm through personal or external factors e.g. naïveté, low insight, family social or community pressure, poverty, homelessness, or other resource or capability deficits
Self-harm/suicide	Risk of self-harm, intentional injury or killing oneself, action/behaviours destructive to one's own safety or health
Mental instability	Risk to self or others because of fluctuating and/or unpredictable mental health function especially in relation to command hallucination and other 'at risk' psychotic or disturbing phenomena
Risk to others	Risk of causing harm or danger, or encouraging/involving others in the causing of harm or injury to others

(HSE 2009:10-11)

What is interesting about the above categorisation within policy literature is that 'Iatrogenic' risk (Illich 1972), or risk posed to service users by being in mental health services is a neglected part of the risk discourse. Furthermore, there does not appear to be any recognition that service users may be harmed by their engagement with the mental health system, and the processes and treatments used within the system. For example, service users may be damaged by stigma from contact with services, loss of identity through assuming the 'master status' (Goffman 1963) of the diagnostic label, experience PTSD following coercive treatments such as seclusion, restraint, or forceful admission under the Mental Health Act, as well as other negative impacts of ineffective care and treatment. The risks associated with adverse reactions and side-effects of prescribed medication are under-scrutinised despite the potentially long-term adverse impacts associated with prolonged usage (Busfield 2004; Muir-Cochrane *et al.* 2011; Nash *et al.* 2014). Busfield (2004) argues that these risks are often downplayed for reasons embedded in the structures of the pharmaceutical and health care industries.

In addition to these omissions, there also appears to be little if any recognition of the negative impact of what Heyman (2004:299) calls the 'creeping hegemony of risk frameworks'. In his view the preoccupation with risk assessment and management has added to institutional induced harm, as opposed to minimising it and argues that the pressure to predict and prevent for example violence has increased rates of false positives, leading to unnecessary restriction on peoples' rights and civil liberties. Clancy *et al.* (2014:551) in a similar vein argue that the risk discourse is changing the focus on care completely, with people who once were in crisis and in need of 'sensitive, creative, therapeutic responses' becoming 'risk-laden objects' that are tracked through their stay within the services and who run the risk of losing independence, choice and control. They go on to comment on how within the risk discourse the therapeutic relationship becomes eroded by the language of risk, and rather than the person being at the centre of care they are constructed as either 'a risk' (danger) or 'at risk' (vulnerable) thus further marginalising them from the wider community.

Broader conceptualisations of risk have been found among some groups of mental health stakeholders, in particular service users. Ryan (1998) explored the risk perceptions about people with serious mental health problems held by four different groups of stakeholders including service users, their carers, mental health professionals, and the public. In this study, risk was also conceptualised on a continuum ranging from high-consequence/low frequency to low consequence/high frequency. Six categories of risk emerged, which reflected a broader multi-dimensional understanding of risk among these groups encompassing not only risks to self and risks to others but also risks that service users face from others and the institution of medicine. The six categories identified included:

- underclass: people disadvantaged in matters such as relationships, employment and housing;
- medical disempowerment: defined as the person being 'subordinated to illness and its management'
- threat: the danger that people may present to others;
- vulnerability: this factor identified the danger of people being exploited by others and not being aware of their right to help from agencies;
- self-harm: this can be equated with intentional or unintentional self-inflicted injury, and includes self-imposed social isolation; and
- dependency: being dependent on others.

Approaches to risk and safety planning

A review of the literature clearly indicates an approach to risk and safety planning that is conceptualised within the language of risk assessment, risk formulation, risk planning and risk evaluation (HSE 2009). Best practice in the area also highlights the need for a multidisciplinary and multiagency approach, with national and international policy and guidance documents all emphasising the importance of partnership and collaboration between professionals, service users and carers (DOH UK 2007; DoH&C 2006). The HSE assert that risk assessment and safety planning 'does not fall exclusively within the domain of any single profession or discipline…as people require a spectrum of services and supports' (HSE 2009:11). To ensure good communication between agencies and practitioners, risk assessment should be structured, evidence-based and as consistent as possible across practitioners, settings and service providers (DoH UK 2007). The HSE document (2009:25) states that effective management should be empowering, health promoting, built on the service users' strengths and protective factors and 'sensitive to the individual's needs, vulnerabilities and evolving behaviours'.

Within the literature there are three main approaches to risk assessment discussed namely: unstructured clinical judgement, actuarial methods and structured clinical judgement. Unstructured clinical judgement or what is sometimes called 'impressionistic' or 'first generation' risk assessment typically involves practitioners making judgements based on 'gut feeling' or 'intuition' in light of a past experience (Doyle & Dolan 2002). Actuarial methods of risk assessment, or 'second generation' approaches, involves the use of a formal reasoned approach to assess empirically measured risk factors through the use of validated instruments or tools (Kettles and Woods 2009; Godin 2004). Emphasis within this approach is on measurement and prediction of risk. Structured clinical judgement, the third approach, views risk assessment as a dynamic process and uses a combination of the previous two approaches. The third approach involves the practitioner combining their knowledge from the literature and research evidence with the flexibility to use tools when appropriate. Emphasis within this approach is also on exploring static and dynamic factors associated

with risk, protective factors, past history, service user and other perspectives as well as using tools or other guidelines as aids to clinical judgement (Doyle and Dolan 2002; Kumar and Simpson 2005).

Each approach has its proponents and critics, with a variable evidence base. Research into the unstructured clinical judgement approach suggests that it is extremely unreliable, subjective and highly variable with clinicians frequently opting to err on the side of extreme cautiousness (Woods 2013; Pedersen *et al.* 2010). Others highlight that this approach relies on anecdotal evidence and ignores the experience of other practitioners and research. Those who are in favour of the actuarial approach highlight that a structured approach to assessment removes subjectivity and provides greater inter-rater reliability and scientific validity. In addition, they argue that an empirically based, documented risk assessment provides greater transparency around decisions taken, as well as providing documentation for review, audit and analysis should a negative event occur (Doyle and Dolan 2002). In contrast, critics of the actuarial method comment on the little empirical evidence available to support the ability of tools to predict accurately (Cocozza and Steadman 1976; Feeney 2003), arguing that this method is based on information about groups, which is of limited value in predicting the behaviours of an individual (Kumar and Simpson 2005; Woods and Kettles 2009). In addition, critics argue that tools tend to focus on historical (static) risk factors thus ignoring the dynamic or situational variables, which impact on the person (Doyle and Dolan 2002). Others highlight that there is a risk that the tools become the focus of the assessment, and the engagement and relationship skills which are central to good safety assessment and planning take a secondary position (DoH WA 2008). The third approach, the structured clinical judgement approach seems to be the most favoured method within the literature and reflects the sentiment expressed in the international policy literature on risk and safety (DoH UK 2007). Proponents of the structured clinical judgement approach argue that this approach enables the practitioner to use their knowledge of the most up to date literature while at the same time retain decision making discretion around how and what information is gathered. This approach is also said to allow the practitioner to consider specific factors that may be idiosyncratic to the individual and the context; therefore factors that might not be found in empirical research, and allow a range of multidisciplinary perspectives to be included, including the person themselves, and family/carers (Doyle and Dolan 2002). While this approach incorporates the use of tools that are designed to specifically predict risk as well as other guidelines, check lists or aide memoirs, proponents of this approach stress that tools and guidelines are designed to aid clinical decision making and not act as a substitute to it (DoH UK 2007).

Engaging in a risk assessment is only effective if it is followed with a risk or safety management plan that includes some form of intervention to 'reduce, contain or otherwise ameliorate the risk, thus changing the outcome' (Thomas *et al.* 2009:3 cited in Gerace *et al.* 2013). However, the research literature on this aspect of practice is sparse, with very few

research papers evaluating risk management interventions. What is available tends not to discuss risk management in any detail, bar stressing the importance of strategies that take into consideration both static and dynamic risk factors, the provision of care that is proportionate to the risk identified, the importance of collaborative working, and clear and consistent communication between members of the multidisciplinary team (DoH UK 2007). The importance of regular reviews, recognising the fluidity of risk and the importance of clear documentation including who is responsible for the actions identified is also emphasised (HSE 2009). The use of advanced directives to facilitate service users to record their wishes for intervention which could be factored into risk management and safety plans has been advocated (NICE 2005) as well as 'Joint Crisis Plans' (Henderson *et al.* 2004), crisis cards (Sutherby *et al*. 1999) and the use of Wellness Recovery Action Planning (WRAP) as a tool to support safety management (Copeland 2002). Kaliniecka and Shawe-Taylor (2008) described the benefits of 'a risk management panel' developed within an NHS trust to support clinicians to engage in reflective case discussion around risk management. While the panel was positively evaluated, its membership solely comprised professionals with no mention of input from service users.

Positive/therapeutic risk taking and recovery

A recovery orientated approach to care has implications for risk assessment and safety management practices (Muir-Cochrane *et al.* 2011). Boardman and Roberts (2013:4) 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 and Roberts 2013:4). Despite this both recovery and risk management practices are compatible but require a fundamental shift in thinking around the meaning of risk and risk taking. Within the recovery model, risk and risk taking are viewed as an aspect of everyday life, as all decisions carry some sort of risk, with therapeutic or positive risk taking being viewed as a fundamental part of a persons' recovery journey (Higgins and McGowan 2014; Royal College of Psychiatrists 2008; Stickley & Felton 2006). Morgan (2004:19) notes that 'positive risk taking is not negligent abdication of clinical responsibility' or ignoring professional obligations to intervene in certain circumstances ...[but] '…about making good quality clinical decisions to support and sustain a course of action that will lead to positive benefits and gains for the individual service users'.

Drawing on Morgan's work, Boardman and Roberts (2013:4) describe positive risk taking or constructive and creative risk taking as '….*weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It*

involves using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes…. A positive perspective on risk also emphasises the ubiquity and inevitability of risk in people's daily lives and that a person's confidence, capacity and resilience are not enhanced by avoiding risk but may be improved through carefully considered and appropriately supported engagement with risk'. One of the fundamental principles underpinning positive or therapeutic risk taking is co-production and shared responsibility for: developing safety plans; exploring options and choices including the benefits and drawbacks of each option and choice; and developing strategies to deal with challenges of personal safety. Other principles include supporting service users to recognise and use their own skills, resources and resourcefulness and develop their skills and confidence in their ability to control their life through supported risk taking (Boardman and Roberts 2013; Slade 2009; Stickley and Felton 2006). While the focus is always on shared responsibility as opposed to compliance and conformity, it also recognises that practitioners have a professional and ethical responsibility to intervene in some circumstances, however, even in the most extreme of circumstances emphasis should be on collaboration and co-production.

A culture of positive risk taking is supported by the Mental Health Commission, who assert in *A Recovery Approach within the Irish Mental Health Services: A Framework for Development* 'the right of service users to take informed risks, even if they result in failure' and their right to 'disagree with professional judgments…' (Higgins 2008:16). Similarly, the *Guiding A Vision for Change – Manifesto* states that one of the key steps in implementing recovery orientated services is the development of 'service procedures that operationalise recovery values such as positive risk management policies that promote self-determination' (MHR 2012:11). The recently published *Mental Health Division Operational Plan* also emphasises the importance of staff working collaboratively with service users and taking appropriate risks to support the reintegration of service users into the wider community (HSE 2014:15).

While positive or therapeutic risk taking dovetails with the growing emphasis on promoting service user self-determination and autonomous decision-making in risk assessment and management (Raven & Rix 1999), little evidence exists on approaches or examples of positive risk taking within the literature (Robertson & Collinson 2011). In fact, a number of writers draw attention to the challenges of reconciling this approach with increasing demands for personal, professional and public accountability (Raven & Rix 1999; Higgins 2008). In addition, there is also the question of whether the current focus on risk assessment and management policies and procedures is contributing to defensive anti-therapeutic practices of practitioners and services owing to concerns about liability (Stickley & Felton 2006). Indeed, practitioners report that the emphasis on risk and safety measures in in-patient settings restricts the opportunity for positive risk taking and undermines work undertaken in community mental health settings (Robertson & Collinson 2011). Busfield

(2004) also draws attention to the challenges clinicians face; in her view they are caught between the possibility of adverse publicity from the media, other professionals and the general public and as a consequence frequently side with these powerful groups in decision making over the 'relatively marginal individual with little power'. The more recent MHR (2013) document *Recovery … what you should expect from a good quality mental health service* also emphasises the challenge a culture of positive risk taking and a recovery ethos poses to families, local communities and public leaders who must be willing to accept and support positive risk taking by people experiencing mental health problems.

Mental health service users' involvement

Involvement of services users in all aspects of care is core to recovery principles (Higgins and McGowan 2014). The involvement of users in both the assessment and safety planning process is also advocated as best practice within policy (DoH UK 2007; HSE 2009). As previously stated the HSE (2009) advises that safety management can be achieved more effectively through the type of partnership embodied in the recovery approach, where individual responsibilities are teased out and negotiated, and service users are supported to make choices and decisions about risks that affect their lives.

Service user involvement, or the co-production of safety plans, is viewed as having several benefits. It leads to a better understanding of the persons' perspective on how they view their own situation (e.g. their potential triggers), together with the development of closer working relationships between user and practitioner with a resulting increase in trust, respect, dignity, understanding and empowerment (Langan and Lindow 2004; Boardman and Roberts 2013).

Involvement of service users is also considered a means of minimising the variation between professionals and service users' perception of risk as reported in the literature (Alaszewski *et al*. 1998; Clancy *et al.* 2014; Stickley & Felton 2006; Robertson & Collinson 2011). This in turn ensures that safety plans developed are responsive to service user needs and priorities. Indeed without user involvement important information that may inform safety planning may be minimised or ignored resulting in plans being developed using out of date or inaccurate information. More importantly, involvement is about creating a culture that enables service users to share or take responsibility for their choices and to grow in confidence in their ability to control their own lives (Boardman and Roberts 2013).

However, as indicated earlier a review of literature on service user involvement located few examples of how service users are involved in risk assessment and safety planning. Langan (2010:95) highlights the 'undoubted tension in attempting service user involvement against the coercive backdrop within which much of the interaction between mental health professionals and service users occur'. Indeed Langan and Lindow's (2004) study found that

it was not possible on many occasions to ask service users for their perceptions of being designated 'at risk' as it was rare that professionals clearly communicated this judgement to service users, or told them that they had been the subject of a risk assessment.

Nurses' knowledge, attitudes and practices in relation to risk and safety planning

Despite researchers' and authors' repeated claims that risk assessment and safety management, including the promotion of safe and positive risk taking are core aspects of the mental health nurses' role, limited research exists into how nurses conceptualise 'risk', how they engage with assessment or safety planning, or how they resolve the tensions between working in a recovery oriented manner and fears around professional and public accountability.

The limited research that is available suggests that the emphasis within policy and literature on risk management around risk to self and others is reflected in the way nurses conceptualise risk (Briner and Manser 2013). In the majority of research studies reviewed, nurses tended to define risk as something negative and harmful and as a phenomenon that is located within the individual and one which had to be assessed, managed and prevented (Clancy *et al.* 2014; Woods 2013). Consequently as opposed to viewing risk in a holistic and positive way, risk was conceptualised primarily as harm to self (suicide, self-harm) or harm to others (violence) (Clancy *et al.* 2014; Woods 2013; Godin 2004; Alaszewski *et al.* 1998), with little emphasis on risks posed to services users from the mental health system, or from the wider community. Indeed, only one study, albeit over a decade old, was located that explored nurses' perspectives or practices in relation to other types of risk, namely risk of self-neglect (Gunstone 2003).

In terms of the decision making process used, nurses reported using a combination of 'intuition' and clinical judgement. In Wood's (2013) Canadian study risk assessment appeared to be part of an informal process of 'getting to know the person', with little evidence of proactive safety planning practices. Consequently, the focus was on crisis intervention as opposed to proactive safety planning and therapeutic risk taking. Other studies also describe nurses' reliance on informal unstructured processes, intuition and 'gut feelings' to guide decision-making (Muir-Cochrane *et al.* 2011; Raven & Rix 1999). Similarly, research that focused on specific risks such as violence report a preference for informal means of assessing service users over formal structured approaches, with nurses relying on clinical experience and a 'knowledge of the patient' to make decisions (Murphy 2004; Delaney *et al.* 2001; Trenoweth 2003). Only 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 (CMHNs) (n=20) in this study reported using tools they still favoured clinical judgement and 'interpretative' approaches and relied heavily on their own 'instinct' to guide assessment, in particular assessment of their own safety.

Research suggests that nurses have mixed views on the use and value of standardised tools. In studies involving mental health professionals including nurses, risk assessment and management tools were viewed as a means of facilitating 'strategic and structured information collection'; thus enabling communication and further discussion of risk issues among staff (Gerace *et al.* 2013:561). Tools were also viewed as assisting staff in identifying areas for assessment (Muir-Cochrane *et al.* 2011) and as a means of giving a measure of legal protection from liability. In addition, nurses saw the strength of the tools not in replacing or marginalising clinical judgement, but as an adjunct to support experientially derived knowledge and as a means to inform and help justify decisions made on the basis of clinical experience (Godin 2004; Woods 2013). While some viewed them as a support for inexperienced practitioners (Godin 2004), those who disagreed with their use were of the view that formalised tools are too mechanical, behaviourally reductive, and dehumanizing. Critics also argued that the use of tools was often pursued at the expense of service users' personal development, thus denying the person any opportunity to take risks that might positively improve their lives (Godin 2004). In a similar vein mental health managers in Clancy *et al.*'s (2014) study questioned the 'one tool fits all' approach and instead favoured the development of practice guidelines to underpin risk assessment and safety management.

Although there is little research on how risk assessments inform therapeutic responses and safety management (Grotto *et al*. 2014), some studies highlight the dissociation between risk assessment and safety management plans (Gilbert *et al.* 2011; Woods 2013; Langan and Lindow 2004). Gilbert *et al.*'s (2011) mixed methods study into nurses' use of a web-based decision support system for risk assessment and management in an acute inpatient unit in the UK highlights the gap between assessment and planning. Of the service user records reviewed, approximately 50% (n =21) had aspects of an incomplete assessment, with large variability in the amount and type of information recorded. Where plans existed, in 40% of cases the plan consisted of a list of identified risks as opposed to an actual care plan to address the risk identified. In some cases the plan did not correspond with the risk identified in the assessment process, and in other cases information about risk was recorded elsewhere in the persons' record as opposed to within the safety management plan. Awareness of the dynamic and changing nature of risk was also low, as just 50% of the records reviewed included a review of the risk assessment previously completed. Of those reviews completed, a positive change in risk levels was rarely recorded. Similarly, Delaney *et al.* (2001), Woods (2013), and Godin (2004) all report a disconnect between the risk assessment process and the formulation of a safety plan. Nurses in Godin's (2004) study reported that the outcome of their risk assessment was used to fulfil two broad objectives; namely to ensure the person did not lose contact with the service and ensure that they continued to take prescribed medication.

In terms of whom nurses consult and involve in the assessment and safety planning process, it is clear that risk assessment and planning generally takes place without service user involvement or knowledge, with nurses giving little consideration to how they could involve service users. This lack of involvement in the process suggests that nurses continue to view service users as passive recipients of care as opposed to core contributors to safety planning (Trenoweth 2003; Muir-Cochrane *et al.* 2011; Delaney *et al.* 2001; Kumar and Simpson 2005; Langan 2008). In the absence of engagement and collaborative planning with service users, nurses rely heavily on collating and examining documentary evidence from previous admissions as well as verbal reports from a range of collateral sources, such as psychiatrists, police, community staff, friends and relatives (Wood 2013; Trenoweth 2003; Muir-Cochrane *et al.* 2011; Delaney *et al.* 2001; Kumar and Simpson 2005; Langan 2008). Similarly in Gilbert *et al.*'s (2011) study the most popular source of information was previous documentation and records as opposed to the persons' own view, with family/carers and other members of the mental health team being consulted less than 50% of the time. Furthermore, the CMHNs in Godin's (2004) study also spoke of how the strong orientation towards risk within society and control of risk within health care policy had led them towards extensive data collection before they even met the person, in order to create a 'risk profile'.

A number of reasons are put forward for the possible omission or reluctance of practitioners to involve service users. Nurses viewed discussion of risk 'when someone is acutely unwell as harmful or counterproductive', with a concern that discussion could damage relationships, increase service user stigma, increase likelihood of the person disengaging from the service or provoke anger and aggression thus increasing risk to nurses' safety (Langan 2008; Langan and Lindow 2004). Other reasons put forward include an anxiety around increasing the persons' shame by discussing behaviours that the person engaged in and may not remember (Langan 2008). Practitioners, including nurses in Clancy *et al*.'s (2014:554) study reported a reluctance to use the language of risk believing that risk language is meaningless to the service users' life and brings an 'uncomfortable legal connotation' to the interaction. Indeed, the service users and carers involved in the study did not use a risk language or experience their lives through a risk framework. Instead they used the language of safety and spoke of being safe or secure, a language that they considered more empowering and inclusive. The reluctance of nurses to include service users in 'risk assessment' may also be influenced by the historical emphasis on risk minimisation and prevention, which reinforces professional power and control as opposed to promoting service user involvement (Busfield 2004). The lack of involvement or discussion of risk with service users may be understandable if nurses are attempting to minimise the stigmatising impact of risk language on the person or attempting to avert any negative impact on the relationship. However, as Langan and Lindow (2004) point out there are considerable ethical and human rights issues around placing people in a 'stigmatizing category' without their knowledge, and communicating that information to others without their knowledge. Others raise issues around consent to screening including the right of

service users to be informed if actuarial assessment tools are being used, as well as the right to information about the reliability of tools in terms of false positive or false negative rates (Langan 2008; Hart *et al.* 2007; Swanson 2008).

Summary

- Risk assessment and management have become key features of mental health practice and are articulated in both international and national policies as necessary for the safe and effective delivery of care within mental health services.
- The dominant discourse on risk tends to emphasise the risk that the person experiencing mental health problems poses to themselves or their risk to others, however, more recently other categories have been included, such as risk to service users by others and iatrogenic risks.
- Critics of risk assessment and management argue that the dominant discourse framed by the language of 'risk assessment', 'risk formulation' and 'risk evaluation' is at odds with the language of safety and recovery which underpins health policy.
- Evidence from the literature suggests that mental health nurses' decision-making in relation to risk is guided by historical data, informal processes or 'intuition', with evidence of a lack of service user consultation and collaboration in the risk assessment and safety management process.

2. Methods

Introduction

This chapter describes the aim and objectives of the study, which consisted of two separate modules using different methods to collect the data. Issues relating to recruitment, data analysis, validity and reliability and ethics are also discussed.

Aim

The aim of the study was to explore practices, policies and processes around risk and safety management within mental health nursing and within a number of mental health services.

Objectives of Module One

The objectives of module one were to:

- identify mental health nurses' practices, confidence and attitudes in relation to risk assessment and management
- explore if there were any relationships between nurses' practices, confidence and attitudes in relation to risk assessment and management and the demographic variables of area of work, education, age, gender, nursing role, years qualified as a mental health nurse and prior training in risk assessment and safety planning
- identify mental health nurses' education and training needs in relation to risk assessment and management.

Objectives of Module Two

The objectives of module two were to:

- explore the focus of policies, procedures and guidelines on safety management and risk currently in use within mental health services from the perspective of positive risk
- identify the tools used by mental health nurses in the safety planning process, including the assessment of risk
- develop baseline knowledge on the types of tools and policies currently being used.

Research design and methods

Data for the study were collected using a mixed method design involving an anonymous, self-completed survey and documentary analysis.

Module 1: The anonymous, self-completion survey was used to meet the objectives of module one and focused on mental health nurses' practices, confidence and attitudes in relation to risk assessment and management. This approach was deemed the most feasible

and cost-effective method of obtaining information from the target sample. Surveys allow a great deal of information to be collected in a structured format, thus ensuring that the answers elicited from respondents are as consistent and accurate as possible. This approach also ensured the anonymity of respondents which is important for reducing the likelihood of socially desirable responding (de Vaus 2013).

The survey sought information on risk assessment and management training undertaken by mental health nurses as well as training needs in this area. The survey was designed by the research team and consisted of 16 closed-ended questions, using a combination of binary (yes/no), categorical and Likert scale responses. Three open-ended questions were included. See table 2.1 for a complete description. (The survey is available from the PI on request).

Table 2.1 Survey content

Topic	Question(s)	Description
Demographic data	Q1-Q6	Respondents were asked to provide information on their area of work, highest level of educational attainment, age, gender, current role and number of years qualified as a mental health nurse.
Risk assessment and safety planning training	Q7, Q8 & Q17	Respondents were asked whether they had received training in risk assessment and safety planning. Respondents were also asked to indicate their top four educational needs and training priorities in relation to risk assessment and management using an open-ended format question.
Risk assessment and safety planning practices	Q9, Q10, Q11 & Q12	Respondents were asked to indicate (yes/no) whether they currently assess risk and develop personal safety plans in their clinical area. Respondents were then asked to indicate on a four point scale ranging from 1 (never) to 4 (always) the frequency with which they consider a range of factors from a list of 28 items in their risk assessment practice. Respondents were also asked to indicate on a four point scale ranging from 1 (never) to 4 (always) the frequency with which they consider a range of factors from a list of 21 items in their safety planning practice.
Risk assessment and safety planning processes	Q13 & Q14	Respondents were asked to indicate how often they involve service users, family members/carers, other nurses, psychiatrists and other members of the MDT team in their risk assessment and safety planning practice. The response category options were 'always', 'sometimes' and 'never'.
Organisational risk assessment and safety planning policies and procedures	Q15	Respondents were asked about their knowledge of whether their organisation had risk assessment and safety planning policies and procedures in place. The response category options were 'yes', 'no' and 'unsure'.
Confidence in risk assessment and management	Q16	Respondents were asked to rate their confidence in their ability to perform a range of tasks related to risk assessment and management on a five point scale ranging from 1 (no confidence) to 5 (very confident). The scale was summed to provide an overall mean score for confidence among respondents in relation to risk assessment and

		safety planning on which scores range from 1 to 5 with a higher score indicating higher confidence.
Attitudes to risk assessment and management	Q18	Respondents were presented with 13 attitudinal statements related to risk assessment and management. It included statements relating to the use of risk assessment tools, positive risk taking and role responsibility in risk assessment and management. Respondents were asked to indicate their level of agreement/disagreement with the statements on a five point scale ranging from 1 (strongly agree) to 5 (strongly disagree).
General Comments	Q19	Respondents were given a space at the end of the survey to make comments.

Module 2: Documentary analysis was the methodology chosen to meet the objectives of module 2. Official documents drawn up at the organisational level provide insight into the context and culture of the organisation(s) being studied (Fitzgerald 2012). They also provide an opportunity for the triangulation of other data (Bryman 2012), which in the case of the present study is the survey of nurses' practices around risk-taking roles and activities.

Compared to other methods of data analysis, documentary analysis is what Bryman (2012) calls a relatively 'non-reactive' methodology. In other words, the data that are contained within official documents (which are later examined using content analysis) are constructed independently of any research study; consequently, there is little risk of the data collection process intruding upon or influencing the quality of the data in question. The primary advantage of analysing documents in a research study of this nature is the relative accessibility of data as well as the opportunity to access information that otherwise may or may not be reported by nurses within the survey. Despite being secondary sources of data, risk-related documents are of further value in their ability to point to the practical ways in which an organisation conceptualises, frames and assesses risk in clinical practice. It also illustrates if there is homogeneity of risk practice within HSE mental health services, or whether there is a disparity in risk policies, procedures and practices.

Inclusion and exclusion criteria

Module 1: The inclusion criteria for module 1 were that participants must be:

- registered mental health nurse with the Nursing and Midwifery Board of Ireland (NMBI)
- be employed either full time or part time in one of the seven participating sites.

The exclusion criteria included:

- mental health nurse working as an agency nurse
- student mental health nurse in one of the seven participating study sites
- mental health nurse working in child and adolescent service or in old age psychiatry (the needs of these groups are different)

Module 2: The inclusion criteria for module 2 were that services must be:

- adult mental health service within the public health service

The exclusion criteria included:

- private adult mental health service

Recruitment and data collection

Module 1: Mental health nurses from seven HSE regions were recruited to participate in module 1. The seven regions had a wide geographic spread. The Area Directors of Nursing in each region granted approval to the research team to recruit registered mental health nurses from within their site. In order to distribute the surveys the Area Director of Nursing in each study site was asked to nominate a member of their team in each respective area to act as a gatekeeper. The role of the gatekeeper was to distribute the study information to all mental health nurses meeting the inclusion criteria in their area. A hard copy information pack containing a letter of invitation, a participant information leaflet, a questionnaire and a stamped addressed envelope was sent to the gatekeepers who then distributed the packs to individuals meeting the inclusion criteria. Completed surveys could be returned directly to the research team in a pre-paid envelope supplied or returned centrally to the gatekeeper who forwarded them on to the team.

Module 2: Data for module two were collected after contacting Directors of Nursing or Acting Directors for all HSE mental health services requesting their involvement. Participants were invited to send, via post or email, any organisational policies, working models or risk assessment and management tools, which they considered related to safety planning and were in use by mental health nurses in their service. Issues such as suicide, violence and aggression, self-neglect, sexual abuse, medication compliance and self-harm were given as examples of the risk-related topics that documentation might include. Participants were initially contacted by email, although some follow-up communication was made via telephone as needed.

Data analysis

Module 1: Statistical analysis of respondents' responses to the survey was performed using the Statistical Package for the Social Sciences (SPSS), version 21 (IBM Corp, 2011). Descriptive statistics including frequency distributions, means and standard deviations were generated to describe the data. Inferential statistics were performed in order to establish the relationships between nurses' risk assessment and management practices, confidence and attitudes and a range of other variables, including area of work, education, age, gender, current role, number of years qualified as a mental health nurse, and whether respondents'

had received any education on either risk assessment or safety planning. The types of parametric or nonparametric 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 ANOVAs, cross tabulation chi-square tests and Pearson product moment correlation co-efficient tests. Non-parametric statistical tests conducted included the Mann-Whitney and Kruskal-Wallis tests. Multiple and logistic regression was conducted to assess whether certain variables significantly predicted confidence in risk assessment and management and the development of safety management plans. 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 made by respondents were subjected to a thematic content analysis by two members of the research team, while the training priorities identified by respondents were grouped into broader training content areas.

Module 2: The primary aim of data analysis was to explore and compare the content of the documents received. The Microsoft Excel 2011 software programme was used to code data and run descriptive statistics.

Documents were initially assessed for their location of origin (i.e. mental health service area) and type of document (tool, policy or other/unspecified). Each document was then categorised as belonging to one of the following four groups: assessment tools, risk management and safety planning documentation, policies and other/miscellaneous. The assessment tools were sub-categorised into the following two groups: validated assessment tools and un-validated or general screening assessment tools. Policies were sub-categorised as being either general policies or policies with a risk assessment focus, and analysed regarding their focus.

Reliability and validity

The face validity of the survey for module one was established by asking experts and specialists in the field of nursing to review the survey and provide feedback in relation to its relevance and appropriateness as well as to identify any gaps in the survey. A questionnaire feedback form was provided to respondents for this purpose.

Internal reliability analysis was conducted on the 12-item Likert scale developed to measure respondents' self-reported confidence in practicing risk assessment and safety management. A Cronbach's alpha level of 0.948 resulted, which indicated that the scale is very reliable.

Internal reliability analysis was also conducted on five items related to the use of risk assessment tools (18.4, 18.7, 18.8, 18.9 and 18.10) which comprised part of the 13-item

question developed to assess respondents' attitudes to risk assessment and management, in order to determine if these items could be treated as a scale. First, the positively worded item (Item 18.10) was reverse scored prior to the analysis. A Cronbach's alpha level of 0.684 was obtained, which is deemed acceptable, though item 18.10, which related to whether risk assessment tools support professional decisions, did have a low corrected item-total of .113 and if removed would have resulted in a slightly improved alpha level.

Ethical considerations

Ethical approval for the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. Respondents for both module one and two were informed that their participation in the study was voluntary and anonymous. Return of the survey was taken as evidence of implied consent. The questionnaires were distributed by gatekeepers on behalf of the research team and completed questionnaires were returned indirectly to the research team either in the pre-paid envelope supplied or via the gatekeeper. Therefore, the research team had no access to respondents' details. As the survey was anonymous, no identifying information was requested and respondents were assured that no study site would be identified in any study publications.

Information received for the documentary analysis was treated confidentially and anonymously and all documents were handled and reviewed by the research team only.

3. Survey Results Part I: Descriptive findings

Introduction

This first chapter of findings presents the descriptive analysis of the module one survey that was designed to explore mental health nurses' practices around risk and safety management. Prior to presenting the findings a profile of the respondents who completed the survey is presented.

Respondent profile

Among the participating regions, it was estimated that there was approximately 1320 eligible mental health nurses to whom the survey could be distributed. In total 396 surveys were returned, however, 15 of these were deemed ineligible as they were from mental health nurses working in child and adolescent services or in old age psychiatry and were excluded from the analysis. Thus, 381 eligible surveys were received, yielding an estimated response rate of 28.9%.

Over two thirds of respondents were female (69.5%), less than one third of the sample comprised males (29.9%) while one person identified as transgender and another person choose not to disclose their gender. A small proportion of the sample were in the lower and upper age brackets with less than four per cent aged between 20-24 years and approximately eight per cent aged 55 years and over. Over one third of the sample was aged between 45-54 years (34.1%) while just less than one third represented those aged 25-34 years (32.2%). Just over one fifth were aged 35-44 (22.1%) (See table 3.1).

Table 3.1 Respondents' demographic characteristics

		% (n)
Gender (n=374)	Male	29.9 (112)
	Female	69.5 (260)
	Transgender	.3 (1)
	Not disclosed	.3 (1)
Age (n=379)	20 - 24	3.7 (14)
	25 - 29	14 (53)
	30 - 34	18.2 (69)
	35 - 39	10.8 (41)
	40 - 44	11.3 (43)
	45 - 49	15.6 (59)
	50-54	18.5 (70)
	55+	7.9 (30)

Respondents were asked to indicate their area of work. Based on these responses, area of work was classified for respondents according to whether they worked in acute inpatient settings, community settings (day hospital, day centre, community, crisis or outreach teams) and residential rehabilitation settings (residential rehabilitation units within hospitals, community residents/hostels). 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%).

The majority of the sample comprised staff nurses (49.5%). Clinical Nurse Mangers (CNMs) made up just over one fifth of the sample (21.5%) with the majority of these at level two. The remainder of the sample comprised Community Mental Health Nurses (CMHNs) (15%), Clinical Nurse Specialists (CNSs) (9.7%) and other (4.7%). Just one respondent worked as an Advanced Nurse Practitioner (ANP). The number of ANPs/CNSs who returned the survey represented 12.2% of total ANPs/CNSs working in mental health services nationally while a tenth of CNMs working in the Irish mental health service participated in the survey. Although staff nurses and CMHNs comprised the largest proportion of sample respondents, they represented approximately 8% of all staff nurses and CMMHs within the national mental health service (See table 3.2).

Table 3.2 Study sample as proportion of national sample

	National sample*	**Study sample as % of national sample**
Nursing role	**n**	**% (n)**
ANP/CNS	309	12.2 (38)
CNMs	790	10.3 (82)
Staff Nurses (including CMHNs)	3098	7.9 (247)

*Source: Workforce Planning, Analysis, & Informatics | National HR Directorate | (December 2014 figures)

Just under one tenth of the sample was educated to Certificate level (9.3%), while just over one tenth of the sample was educated to Diploma level (11.7%). Two fifths (38.3%) of the sample had a primary degree, with almost a quarter of respondents holding a postgraduate qualification (24.5%). A Masters was obtained by 16% of the sample, and one respondent had a PhD.

With regard to number of years qualified as a mental health nurse, the sample ranged from as little as less than one year's qualification to a maximum of 40 years. The average number of years qualified for the sample was 16.25 (SD=11.279). Over two fifths of the sample had been qualified for 10 years of less (41.3%). Over a fifth had been qualified between 11-20 years (22.9%) and a similar proportion had been qualified between 21-30 years (22.9%). Just

over one tenth of the sample had been qualified between 31-40 years (12.9%) (See table 3.3 for details of respondents' profile).

Table 3.3 Respondents' employment and educational details

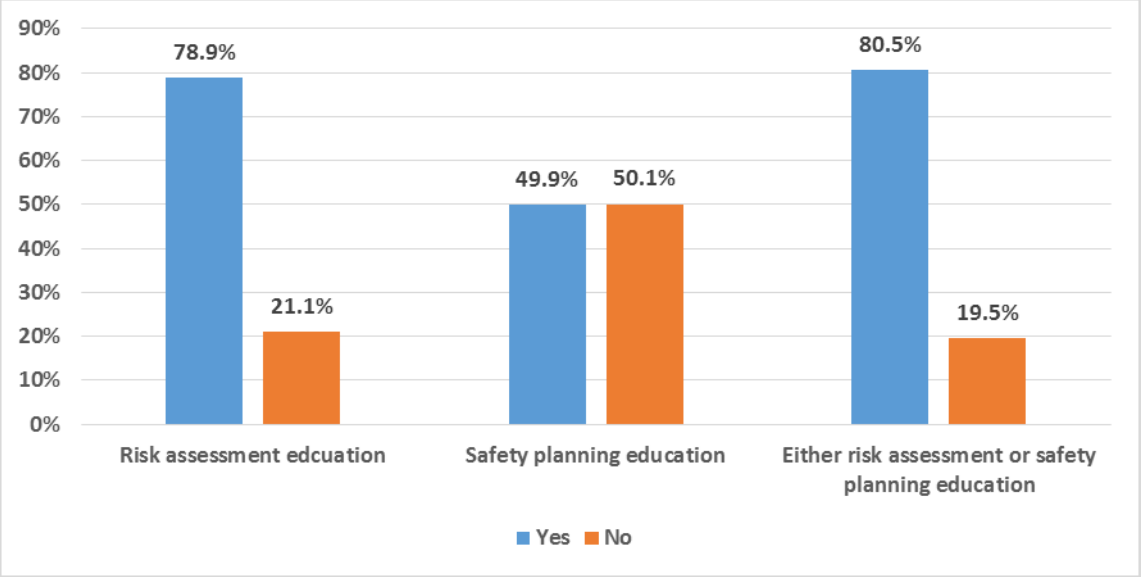
		% (n)
Area of work (n=292)	Acute inpatient	42.1 (123)
	Community	47.3 (138)
	Residential rehabilitation	10.6 (31)
Current Role (n=385)	Staff Nurse	49.5 (190)
	CNM 1	2.9 (11)
	CNM 2	16.8 (64)
	CNM 3	1.8 (7)
	CNS	9.7 (37)
	ANP	0.3 (1)
	CMHN	15 (57)
	Other	4.7 (18)
Highest education (n=376)	Certificate	9.3 (35)
	Diploma	11.7 (44)
	Degree	38.3 (144)
	Postgrad	24.5 (92)
	MSc	16 (60)
	PhD	0.3 (1)
Years qualified as MHN (n=380)	0-10	41.3 (157)
	11-20	22.9 (87)
	21-30	22.9 (87)
	31-40	12.9 (49)

Education on risk assessment and safety planning

Respondents were asked if they had received education on risk assessment and safety planning. Nearly four fifths of the sample indicated that they received education on risk assessment (78.9%) while just under half of the sample had received education on safety planning (49.9%). Overall four fifths (80.5%) of the sample indicated that they had received some education on either risk assessment or safety planning. In other words, just under a

fifth (19.5%) of respondents received no education in either risk assessment or safety planning (Figure 3.1).

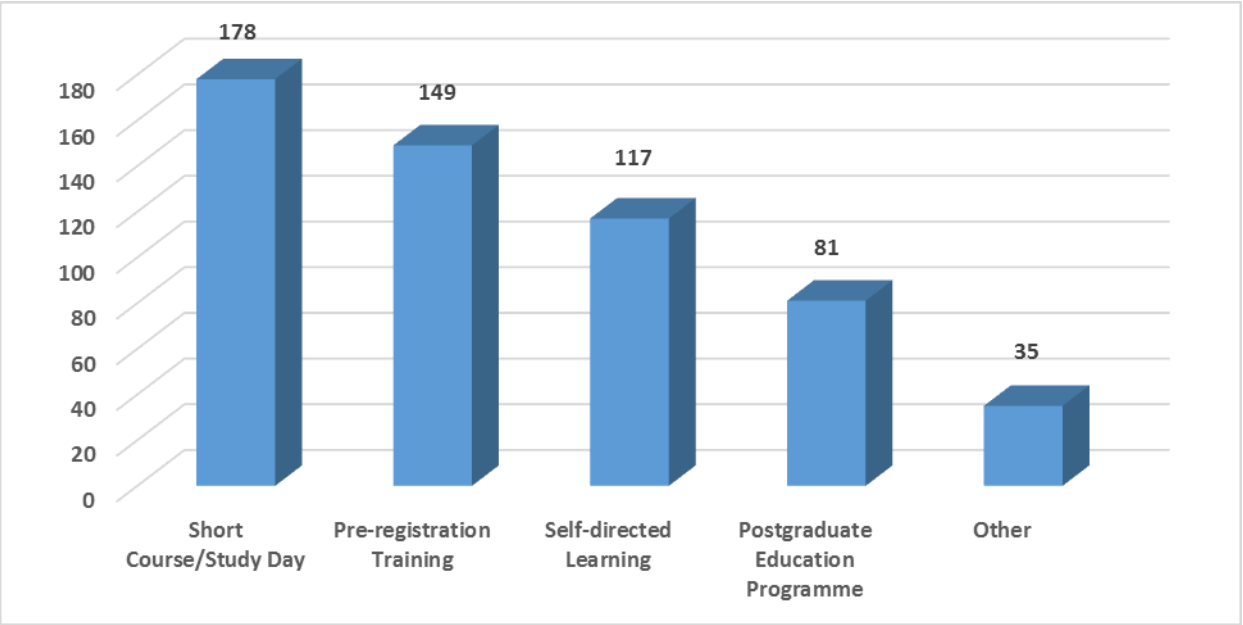
Figure 3.1 Education on risk assessment and safety planning



Source of education programme

Respondents were asked to identify the source of education programme they attended (Figure 3.2). Of those who had received training on either risk assessment or safety planning (n=306), nearly three fifths (58.2%) received education during attendance at a short course or study day. Just under half (48.5%) received training as part of their pre-registration nurse education programme. Nearly two fifths (38.1%) of the sample undertook self-directed learning to educate themselves on risk assessment or safety planning. A quarter (26.4%) of those who received training did so as part of a postgraduate education training programme. Over a tenth (11.4%) of the sample stated that they received education via some other means of learning, however they did not indicate the source of education.

Figure 3.2 Source of education on risk assessment or safety planning



*Percentages do not add up to 100% as respondents could choose multiple answers

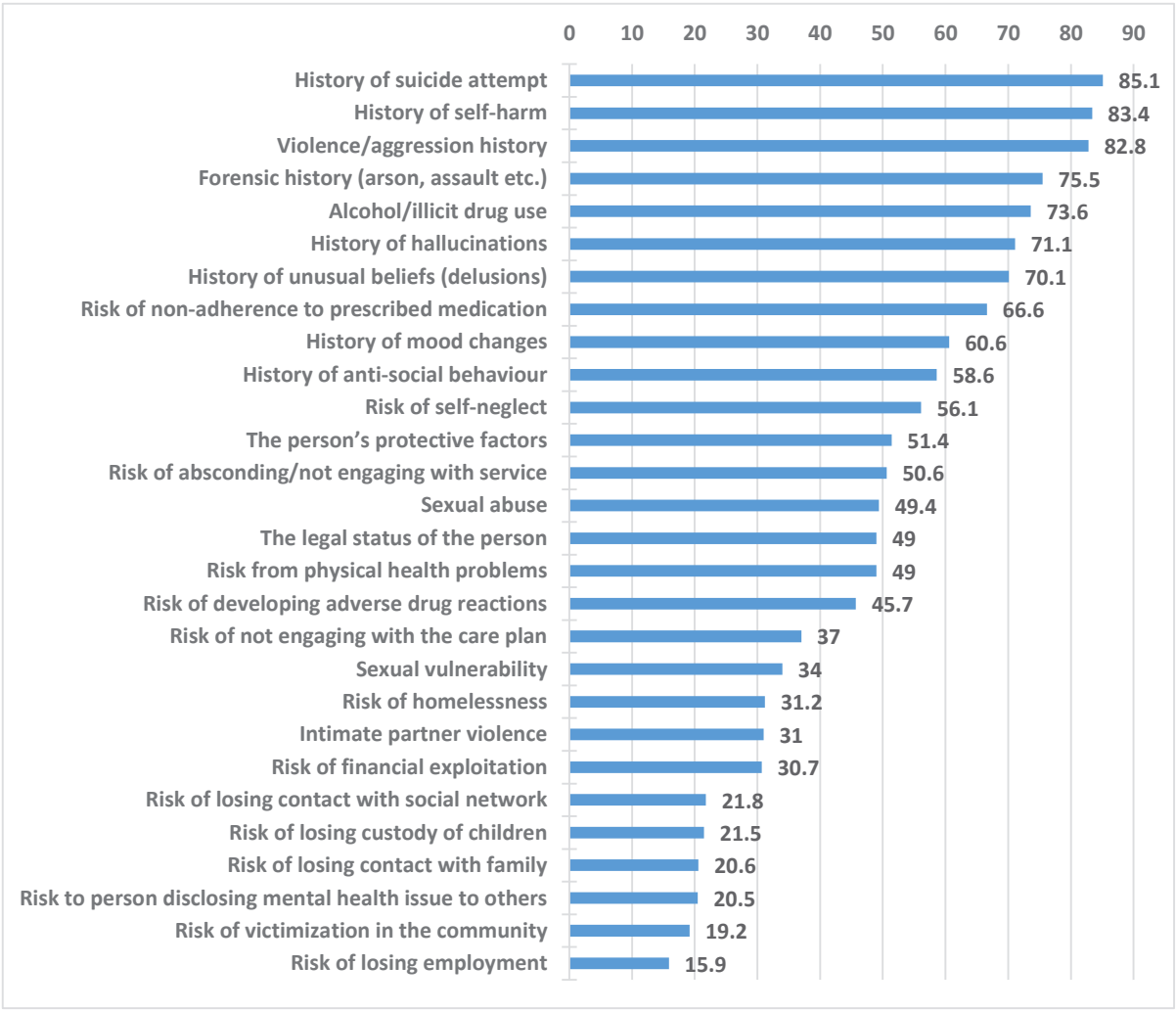
Risk assessment practice

Respondents were asked if they currently assess risk in their clinical area. According to the results, the majority (95.7%, n=352) of the sample indicated that they currently complete a risk assessment as part of their practice. For the purpose of analysis, the 'never' and 'rarely' response categories were combined.

Of those who indicated that they assessed risk they were then asked to indicate on a four point Likert scale ranging from 'never' to 'always' the frequency they considered a list of 28 issues when completing a risk assessment. More than four fifths of the sample 'always' took history of suicide attempt (85.1%), self-harm (83.4%), and violence/aggression (82.8%) into account when assessing risk. Approximately three quarters 'always' considered a persons' history of arson or assault (75.5%). These four highest ranked factors in the 'always' category relate to immediate risk to self and risk to others. Over 70% of the sample 'always' considered the issue of substance abuse (73.6%), a history of hallucinations (71.1%) and unusual beliefs (70.1%) while two thirds 'always' considered the risk of non-adherence to prescribed medication (66.6%). These factors appear to relate mostly to a persons' mental health status and factors which might impinge upon effective mental healthcare treatment. Over half of the sample indicated that they 'always' took a range of other factors into account, including history of mood changes (60.6%), history of anti-social behaviour (58.6%), risk of self-neglect (56.1%), the persons' protective factors (51.4%) and the risk of not engaging with the service (50.6%). Less than half of the sample but more than two-fifths indicated that they 'always' considered the risk of sexual abuse (49.4%), the legal status of the person (49%), the risk from physical health problems (49%) and the risk of developing adverse drug reactions (45.7%). The risk of not engaging with the care plan was 'always'

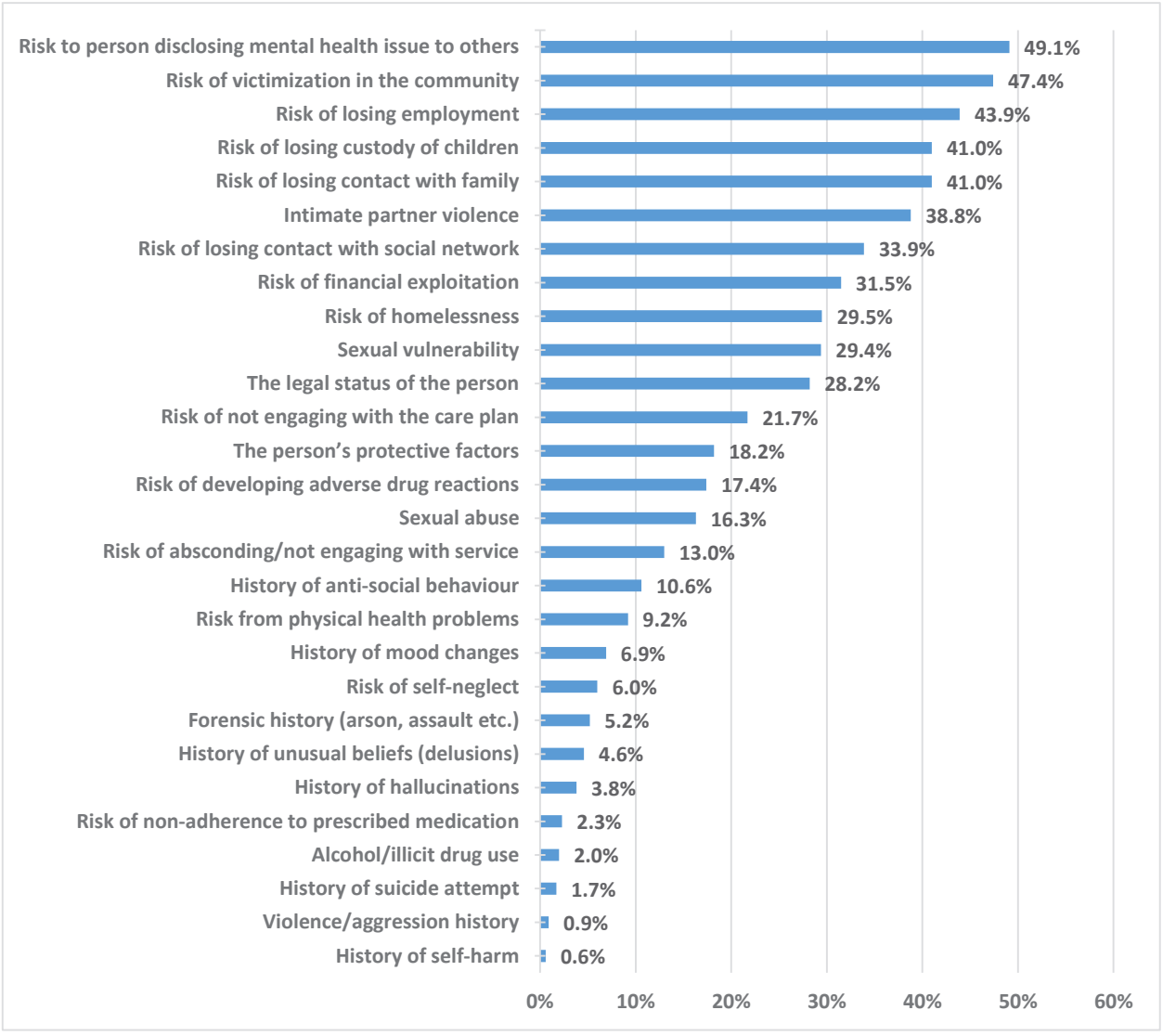
considered by just less than two-fifths of respondents (37%). Approximately one third of respondents 'always' considered the risk of sexual vulnerability (34%), the risk of homelessness (31.2%), the risk of intimate partner violence (31%) and the risk of financial exploitation (30.7%). Although around half of respondents involved in risk assessment practice purported to 'always' consider the persons' protective factors when conducting risk assessments, potential protective factors such as a persons' family and wider social networks rank lower in the list of 'always' considered risk factors with approximately a fifth of respondents 'always' considering the risk of losing contact with social networks (21.8%), the risk of losing custody of children (21.5%) and the risk of losing contact with family (20.6%). A similar proportion 'always' took risks related to disclosing mental health issues to others (20.5%) and victimization in the community (19.2%) into account in their risk assessment practice. The risk of losing employment ranked lowest in the list of 'always' considered risk factors. Figure 3.3 shows the proportion who 'always' considered the 28 items in their assessment, ranked from highest to lowest.

Figure 3.3 Risk factors 'always' considered (%)



A further analysis of the factors 'never' or rarely' considered by respondents in risk assessments indicate that the three highest factors to which consideration is 'never/rarely' given is the risk of a person disclosing their mental health status to others (49.1%), the risk of victimization in the community (47.4%) and the risk of losing employment (43.9%) (See figure 3.4 for the proportion who 'never/rarely' considered the 28 items in their assessment, ranked from highest to lowest). The figure also confirms that approximately 40% do not consider the risk of losing custody of children (41%), losing contact with family (41%) while around a third 'never/rarely' considered the risk of losing contact with social networks (33.9%).

Figure 3.4 Risk factors 'never/rarely' considered

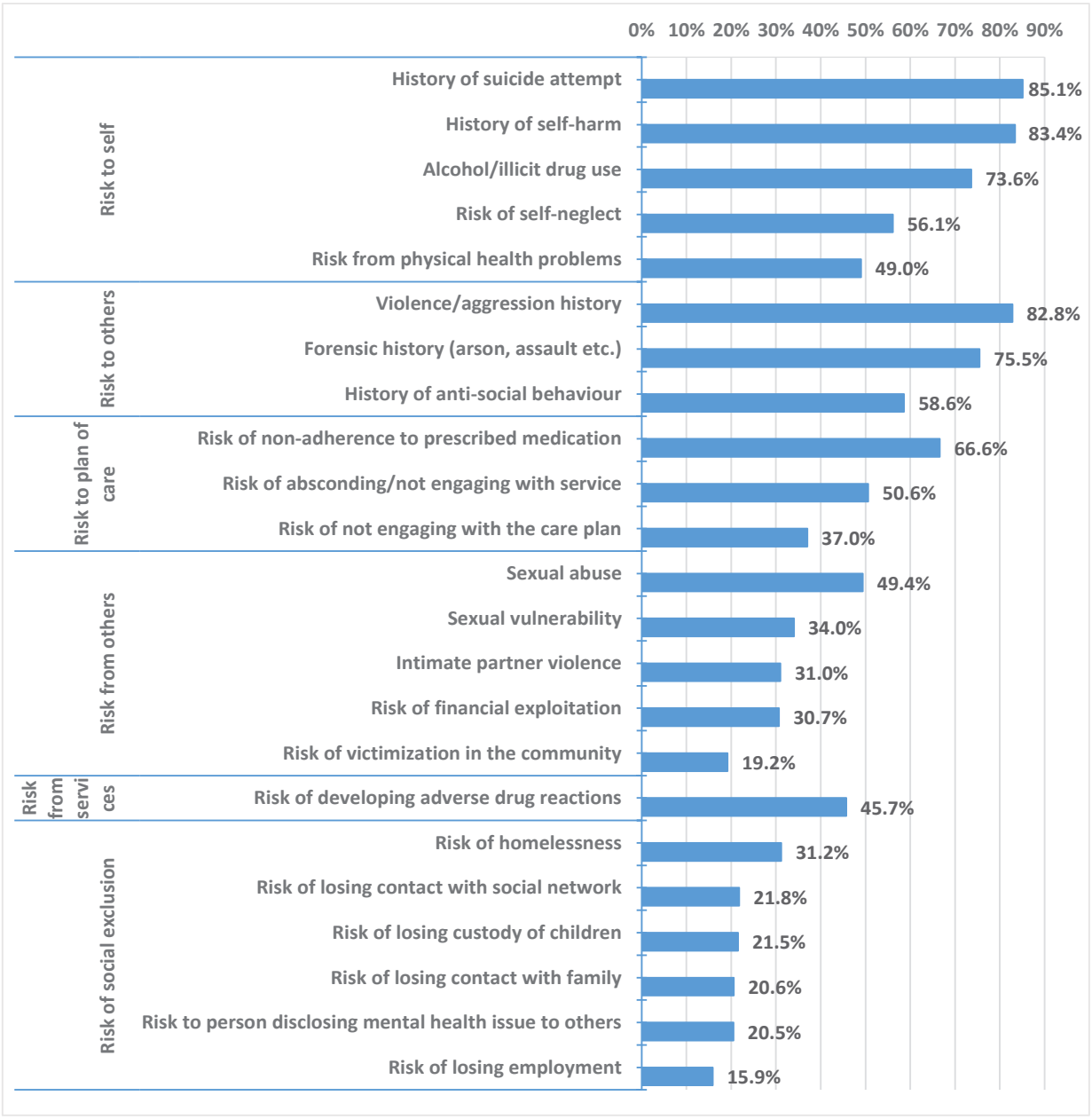


Categorisation of risk

Using an adapted version of Taylors' (2001 cited in Cordall 2009) model of risk categorisation a further analysis of the 28 items was performed. The 28 items were categorised under the following: risk to self; risk to others, risk from others, risk to plan of

care, risk from services, risk of social exclusion and contextual issues that many impact or influence risk. From this perspective a pattern emerged in the types of risk factors afforded most consideration in risk assessment practice. It is clear that while mental health nurses frequently assess risk to self and risk to others, they are less preoccupied with the risk that others pose to service users and the ways in which they are vulnerable to exploitation by others (Risk from others). Least consideration is notable in the risks that pertain to a persons' family and social network and broader social circumstances related to service users' housing and employment situation (Risk of social exclusion). Figure 3.5 displays the proportion who 'always' considered the 28 items in their assessment categorised according to the model of risk categorisation.

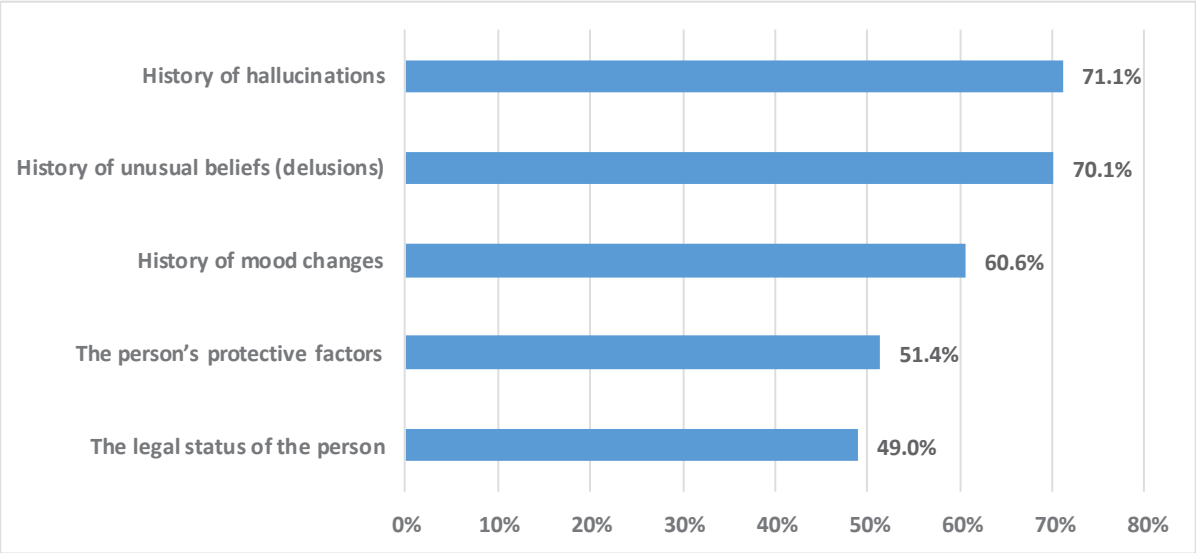
Figure 3.5 Risk factors 'always' considered by risk category



Contextual issues impacting on risk

In relation to the contextual issues that impact on the persons' risk factors, personal mental state was considered by over 70% of respondents while only 52% indicated that they 'always' consider the persons' protective factors when completing a risk assessment. Figure 3.6 displays the proportion of respondents who 'always' considered the contextual risk factors in their risk practice.

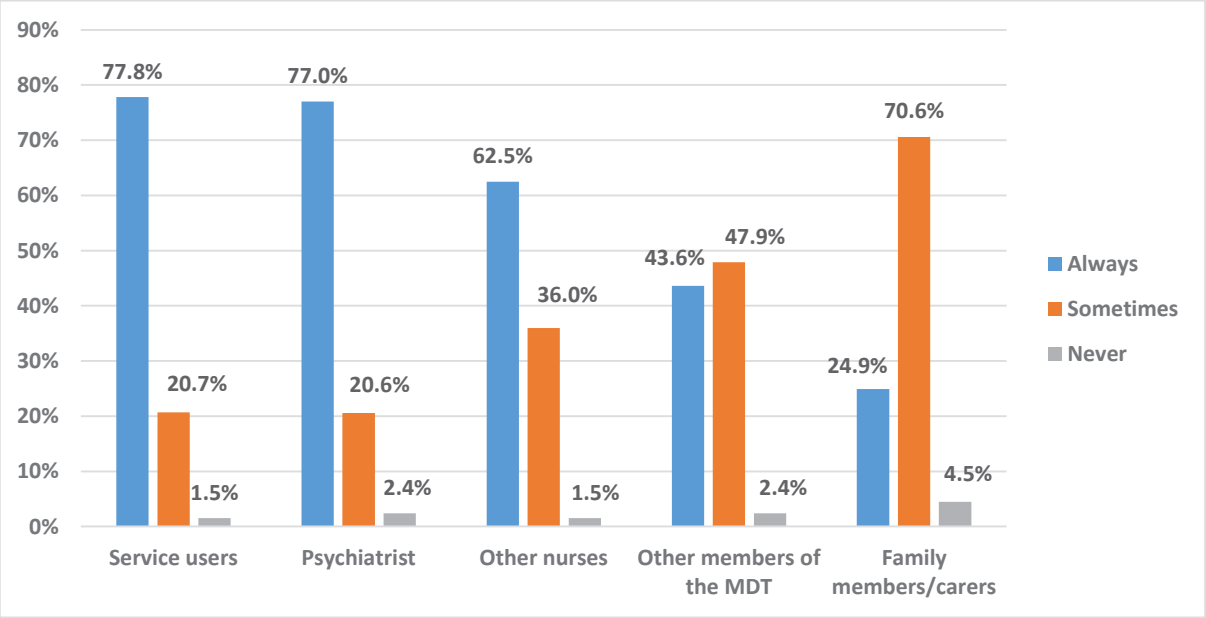
Figure 3.6 Contextual risk factors 'always' considered



Involvement of stakeholders in the risk assessment process

Respondents were asked how often they involve certain individuals and healthcare professionals in the risk assessment process. The three options were 'always', 'sometimes' and 'never'. Of those who indicated that they currently assess risk in their clinical practice (n=352), more than three quarters 'always' involved both the psychiatrist (77%) and service users (77.8%) in the risk assessment process. Approximately two-thirds of respondents 'always' involved other nurses (62.5%). A higher proportion of respondents 'sometimes' involved members of the multidisciplinary team than 'always' involved them (47.9% compared to 43.6%). Similarly consultation with family members and carers when conducting risk assessments was reported as occurring 'sometimes' (70.6%) more often than occurring always (24.9%). Compared to other groups, family members and carers was the group with the highest proportion of responses for 'never' being involved in the risk assessment process (4.5%) (See figure 3.7).

Figure 3.7 Involve in risk assessment process



Development of safety plan

Respondents were asked if they currently develop safety plans to assist service users in managing risks. According to the results, approximately two-fifths of the sample (39.5%, n=134) always engaged in this practice while a similar proportion are sometimes engaged in this practice (43.7%, n=148). Thus, 16.8% (157) of the sample do not currently develop personal safety plans.

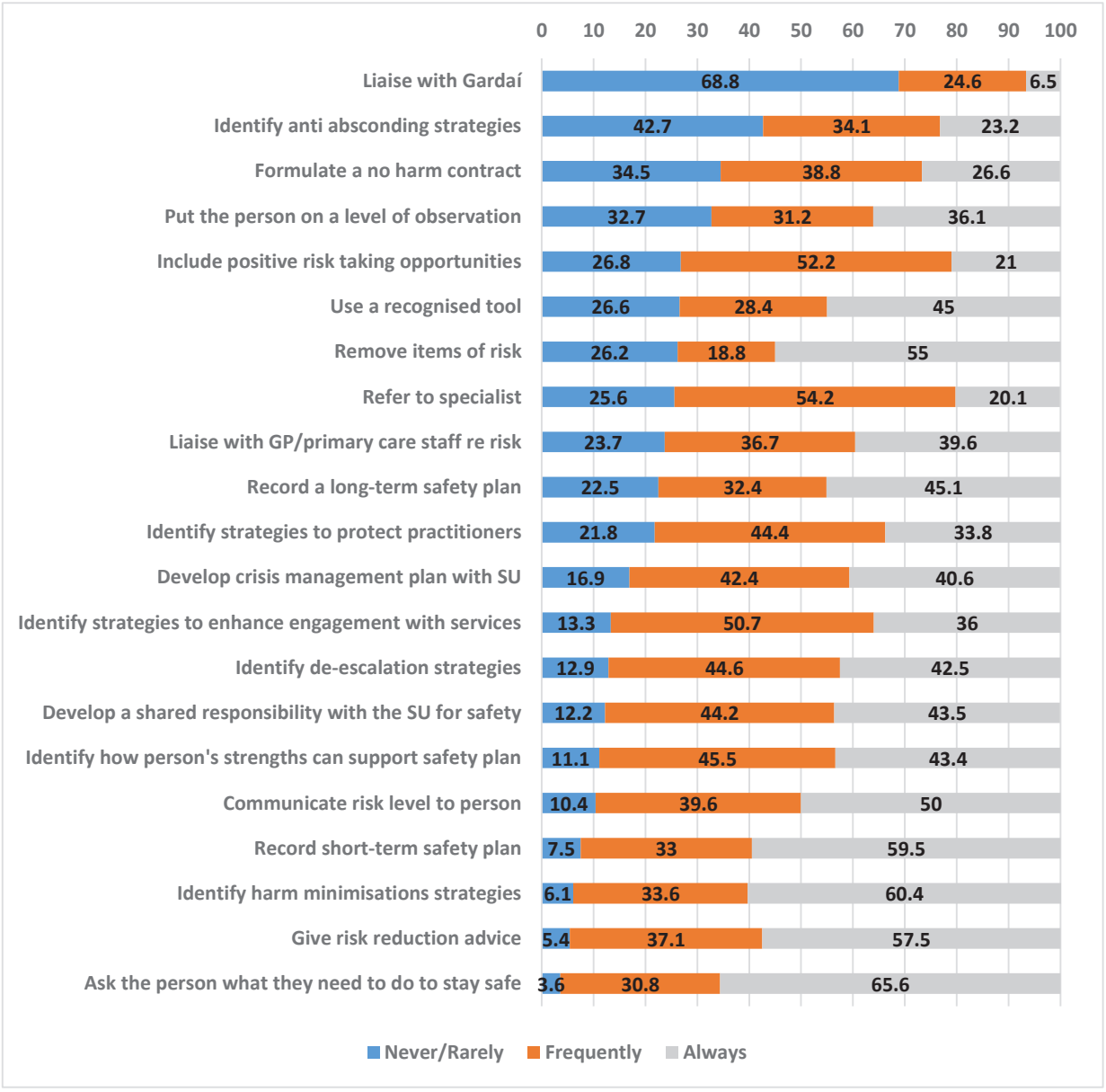
Safety planning practices

Respondents were asked about the frequency they engage in a range of actions when developing a personal safety plan from a list of 21 items. The responses were analysed for those who indicated that they currently develop safety plans (n=282). For the purpose of analysis, the 'never' and 'rarely' response categories were combined.

Liaising with Garda was not implemented very often by respondents as this was 'never/rarely' done by more than two-thirds of the sample (68.8%). It was also not routine practice among respondents to identify anti-absconding strategies (42.7%), formulate a no harm contract with service users (34.5%) or place a person on a level of observation (34.5%). Just over a quarter of respondents 'never/rarely' included positive risk taking opportunities (26.8%), used a recognised tool (26.6%), removed items of risk (26.2%) or referred to a specialist (25.6%) when developing personal safety plans. Between a fifth and a quarter of respondents 'never/rarely' liaised with GP or primary care staff (23.7%), recorded a long-term safety plan (22.5%) or identified strategies to protect practitioners (21.8%). Asking the person what they need to stay safe (65.6%) ranked the highest among

actions ‘always’ completed when developing a safety plan. The top five highest ranked actions ‘always’ performed also included identifying harm minimisation 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%). Figure 3.8 shows the proportions of respondents who ‘always’, ‘frequently’ and ‘never/rarely’ considered the 21 items in their safety planning practice ranked highest to lowest according to the ‘never/rarely’ category.

Figure 3.8 Frequency of actions taken when developing a personal safety plan

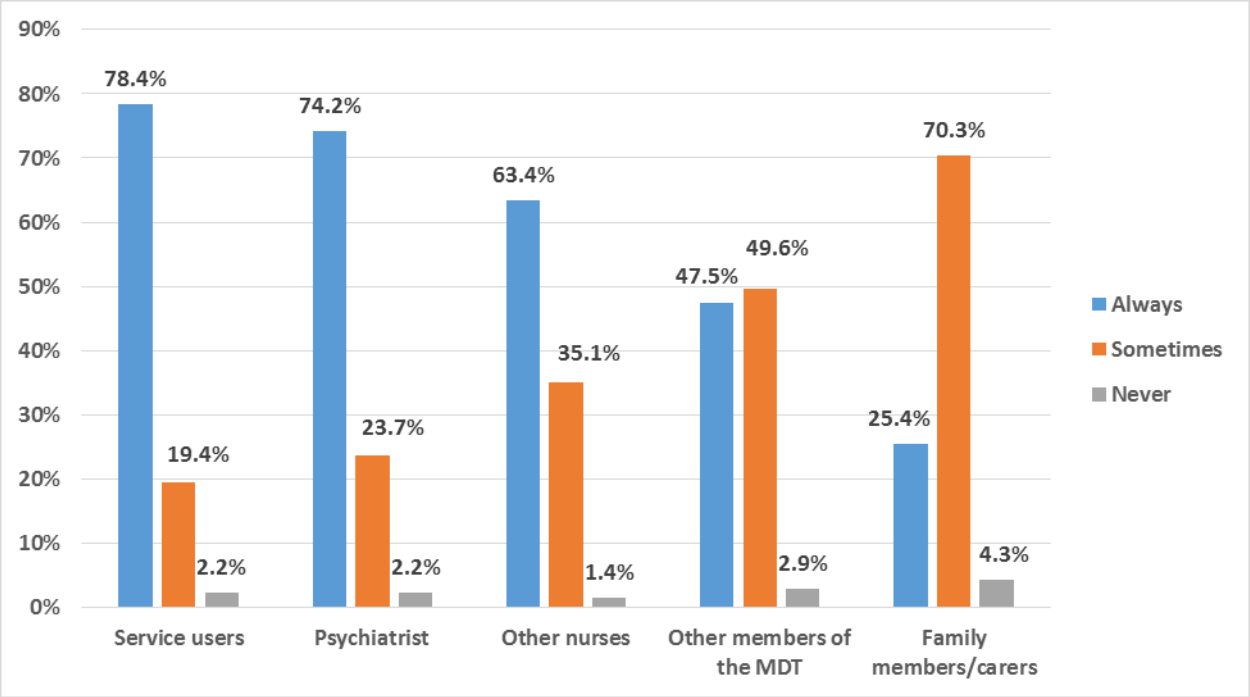


Involvement of stakeholders in the safety management plan

Respondents were asked how often they involve certain individuals and health professionals in the development of a safety plan. The responses were analysed for those who indicated that they currently develop safety plans (n=282). Approximately three quarters of the

sample reported 'always' involving service users (78.4%) and psychiatrists (74.2%). Two-thirds of respondents 'always' involved other nurses (63.3%). Just less than half of the respondents 'always' consulted other members of the MDT (47.5%). Family members and carers stand out for being the group who are least often involved in the safety planning process with just over a quarter being 'always' involved (25.4%). They are also the group with the highest proportion for 'never' being involved in the process (4.3%) (See figure 3.9).

Figure 3.9 Involve in the development of a safety management plan



Risk assessment and safety planning policies and procedures

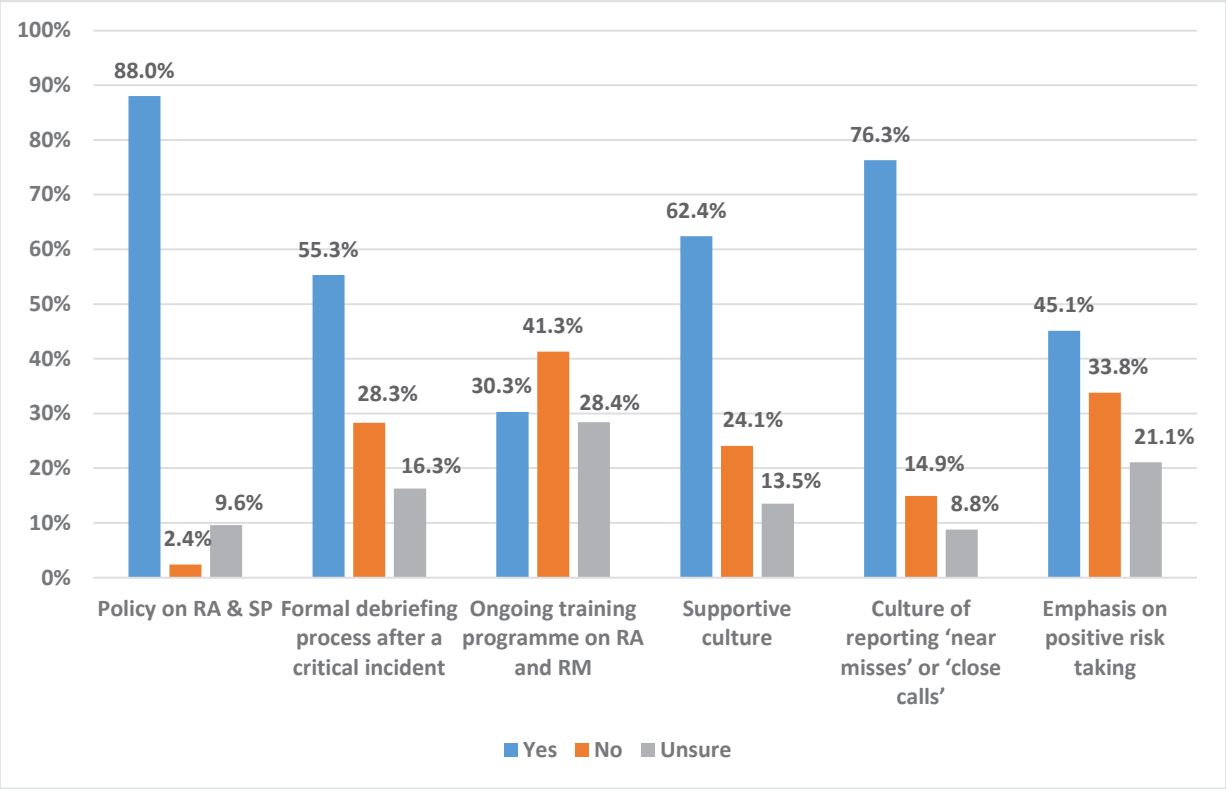
All respondents were asked about the presence of risk assessment and safety planning policies and procedures within their organisation. The majority of respondents reported that their organisations have a policy on risk assessment and safety planning (88%). However, just under a tenth of respondents (9.6%) indicated that they were unsure if such policies existed. Just over half of the sample worked in organisations in which there was a formal debriefing process following a critical incident (55.3%).

Just over three quarters (76.3%) of respondents perceived that there was a culture of reporting near misses or close calls that could have posed a potential for harm but did not result in an adverse event. Three fifths (62.4%) of the sample perceived that a supportive culture was present in their organisation at times when things 'go wrong'. While approximately 31% indicated that an ongoing training programme on risk assessment and management existed within their organisation, 41.3% of respondents indicated that this was

absent and over a quarter of respondents (28.4%) were unsure of the existence of a training programme on risk assessment and safety planning.

In the context of positive risk taking, less than half the sample (45.1%) perceived that there was an emphasis on positive risk taking within the organisation with a third (33.8%) of respondents saying 'no' to this question and approximately a fifth (21.1%) being unsure as to whether there was an emphasis on positive risk taking (See figure 3.10).

Figure 3.10 Organisations' risk assessment and safety planning policies and procedures



Reported confidence in relation to risk assessment and safety planning practices

The survey sought to ascertain respondents' level of reported confidence in a range of situations related to risk assessment and safety planning. Respondents were asked how confident they perceived themselves on a scale of one (no confidence) to five (very confident), with higher scores on the scale indicating higher levels of confidence. Table 3.4 below shows respondents' confidence with risk assessment and safety planning tasks ranked in order of highest to lowest confidence. On average respondents were most confident with liaising with MDT members regarding risk. An average score of above or close to four was obtained for items related to speaking to service users about safety management strategies, identifying service users' protective factors and completing a risk assessment interview. The item which respondents were least confident about was working

with positive risk taking opportunities. Other items with the lowest mean scores included liaising with Gardaí regarding risk, formulating a risk assessment profile, developing a safety management plan and involving family members in this process. The scale was summed to provide an overall mean score for confidence among respondents in relation to risk assessment and safety planning. The average sum score for the scale was 3.85 (SD=.790) which indicates a high level of confidence among respondents in relation to risk assessment and safety planning overall.

Table 3.4 Respondents' confidence with risk assessment and safety planning

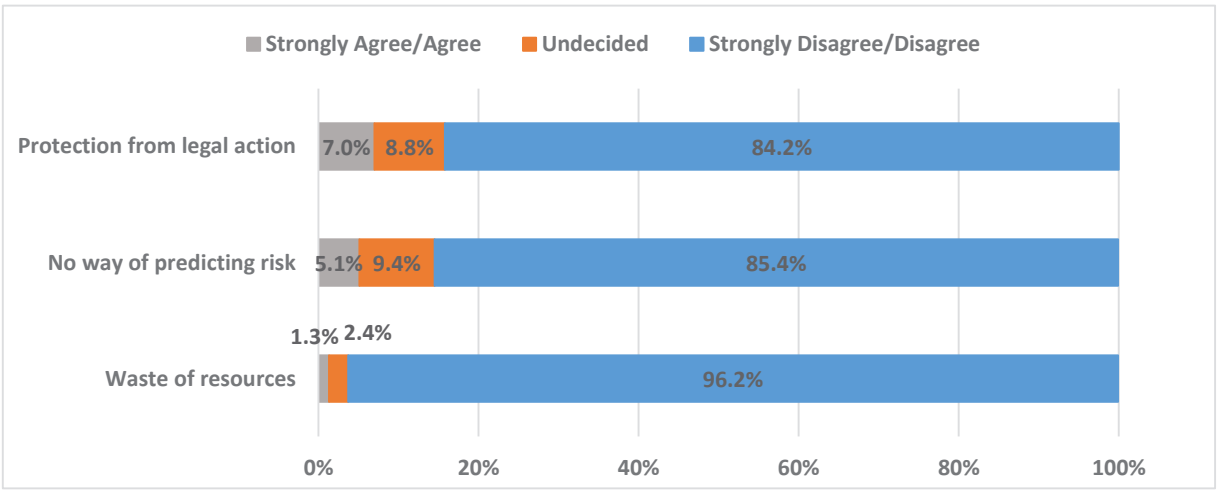
	N	Mean (SD)
Liaising with MDT regarding risk	374	4.30 (.851)
Speaking to service users about safety management strategies	372	4.05 (.982)
Identifying service user's protective factors	374	3.98 (.945)
Completing a risk assessment interview	375	3.97 (.886)
Involving the service user in developing a safety management plan	372	3.89 (1.022)
Using validated risk assessment tools	374	3.87 (.934)
Liaising with social services regarding risk	373	3.78 (1.104)
Involving family members in developing a safety management plan	375	3.74 (1.047)
Developing a safety management plan	374	3.73 (1.022)
Formulating a risk assessment profile	375	3.69 (.969)
Liaising with Gardaí regarding risk	373	3.63 (1.118)
Working with positive risk opportunities	368	3.60 (1.073)

Attitudes toward risk assessment practices

In order to ascertain respondents' attitudes towards risk assessment and management and in particular the use of validated risk assessment tools, respondents were asked to rate their agreement with thirteen statements on a scale of one to five, one indicating strong agreement and five indicating strong disagreement. For the purpose of analysis, strongly agree/agree and strongly disagree/disagree were combined.

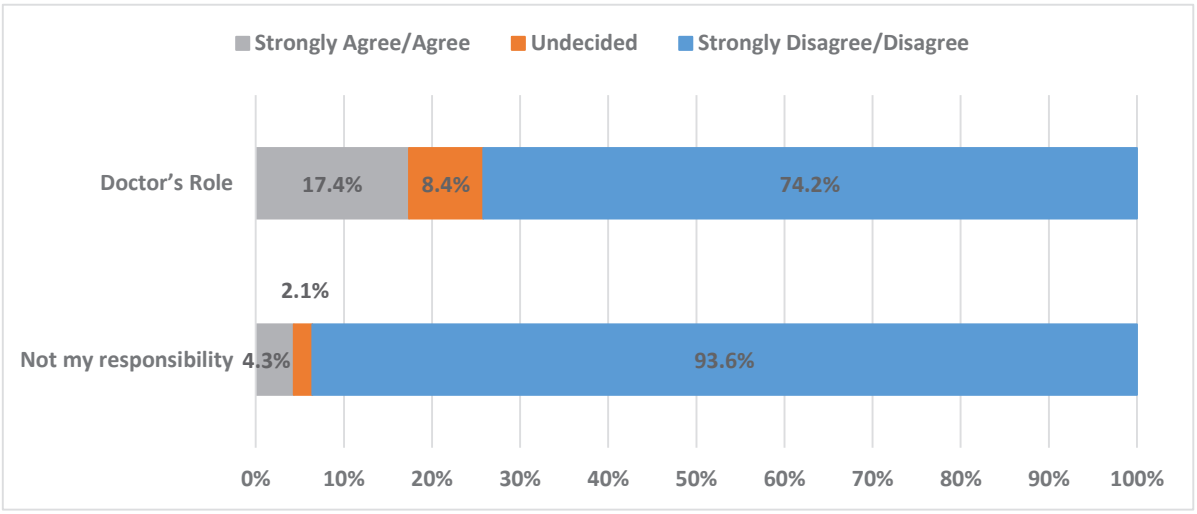
There was overwhelming support for the practice of risk assessment and risk management in principle (Figure 3.11). Only five respondents (1.3%) agreed that developing risk management plans is a waste of resources while over four fifths of the sample disagreed that the purpose of risk management was primarily to protect services from legal action (84.2%) and that risk cannot be predicted (85.4%).

Figure 3.11 Respondents' attitudes to risk assessment and management



With regard to role responsibility for risk assessment and management (Figure 3.12), more than nine tenths of the sample (93.6%) disagreed with the statement that risk assessment and management was not their responsibility while approximately three quarters of respondents (74.2%) believed that it was not the doctor's role to do risk assessment and planning.

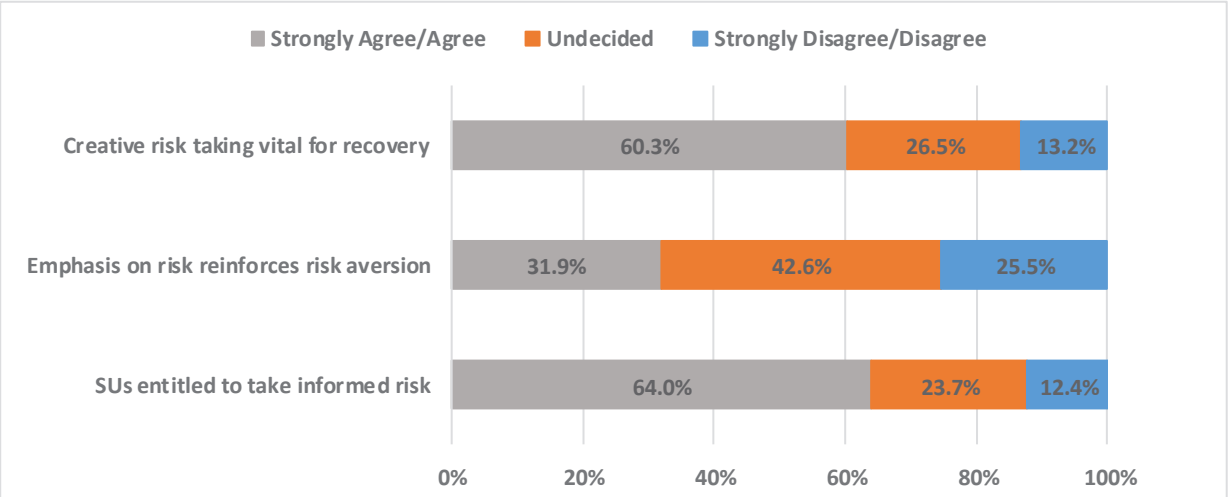
Figure 3.12 Respondents' attitudes to role responsibility



In relation to respondents' attitudes to risk taking, a greater proportion of the sample agreed rather than disagreed that service users are entitled to take informed risks even if it results in a negative outcome (64% compared to 12.4%), however, approximately a quarter were undecided on this matter (23.7%) (Figure 3.13). Similarly creative risk taking was perceived more positively than negatively (60.3% compared to 13.2%). However, just over a quarter of the sample were also undecided on this point (26.5%). The highest proportion of undecided responses was in relation to the item stating that 'the emphasis on risk reinforces

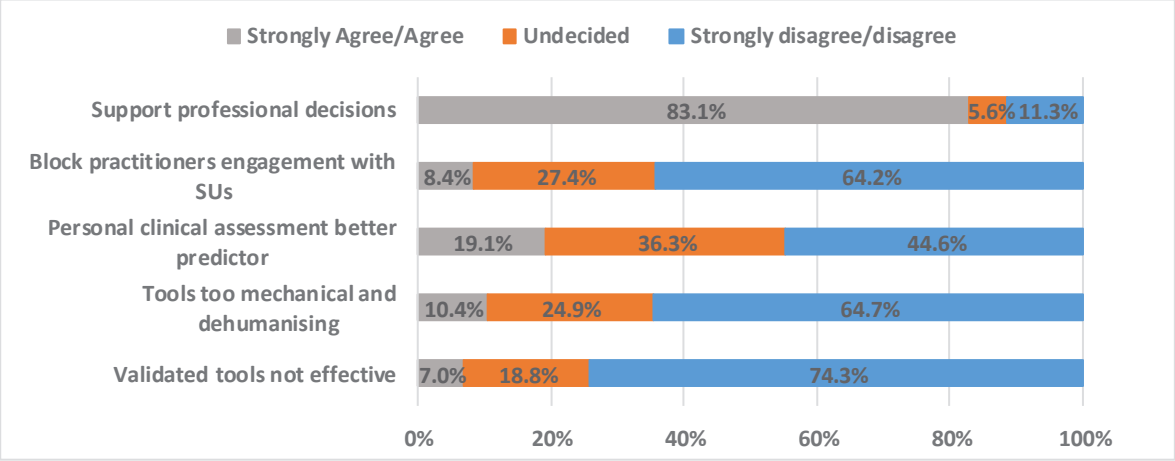
risk aversion' (42.6%). However, more respondents agreed with this statement than disagreed (31.9% compared to 25.9%).

Figure 3.13 Respondents' attitudes to positive risk taking



There was some degree of uncertainty in the sample as to the value of validated risk assessment tools (Figure 3.14). While over four fifths (83.1%) of the sample believed that risk assessment tools facilitate professional decision-making, around a fifth (19.1%) believed that their own clinical judgement served as a better predictor of risk compared to a validated screening tool, and 25.8% were either of the view that validated assessment tools were not effective at identifying people at risk or were undecided on the issue. Over one third (35.8%) of the sample agreed or were undecided on whether risk assessment tools block practitioners' engagement with service users, with 35.3% either of the view that tools are mechanical and dehumanising or were undecided on the issue.

Figure 3.14 Respondents' attitudes to risk assessment tools



The following five items relating to risk assessment tools were also examined as a scale in terms of mean scores. A score closer to five on the scale indicates a positive attitude

towards risk assessment tools while a score closer to one indicates a negative attitude towards risk assessment tools. The scale was summed to provide an overall mean score for respondents' attitudes towards risk assessment tools. The average sum score for the scale was 3.72 (SD=.618) which indicates a more positive than negative attitude among respondents to risk assessment tools overall. The mean scores for individual items are displayed in table 3.5. The results indicate that respondents are most positive about the ability of validated tools to effectively identify risk and least positive about the tool's ability to predict risk compared to respondents' own clinical assessment.

Table 3.5 Respondents' attitudes to risk assessment tools

	N	Mean (SD)
Validated risk assessment tools are not effective at identifying people at risk	373	3.99 (.922)
Risk assessment tools help support professional decisions	373	3.92 (1.003)
Risk assessment tools are too mechanical and dehumanising	374	3.73 (.909)
Validated risk assessment tools block practitioners engagement with service users	369	3.68 (.847)
My own clinical assessment is a better predictor of risk than validated tools	372	3.29 (.950)

Respondents also offered comments on risk assessment tools within the open comments section of the survey. Comments included the importance of using risk assessment tools in conjunction with clinical judgement/assessments to identify risk. However, there was a view that tools should only be used if the practitioner was in need of guidance while others cautioned that risk assessment tools were limited in so far as they only provide an indicator of risk at a specific time point and produced false negatives:

> *'Risk assessment tools should be used only if the professionals need guidelines as all clients are different'*

> *'Risk assessment tools should be an aid to compliment clinical judgement. Some risk assessment lead to false positive'*

Educational needs

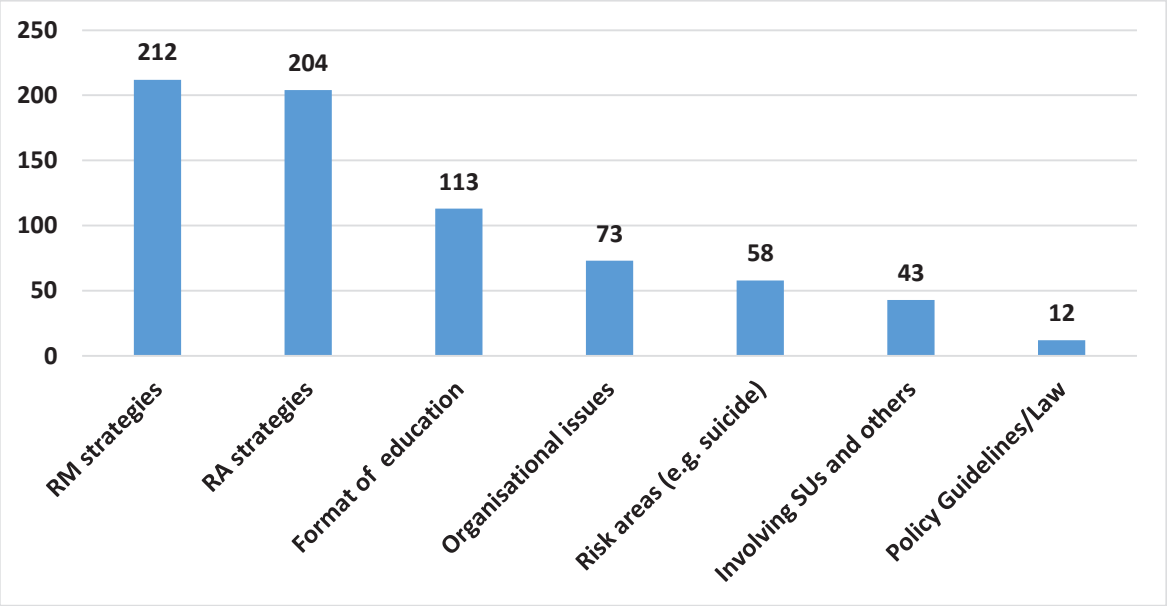
Respondents were also asked to identify their top four education priorities in relation to risk assessment and management. Responses to this question were mainly short descriptors of education requirements without any rationale. The answers were categorised according to

seven categories: Risk areas; Organisational issues; Policy guidelines/Law; Risk assessment strategies, Risk management strategies; Format of education and involving service users and others. Figure 3.15 displays the number of respondents who mentioned each category.
Most of the responses reflected a desire for education around the processes and strategies involved in assessing and managing risk. In relation to risk assessment respondents were interested in obtaining training around identifying risks indicators, formulating and developing a risk profile, and evaluating the level of risk. Respondents recognised the skills needed for risk assessment practice including interviewing skills, gathering collateral history from family and multi-disciplinary team working. Respondents also identified training needs in relation to risk management, safety and care planning and indicated the importance of training in how to ensure the safety of staff, clients, families and children. In relation to risk areas, respondents identified the following areas: risk of suicide, self-harm, violence and aggression, forensic risk and the side effects of medication. Respondents also indicated that they wanted more training around positive risk taking opportunities, identifying protective factors and the issue of medication compliance as well as skills training in reviewing risk, observation and multidisciplinary team working in risk management. In addition, respondents mentioned a desire for a broader view of risk through an understanding of risk theory as well as relating practice to research based evidence. Education on screening tools featured strongly in responses. Another area of education identified related to how to work with and involve service users and others in the risk assessment and management process.

Respondents also identified training needs around organisational policies, procedures and guidelines in relation to debriefing, incident reviews and documentation generally. Other comments emphasised some of the pertinent issues at an organisational level that could be addressed through education. This included issues such as the culture of the organisation, organisational risk and interagency working. Finally a small number of responses reflected the desire for education on policy and law at a national level.

In relation to the format of education responses emphasised the need for training to be on-going, mandatory, available to all staff locally and informed by best practice. The incorporation of role play into training was included in respondents' suggestions. Other comments reflected views that organisations could facilitate education by providing time for staff to engage in training and emphasised the importance of standardisation within an organisation as well as support from management and support for clinical supervision. It was suggested that training could be incorporated into the HSE's online resource for Learning and Development and that training modules be completed as part of ongoing Continuous Professional Development (CPD) requirements.

Figure 3.15 Educational needs



Other comments

Respondents were given space at the end of the survey to make comments. Content analysis of the comments revealed a recurring theme of the need for more information, education and training.

Some comments highlighted some of the practices and approaches to risk assessment and management that currently prevail in services and among staff. In this context it was mentioned that services are often reactive rather than proactive with risk prevention being favoured over positive risk taking:

> *'The service is focused on reaction rather than prevention. Little time is allocated to ongoing education and training of taking positive risk rather than predictive risk. More emphasis is placed on history of static factors less on dynamic factors'*

Other comments included concerns that risk assessment has the potential to minimise personal responsibility which may hinder service users' recovery, or that *'risk assessment if used can actually label and stigmatise'.*

The challenges of working in a risk averse and paternalistic culture was highlighted:

> *'I find it difficult to work with staff who are risk adverse and continue to work in paternalistic fashion with fear of repercussion, disabling service user's recovery'.*

> *'Have found that having a history of forensic/self-harm can follow person … and can lead to risk adverse practice'*

Respondents highlighted some of the practices and approaches to risk assessment and management that they deemed to be good practice. The importance of collaborative working with fellow team members and multi-disciplinary involvement in risk assessment was emphasised, as well as reviewing risk assessments continually, fostering a culture of positive risk taking, a formal debriefing process following incidents or 'near misses' and therapeutic engagement with service users.

Summary of key findings

- Most of the sample were educated to Degree level followed by Postgraduate and lastly by Cert/Diploma. Nearly half of the sample comprised staff nurses and half of the sample was represented by mental health nurses working in community settings. Experience among respondents ranged from one year to a maximum of 40 years with an average of approximately 16 years.
- Four fifths of respondents (78.9%) reported receiving education on risk assessment while just over half (51%) indicated that they received education on safety planning.
- Most respondents received risk assessment or safety planning education informally as part of a short course or study day. Approximately four percent of the sample reported that they did not conduct risk assessments in their clinical area while a great number (approximately 16%) reported that they did not develop safety plans as part of their current practice.
- The top five factors (ranked highest to lowest) which respondents who conducted risk assessments reported 'always' considering were: history of suicide attempt, history of self-harm, history of violence or aggression, forensic history and substance abuse.
- The top five factors (ranked highest to lowest) which respondents who conducted risk assessments reported 'never/rarely' considering included: risk to person disclosing mental health issues to others, risk of victimization in the community, risk of losing employment, risk of losing custody of children and risk of losing contact with family.
- Respondents' risk assessment practice emerged as heavily orientated towards consideration of the risk to self and the risk to others with less emphasis on other risk categories including risk from services, risk from others, risk of social exclusion and contextual issues that influence risk.
- The top five actions (ranked highest to lowest) which respondents who developed safety plans reported 'always' doing included: ask the person what they need to do to stay safe; identify harm minimisation strategies; record short-term safety plan; give risk reduction advice and remove items of risk.
- The top five actions (ranked highest to lowest) which respondents who developed safety plans reported 'never/rarely' doing were: liaise with Gardaí; identify anti-

absconding strategies; formulate a no harm contract; put the person on a level of observation and include positive risk taking opportunities.

- Over three quarters of those who conducted risk assessments and developed safety plans considered that they 'always' involved service users in these processes (77.8% & 78.4% respectively). More often than not family members and carers were consulted 'sometimes' as opposed to being routinely involved in risk assessment and safety planning.
- While nearly nine tenths of respondents reported that they worked in organisations with a policy on risk assessment and safety planning, less than half of respondents perceived that there was an emphasis on positive risk taking in their organisations.
- Respondents were overwhelmingly supportive of the practice of risk assessment and risk management in principle, with the majority (93.6%) disagreeing that it was not their responsibility. Seven percent were of the view that the purpose of risk management was primarily to protect services from legal action, with 1.3% being of the view that it was a waste of resources.
- Overall respondents reported a high degree of confidence in their ability to perform certain risk assessment practices; however confidence was lower with tasks related to safety planning such as formulating a risk assessment profile, developing a safety management plan, and in particular working with positive risk taking opportunities.
- In relation to positive risk taking, approximately two-thirds of respondents perceived it as vital for recovery (60.3%) and agreed that service users are entitled to take informed risk (64%) even if it results in negative outcomes. Around a quarter of the sample (26.5% & 23.7% respectively) reported being undecided on these issues highlighting the uncertainty that exists around positive risk taking.
- Respondents perceived risk assessment tools most positively for their ability to support professional decision-making. However, around a tenth of the sample viewed them negatively being of the view that they blocked practitioner engagement with service users (8.4%) and were too mechanical and dehumanising (10.4%). Around a fifth (19.1%) of respondents were of the view that their own clinical assessment was a better means of identifying risk as opposed to the use of screening tools with 36.3% being uncertain.
- Less than a third of respondents (30.3%) reported that they had access to ongoing education in risk assessment and management within their organisations. Educational priorities identified by respondents related to the skills and strategies for effective risk assessment and management, in particular training in the use of risk assessment tools and working within an ethos of positive risk. Responses underlined the importance of training which is on-going, mandatory, locally available, inclusive and informed by best practice.

4. Survey Results Part II: Factors associated with respondents' practices, attitudes and confidence

Introduction

The previous chapter described respondents' practices, attitudes and confidence in relation to risk assessment and safety management. This chapter examines these findings in more detail by exploring associations between respondents' practices, attitudes and confidence and independent factors such as area of work, education, age, gender, nursing role, number of years qualified as a mental health nurse, and whether respondents' had received any education on either risk assessment or safety planning.

Factors associated with the completion of a risk assessment

There were statistically significant differences in whether respondents conduct risk assessments depending on whether they had training in risk assessment or safety planning [P=0.000, Fisher's exact test] with a higher proportion of those without training not conducting risk assessments (14.7%) compared to those with training who do not conduct risk assessments (2%). There were also statistically significant differences in confidence between those who currently conduct risk assessments and those that do not [t (15.632) =2.473, p=0.025] with a significantly higher mean confidence score among those who do risk assessments (M=3.88, SD=.761) compared to those that reported they do not (M=3.18, SD=1.13). However, the effect size was 0.028 which is small (Cohen 1988).

Factors associated with the inclusion of various issues within the assessment process

There were some statistically significant differences in the inclusion of issues within the risk assessment process depending on whether the respondent had received training on either risk assessment or safety planning (See table 4.1). A higher proportion of those who had received training in either risk assessment or safety planning reported that they 'always' consider the risk of not engaging with the care plan (40.1%) compared to those who had no training (22.4%) and a higher proportion 'always' consider the risk of absconding/not engaging with the service (53.6%) compared to those who received no training (35.1%). A higher proportion of respondents who had not received training reported that they 'never/rarely' consider the risk of losing contact with family (56.1%), or consider the risk of losing employment (64.3%) compared to those who had training (37.8% & 39.8% respectively).

Table 4.1 Risk assessment practices associated with prior training*

	Yes % (n)	No % (n)	x^2	p
Not engaging with the care plan			6.477	0.039
Never/Rarely	20.5% (60)	25.9% (15)		
Frequently	39.4% (115)	51.7% (30)		
Always	40.1% (117)	22.4% (13)		
Absconding/not engaging with service			8.192	0.017
Never/Rarely	13.1% (38)	12.3% (7)		
Frequently	33.2% (96)	52.6% (30)		
Always	53.6% (155)	35.1% (20)		
Risk of losing contact with family			6.885	0.032
Never/Rarely	37.8% (110)	56.1% (32)		
Frequently	40.9% (119)	26.3% (15)		
Always	21.3% (62)	17.5% (10)		
Risk of losing employment			11.765	0.003
Never/Rarely	39.8% (115)	64.3% (36)		
Frequently	43.6% (126)	23.2% (13)		
Always	16.6% (48)	12.5% (7)		

**Only statistically significant relationships displayed*

There were also statistically significant differences in the risks respondents assessed depending on whether respondents worked in acute inpatient services, community settings or residential rehabilitation (See table 4.2). Compared to those working in acute inpatient services, those working in the community had a higher proportion of respondents who 'always' consider the risk of victimization in the community, the risk of losing contact with social network and the persons' protective factors. They also had a higher proportion of respondents who 'always' consider history of mood changes and history of unusual beliefs compared to those working in acute inpatient services. Perhaps unsurprisingly, those working in acute settings were more likely to 'always' consider a persons' legal status and the risk of absconding/not engaging with the care plan compared to staff in community settings.

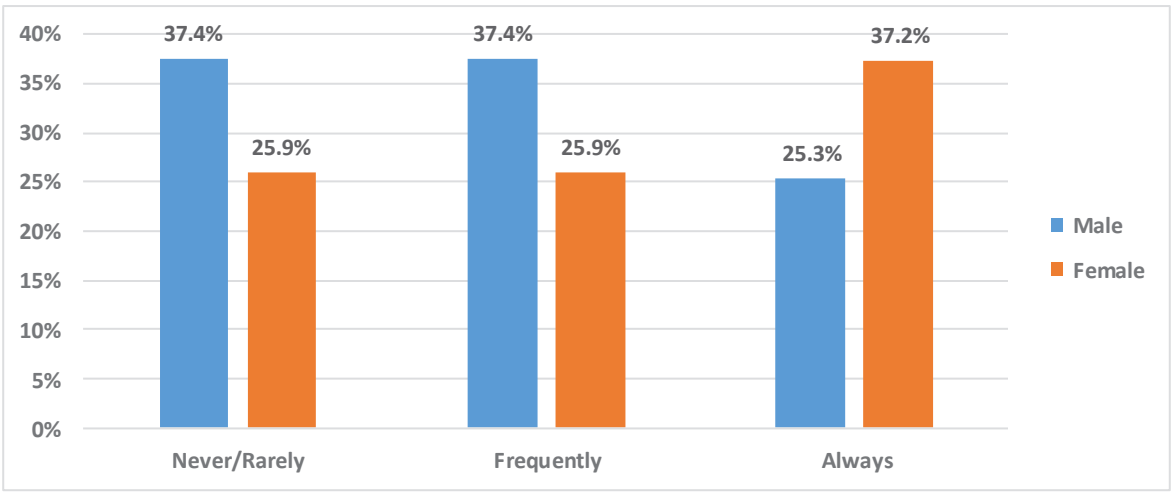
Table 4.2 Risk assessment practices associated with area of work*

	Acute Inpatient % (n)	Community % (n)	Residential Rehab % (n)	x^2	p
Risk of absconding/not engaging with the care plan				10.059	0.039
Never/Rarely	8.1% (9)	20.2% (26)	20.7% (6)		
Frequently	32.4% (36)	35.7% (46)	24.1% (7)		
Always	59.5% (66)	44.2% (57)	55.2% (16)		
Risk of victimization in the community				12.123	0.016
Never/Rarely	53.6% (60)	48.8% (62)	37.9% (11)		
Frequently	33% (37)	33.1% (42)	20.7% (6)		
Always	13.4% (15)	18.1% (23)	41.4% (12)		
Risk of losing contact with social network				9.883	0.042
Never/Rarely	43.8% (49)	26.7% (35)	31% (9)		
Frequently	40.2% (45)	50.4% (66)	37.9% (11)		
Always	16.1% (18)	22.9% (30)	31% (9)		
Legal Status of the person				18.948	0.001
Never/Rarely	16.1% (18)	40.7% (50)	31% (9)		
Frequently	23.2% (26)	22% (27)	24.1% (7)		
Always	60.7% (68)	37.4% (46)	44.8% (13)		
Person's protective factors				10.447	0.034
Never/Rarely	20.7% (23)	16.8% (22)	31% (9)		
Frequently	30.6% (34)	23.7% (31)	41.4% (12)		
Always	48.6% (54)	59.5% (78)	27.6% (8)		
History of mood changes				11.502	0.021
Never/Rarely	12.4% (14)	5.3% (7)	6.9% (2)		
Frequently	33.6% (38)	27.5% (36)	51.7% (15)		
Always	54% (61)	67.2% (88)	41.4% (12)		
History of unusual beliefs				11.24	0.024
Never/Rarely	8.8% (10)	1.5% (2)	6.9% (2)		
Frequently	26.5% (30)	20% (26)	34.5% (10)		
Always	64.6% (73)	78.5% (102)	58.6% (17)		

**Only statistically significant items displayed*

There were statistically significant differences in the assessment of sexual vulnerability in the risk assessment process depending on respondents' gender, being either male or female [x^2 (2) = 6.111, p=.047] with a lower proportion of men (25.3%) 'always' considering the risk of sexual vulnerability in risk assessment practice compared to women (37.2%).

Figure 4.1 Assessment of sexual vulnerability by gender



Age was found to be statistically significantly associated with a number of risk assessment practices. Compared to other age groups, a greater proportion of those aged over 50 years reported that in their risk assessment practice they 'always' consider risks related to intimate partner violence, sexual vulnerability, homelessness, financial exploitation, adverse drug reactions, physical health problems, victimisation in the community, losing contact with family, losing employment, losing social networks and losing custody of children.

Table 4.3 Risk assessment practices associated with age*

	20-29 % (n)	30-39 %(n)	40-49 % (n)	50 and over % (n)	x^2	p
Intimate Partner Violence					23.166	0.001
Never/Rarely	27.1% (16)	46.6% (48)	44.7% (42)	31.8% (28)		
Frequently	49.2% (29)	26.2% (27)	29.8% (28)	22.7% (20)		
Always	23.7% (14)	27.2% (28)	25.5% (24)	45.5% (40)		
Sexual Vulnerability					14.547	0.024
Never/Rarely	25.4% (15)	34.3% (35)	31.9% (30)	23.9% (21)		
Frequently	44.1% (26)	35.3% (36)	42.6% (40)	27.3% (24)		
Always	30.5% (18)	30.4% (31)	25.5% (24)	48.9% (43)		
Homelessness					21.911	0.001
Never/Rarely	26.7% (16)	29.4% (30)	28.7% (27)	31.5% (28)		
Frequently	58.3% (35)	40.2% (41)	41.5% (39)	23.6% (21)		
Always	15% (9)	30.4% (31)	29.8% (28)	44.9% (40)		
Adverse drug reactions					17.544	0.007
Never/Rarely	16.7% (10)	23.3% (24)	16.1% (15)	12% (11)		
Frequently	30% (18)	39.8% (41)	47.3% (44)	28.3% (26)		
Always	53.3% (32)	36.9% (38)	36.6% (34)	59.8% (55)		

Absconding/Not engaging with services					19.436	0.003
Never/Rarely	3.3% (2)	13.6% (14)	20.9% (19)	11% (10)		
Frequently	26.7% (16)	42.7% (44)	38.5% (35)	34.1% (31)		
Always	70% (42)	43.7% (45)	40.7% (37)	54.9% (50)		
Self-neglect					18.403	0.005
Never/Rarely	5% (3)	3.9% (4)	5.3% (5)	8.7% (8)		
Frequently	33.3% (20)	42.7% (44)	51.1% (48)	22.8% (21)		
Always	61.7% (37)	53.4% (55)	43.6% (41)	68.5% (63)		
Physical health problems					18.878	0.004
Never/Rarely	11.7% (7)	8.9% (9)	10.6% (10)	6.5% (6)		
Frequently	33.3% (20)	54.5% (55)	46.8% (44)	29.3% (27)		
Always	55% (33)	36.6% (37)	42.6% (40)	64.1% (59)		
Victimization in the community					19.544	0.003
Never/Rarely	48.3% (29)	57.4% (58)	50% (46)	32.6% (29)		
Frequently	38.3% (23)	24.8% (25)	37% (34)	36% (32)		
Always	13.3% (8)	17.8% (18)	13% (12)	31.5% (28)		
Losing contact with family					30.713	0.000
Never/Rarely	41.7% (25)	52.9% (54)	43.6% (41)	24.2% (22)		
Frequently	41.7% (25)	35.3% (36)	41.5% (39)	37.4% (34)		
Always	16.7% (10)	11.8% (12)	14.9% (14)	38.5% (35)		
Q10.21: Losing employment					28.093	0.000
Never/Rarely	40% (24)	56.9% (58)	45.7% (43)	29.2% (26)		
Frequently	46.7% (28)	31.4% (32)	45.7% (43)	40.4% (36)		
Always	13.3% (8)	11.8% (12)	8.5% (8)	30.3% (27)		
Losing contact with social network					18.119	0.006
Never/Rarely	40% (24)	41.2% (42)	29.8% (28)	26.4% (24)		
Frequently	38.3% (23)	40.2% (41)	56.4% (53)	39.6% (36)		
Always	21.7% (13)	18.6% (19)	13.8% (13)	34.1% (31)		
Losing custody of children					16.544	0.011
Never/Rarely	32.2% (19)	52% (53)	41.3% (38)	33.7% (30)		
Frequently	45.8% (27)	28.4% (29)	44.6% (41)	34.8% (31)		
Always	22% (13)	19.6% (20)	14.1% (13)	31.5% (28)		

**Only statistically significant items displayed*

The inclusion of items in the risk assessment process also differed significantly in terms of years qualified as a mental health nurse on the risk of homelessness [H (2) = 8.191, p=0.017], the risk of losing contact with family [H (2) = 10.747, p=0.005] and the risk of losing employment [H (2) = 6.655, p=0.036]. The results indicate that those who 'always' consider the risk of homelessness in their risk assessment practice were significantly longer

qualified [M=18.34, SD=11.725] than those who 'frequently' consider this factor [M=14.22, SD=10.015] [U=5832.5, p=0.006] and that those who 'always' consider the risk of losing contact with family were significantly longer qualified [M=20.39; SD=12.185] than those who 'never/rarely' consider this factor [M=14.72; SD=9.912] [U=3731.5, p=0.001] or 'frequently' consider it [M=15.87; SD=11.094] [U=3768, p=0.01]. Those who 'always' consider the risk of losing employment were significantly longer qualified [M=20.27, SD=12.974] than those who 'never/rarely' consider this factor [M=15.17, SD=9.964] [U=3188.5, p=0.011]. The effect sizes for each relationship are small according to Cohen's (1988) guidelines (-0.17, -0.19 and -0.19 respectively).

Factors associated with the development of a safety plan

There were statistically significant differences in confidence between those who currently develop safety plans and those that do not [t (337) =8.170, p=0.000] with a significantly higher mean confidence score among those who develop safety plans (M=3.97, SD=.705) compared to those that reported they do not (M=3.11, SD=.808). The effect size was 0.17 which is small (Cohen 1988).

There was also a statistically significant difference in whether respondents develop safety plans in their current practice depending on whether they had received training in either risk assessment or safety planning [x^2 (1) = 18.137, p=.000] with a higher proportion of those without training not developing safety plans (34.9%) compared to 12.7% of those with training who do not develop safety plans.

Factors associated with practices during safety planning process

There were some statistically significant differences in what practices respondents completed during the safety planning process depending on whether they had received training on either risk assessment or safety planning (See table 4.4). Compared to respondents who had received either risk assessment or safety planning training, respondents who had not received the training were more likely to 'never/rarely' use a recognised assessment tool, record the short-term safety plan in the service users' notes, identify anti-absconding strategies, identify strategies to enhance engagement with the services, identify de-escalation strategies, develop a shared responsibility with the service user for safety and identify how the persons' strengths can support the safety plan.

Table 4.4 Safety planning practices associated with prior training*

	Yes % (n)	No % (n)	x^2	p
Use a recognised screening tool			10.271	0.006
Never/Rarely	23.4% (56)	46.2% (18)		
Frequently	28.5% (68)	28.2% (11)		
Always	48.1% (115)	25.6% (10)		
Record the short-term safety plan in the service user's notes			6.295	0.043
Never/Rarely	5.9% (14)	17.1% (7)		
Frequently	33.6% (80)	29.3% (12)		
Always	60.5% (144)	53.7% (22)		
Identify harm minimisation strategies			7.42	0.024
Never/Rarely	5.9% (14)	7.3% (3)		
Frequently	30.5% (73)	51.2% (21)		
Always	63.6% (152)	41.5% (17)		
Identify strategies to enhance engagement with services			7.66	0.022
Never/Rarely	11% (26)	26.8% (11)		
Frequently	52.3% (124)	41.5% (17)		
Always	36.7% (87)	31.7% (13)		
Q12.18: Identify de-escalation strategies			8.719	0.013
Never/Rarely	10.5% (25)	26.8% (11)		
Frequently	45.2% (108)	41.5% (17)		
Always	44.4% (106)	31.7% (13)		
Develop a shared responsibility with the service user for safety			7.567	0.023
Never/Rarely	10.1% (24)	25% (10)		
Frequently	44.5% (106)	42.5% (17)		
Always	45.4% (108)	32.5% (13)		
Identify how the person's strengths can support the safety plan			8.583	0.014
Never/Rarely	8.8% (21)	24.4% (10)		
Frequently	46.6% (111)	39% (16)		
Always	44.5% (106)	36.6% (15)		

**Only statistically significant relationships displayed*

There were also some statistically significant differences in safety planning practices depending on respondents' area of work (See table 4.5). As to be expected, the results indicate that a higher proportion of respondents working in acute inpatient services 'always' put the person on a level of observation, remove items of risk, identify anti-absconding

strategies and identify de-escalation strategies compared to those working in the community.

Table 4.5 Safety planning practices associated with area of work*

	Acute Inpatient % (n)	Community % (n)	Residential Rehab % (n)	x^2	p
Q12.5: Put the person on a level of observation				25.318	0.000
Never/Rarely	23.3% (20)	42.3% (41)	56% (14)		
Frequently	22.1% (19)	34% (33)	28% (7)		
Always	54.7% (47)	23.7% (23)	16% (4)		
Remove items of risk				47.498	0.000
Never/Rarely	6.7% (6)	45.8% (44)	44% (11)		
Frequently	17.8% (16)	24% (23)	16% (4)		
Always	75.6% (68)	30.2% (29)	40% (10)		
Identify anti-absconding strategies				42.727	0.000
Never/Rarely	21.3% (19)	67.4% (64)	56% (14)		
Frequently	46.1% (41)	24.2% (23)	32% (8)		
Always	32.6% (29)	8.4% (8)	12% (3)		
Identify de-escalation strategies				19.096	0.001
Never/Rarely	6.6% (6)	17.3% (18)	25% (6)		
Frequently	38.5% (35)	54.8% (57)	45.8% (11)		
Always	54.9% (50)	27.9% (29)	29.2% (7)		
Develop a crisis management plan				14.246	0.007
Never/Rarely	21.3% (19)	8.7% (9)	36% (9)		
Frequently	39.3% (35)	47.1% (49)	44% (11)		
Always	39.3% (35)	44.2% (46)	20% (5)		
Identify how the person's strengths can support the safety plan				12.82	0.012
Never/Rarely	15.6% (14)	4.8% (5)	24% (6)		
Frequently	36.7% (33)	51% (53)	48% (12)		
Always	47.8% (43)	44.2% (46)	28% (7)		

**Only statistically significant relationships displayed*

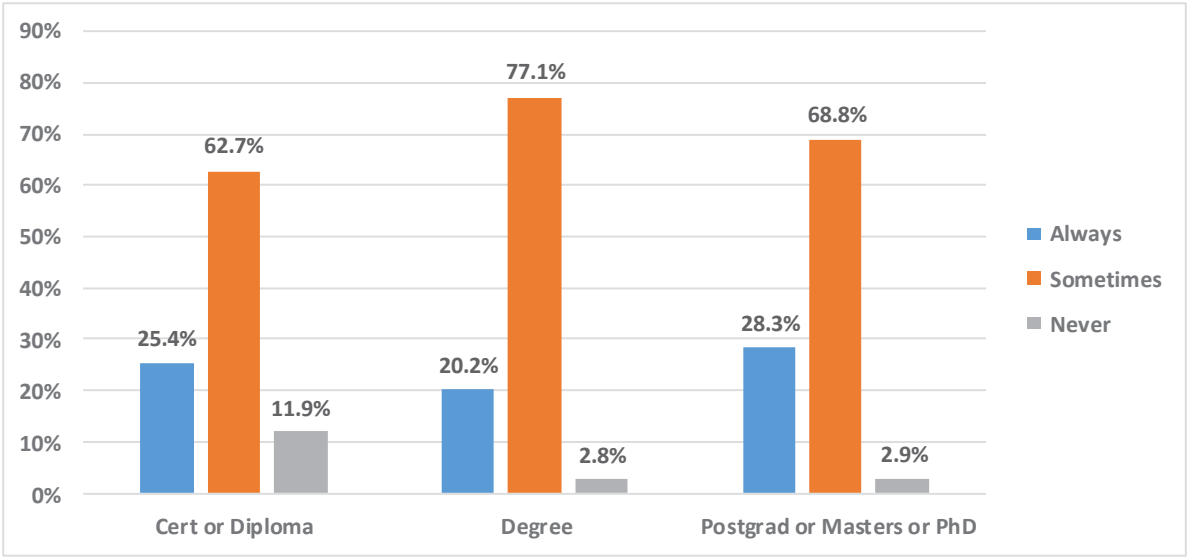
There were statistically significant differences in average number of years qualified between the different groups on putting a person on a level of observation [F (2, 263) = 4.724, p=0.019], on liaising with GP/primary care staff [H (2) = 6.401, p=0.041], on removing items of risk [F (2, 268) = 4.101, p=0.018], on anti-absconding strategies [H (2) = 6.602, p=0.037] and on identifying de-escalation strategies [F (2, 277) = 5.254, p=0.006]. Small effect sizes

for each were found (Cohen, 1988). The results indicate that number of years qualified is on average significantly lower for respondents who 'always' put the person on a level of observation (M=12.94; SD=11.281) compared to those who 'frequently' do so (M=17.2, SD=11.764) and those who do so 'never/rarely' (M=17.34, SD=10.08). Number of years qualified is on average significantly lower for respondents who 'always' remove items of risk (M=14.15, SD=11.309) compared to those who 'never/rarely' do so (M=18.21, SD=10.061) and it was also significantly lower for respondents who 'always' identify anti-absconding strategies (M=13.53, SD=12.028) compared to respondents who 'never/rarely' do so (M=16.99, SD=9.942) [U=2678.5, p=0.008]. Respondents who 'always' identify de-escalation strategies (M=13.6; SD=11.306) are significantly shorter qualified (M=13.6; SD=11.306) compared to those who 'frequently' do so (M=18.17, SD=10.92). Respondents who 'always' liaise with GP/primary care staff are significantly longer qualified (M=18, SD=11.817) compared to those who 'never/rarely' do so (M=13.24, SD=9.608] [U=2823.5, p=0.014].

Factors associated with involvement of stakeholders in assessment process

There were statistically significant differences in the extent to which respondents involve family members/carers in the risk assessment process depending on their highest level of educational attainment [x2 (4) = 12.063, p=0.017] with a higher proportion of those with a Cert or Diploma 'never' involving family members/carers (11.9%) compared to those with a Degree (2.8%) and those with a Postgraduate qualification (2.9%).

Figure 4.2 Involve family members/carers by highest education



Factors associated with confidence in relation to risk assessment and management

There were statistically significant differences in overall confidence between the different role subgroups [F (3, 352) = 7.219, p=0.000]. The results indicated that confidence with risk

assessment and safety planning was on average significantly lower for staff nurses (M=3.69; SD=.803) compared to both CNSs/APNs (M=4.19, SD=.733) and CMHNs (M=4.11, SD=.633). The effect size, calculated using eta squared was 0.06, which is a moderate effect size according to Cohen's interpretation (1988).

There were also statistically significant differences in overall confidence between the education subgroups [F (2, 367) = 4.817, p=0.009] and between those who had received training and those that had not [t (372) = 2.925, p=0.004]. The results indicated that confidence with risk assessment and management was on average significantly higher among those who had a Postgraduate education (M=4.00, SD=.7218) compared to those who highest education was a Degree (M=3.73, SD=.811) and it was also significantly higher among those who had received training (M=3.91, SD=.779) compared to those that had not (M=3.60, SD=.795). Despite reaching statistical significance, the actual difference in mean confidence scores between the groups was small (Cohen 1988); the effect size, calculated using eta squared was 0.025 and 0.02 respectively.

There was a statistically significant positive correlation between confidence in risk assessment and management and number of years qualified as a mental health nurse suggesting that more years qualified tends to be associated with higher confidence (r=.119, N=374, p=.021). The co-efficient of determination for this relationship was r^2=0.01, indicating a rather small relationship (Cohen 1988).

Exploring influences on attitudes in relation to risk assessment and management

There were some statistically significant differences in respondents' attitudes to the statement that 'the emphasis on risk reinforces risk aversion' depending on area of work [x^2 (4) = 9.916, p=.042] with a higher proportion of those working in acute inpatient settings strongly agreeing/agreeing with this statement (39%) compared to those working in the community (23.3%) and those working in residential rehabilitation (27.6%).

Statistically significant associations were also found between highest level of educational attainment and respondents' attitudes to risk assessment and management (See table 4.6). A higher proportion of those with a Degree strongly agree/agree that risk assessment and management is the doctor's role (22.6%) compared to those with a Postgraduate education (12.6%). The results indicate that those with a Postgraduate education also have a more positive view on positive risk taking, with a higher proportion (72.5%) strongly agreeing/agreeing that 'service users are entitled to take informed risk' compared to those with a Degree or Cert/Diploma (55.4%; 60.5%); while a greater proportion of those with a Cert/Diploma strongly disagree/disagree that 'creative risk taking is vital for recovery' (19.5%) compared to those with a Postgraduate education (7.3%).

Table 4.6 Risk assessment and management practices associated with education*

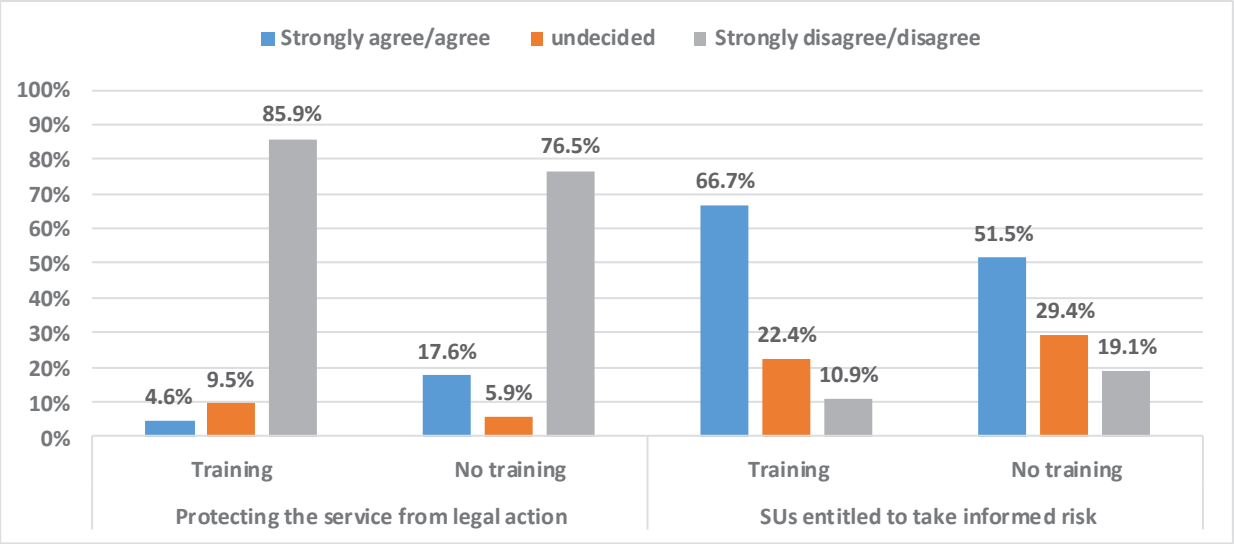
	Cert or Diploma % (n)	Degree % (n)	Postgrad/ Masters/PhD % (n)	x^2	p
Risk assessment and management is doctor's role				13.85	0.008
Strongly agree/agree	18.7% (14)	22.6% (31)	12.6% (19)		
Undecided	9.3% (7)	12.4% (17)	4% (6)		
Strongly disagree/disagree	72% (54)	65% (89)	83.4% (126)		
Service users are entitled to take informed risk				11.29	0.023
Strongly agree/agree	61.5% (48)	55.8% (77)	72.8% (110)		
Undecided	21.8% (17)	31.2% (43)	17.9% (27)		
Strongly disagree/disagree	16.7% (13)	13% (18)	9.3% (14)		
Creative risk taking is vital for recovery				10.068	0.039
Strongly agree/agree	53.2% (41)	56.2% (77)	68.2% (103)		
Undecided	27.3% (20)	27.7% (38)	24.5% (37)		
Strongly disagree/disagree	19.5% (15)	16.1% (22)	7.3% (11)		

**Only statistically significant relationships displayed*

There were some statistically significant differences in respondents' attitudes to whether risk assessment and management is only about protecting the service from legal action [x^2 (2) = 7.121, p=.028] with a higher proportion of men strongly agreeing/agreeing with this statement (12%) compared to women (5.1%). There were also some statistically significant differences in respondents' attitudes to informed risk taking depending on the respondents' gender [x^2 (2) = 7.914, p=.019] with a greater proportion of men (19.4%) strongly disagreeing/disagreeing that service users are entitled to take informed risk even if it results in a negative outcome compared to women (8.9%).

A statistically significant difference was found in whether respondents agreed with the statement that 'risk assessment and management is only about protecting services from legal action' depending on whether they had received either risk assessment or safety planning training [x^2 (2) = 14.943, p=0.001] with a greater proportion of those who had never received this training strongly agreeing/agreeing (17.6%) with this statement compared to those who had received training (4.6%). A statistically significant difference was also found in respondents' attitude to informed risk depending on whether they had received training [x^2 (2) = 6.176, p=0.046] with a greater proportion of those who had never received training strongly disagreeing/disagreeing (19.1%) that 'service users are entitled to take informed risk even if it results in a negative outcome' compared to those who had training (10.9%).

Figure 4.3 Risk assessment and management attitudes by prior training



There were statistically significant differences in average number of years qualified between the different groups on risk assessment and management responsibility [F (2, 370) = 3.633, p=0.027]. The effect size, calculated using eta squared was 0.02, which is a small effect size (Cohen 1988). The results indicate that number of years qualified was on average significantly lower for respondents who strongly disagree/disagree that risk assessment and management is their responsibility (M=16.03; SD=11.165) compared to respondents who strongly agree/agree that it is their responsibility (M=23.69; SD=10.131).

Predictors of confidence in risk assessment and management

A stepwise multiple regression was performed to predict a persons' confidence in risk assessment and management on the basis of a number of independent variables, including area of work, education, age, gender, current role, number of years qualified as a mental health nurse and prior training. The final model consisting of significant predictors only was rerun using the 'enter' method to compensate for missing cases due to variables not included in the final model and the results are displayed in table 4.7 below.

The final model explained 7.4% (6.6% adjusted) of the variance in confidence which was significantly great than zero [F (3, 351)) = 9.353, p<.001]. This is a low degree of explained variance which suggests that they are many factors which impact on confidence in relation to risk assessment and management which are unaccounted for in this study. The significant predictors which contributed equally to the explained variance are being either a CNS/APN or CMHN. Prior training has a lesser impact on confidence. The results indicate that a nurse who practices either as a CNS/APN or a CMHN and had prior training in risk assessment and safety planning had greater confidence in their ability to perform risk assessment and management.

Table 4.7 Multiple regression model of confidence based on predictor variables

	Final model		
Predictors	***B***	***β***	
CNS/APNs	.461	.177**	R=.272
CMHN	.384	.177**	
Prior training (Yes=0)	-.287	-.141*	R^2=.074 Adjusted R^2=.066
Intercept=3.779			*p<.05 **p<.001

Predictors of developing safety plans

A Logistical regression model was computed to identify independent factors associated with whether a person develops safety plans in their clinical practice. The independent factors included respondents' gender, age, highest level of educational attainment, role, area of work, years qualified, previously undertaken training in either risk assessment or safety planning, and confidence in risk assessment and management. The value of the Hosmer–Lemeshow Chi-square test was not significant, implying that the model fit the data well.

Role and confidence in risk assessment and management were identified as predictors of the development of safety plans. Staff nurses were nearly three times more likely to develop safety plans than Community Mental Health Nurses while those who were more confident in risk assessment and management were eight times more likely to develop safety plans (see table 4.8).

Table 4.8 Predictors of developing safety plans

Characteristic	**B (SE)**	**OR**	**95% C.I. for EXP(B)**	
			Lower	**Upper**
Constant	-7470 (1.471)			
Role (Reference=CMHN)				
Staff Nurse *	1.094 (.543)	2.985	1.029	8.657
Confidence (Reference=Not Confident) **				
Confident**	2.124 (.358)	8.361	4.144	16.870

R^2 = .26 (Cox & Snell), .44 (Nagelkerke). Model $\chi 2 = 73.681$, $p < .001$; *p<.05, **p<.001

Summary of key findings

- Respondents who had training in risk assessment and safety planning and who felt more confident in their ability to assess and manage risk were more likely to be involved in conducting risk assessments and developing safety management plans.
- Risk assessment practice varied depending on whether respondents had received risk assessment and safety planning training with a greater number of respondents with training 'always' taking the risk of not engaging with the care plan and the risk of absconding/not engaging with services into account; while higher proportions of those without training 'never/rarely' consider the risk of losing contact with family and the risk of losing employment.
- Safety planning practices were influenced by the context and location in which the practitioner worked. The emphasis on safety and security in acute inpatient settings was evident with higher proportions of respondents working in these settings reporting 'always' putting a person on a level of observation, removing items of risk, identifying anti-absconding strategies and identifying de-escalation strategies compared to those working in the community. Respondents working in acute inpatient services were also found to be more likely to 'always' consider the risk of absconding and a person's legal status.
- Greater emphasis was placed on risks related to social exclusion in risk assessment and management practices in community mental health settings with respondents in these settings more likely to 'always' consider the risk of victimization and the risk of losing contact with social network compared to acute inpatient practitioners.
- Risks related to vulnerability and social exclusion, such as risk of homelessness, risk of losing employment, and risk of losing contact with family were assessed more frequently by those who were longer qualified suggesting a more holistic approach to risk assessment was acquired overtime with experience. Conversely those with less experience reported a greater frequency of putting a person on a level of observation, removing items of risk, identifying anti-absconding strategies and identifying de-escalation strategies.
- Respondents aged over 50 were found to consider more often risk factors related to social exclusion and vulnerability compared to younger age groups. These factors included: risks related to intimate partner violence, sexual vulnerability, homelessness, financial exploitation, victimisation in the community, losing contact with family, losing employment, losing social networks and losing custody of children as well as the risks arising from adverse drug reactions and physical health problems Gender differences in the consideration of sexual vulnerability also emerged with a lower proportion of men 'always' assessing this risk compared to women.
- Respondents without training were found not to practice a range of safety management strategies as often as those with training. These actions included using a recognised assessment tool, recording the short-term safety plan, developing a shared responsibility for safety, identifying anti-absconding strategies, identifying

strategies to enhance engagement with the services, identifying de-escalation strategies and exploring how the persons' strengths can support the safety plan.

- Respondents with the lowest level of qualification (Cert/Diploma) had higher proportions who never involved family members/carers in the risk assessment process compared to those with higher levels of education.
- Higher levels of confidence in risk assessment and safety planning was associated with prior training, having a postgraduate qualification and more years qualified as a mental health nurse. Staff nurses were found to have lower confidence with risk assessment and safety planning than both CNSs/APNs and CMHNs. When all factors were considered together in a multiple regression model, predictors of confidence in the ability to perform risk assessment and management included being a nurse who practices either as a CNS/APN or a CMHN and prior training in risk assessment and safety planning.
- Respondents working in acute inpatient services were more likely to perceive that 'the emphasis on risk reinforces risk aversion' compared to the community and residential rehabilitation settings, suggesting a more risk averse culture within inpatient settings. Differences in risk taking attitudes emerged between educational categories with those with a postgraduate qualification having a more positive attitude to risk taking and those with the lowest level of education (Cert/Diploma) not as agreeable about the necessity of creative risk taking to recovery.
- The view that service users are entitled to take informed risk even if it results in a negative outcome varied according to both gender and training with higher proportions of men and those without prior training disagreeing with this statement.
- The view that risk assessment and management is only about protecting services from legal action also varied according to both gender and training with greater proportions of men and those without training agreeing with this statement.
- Respondents who were qualified a shorter amount of time were less likely to perceive that risk assessment and management was their responsibility compared to respondents qualified for longer.
- Conducting risk assessments and developing safety plans were both associated with higher self-reported confidence in risk assessment and management, and prior training. When all factors were considered together in a logistic regression model to predict the development of safety management plans, prior training remained a significant predictor.

5. Findings from Documentary Analysis

Introduction

This chapter presents the findings of the documentary analysis conducted to explore the safety and risk management policies and guidelines submitted by the services involved in the study.

Response rate

Of the 23 Directors of Nursing/Acting or Assistant Directors of Nursing contacted over a three month period, documents were received from 22, giving a response rate of 95.7%. A total of 123 documents were received, averaging between 1 and 5 documents per service, with one service submitting 35 (28.5%), and another 19 (15.4%), accounting for 43.9% of the documents received.

Types of documents received

The majority of documents received were classified as assessment tools (N= 67, 54.5%), followed by risk management and safety planning documentation (N= 24, 18.9%), policies/ procedures (N= 21, 17%), and other/miscellaneous documents (N= 13, 10.6%). Documents of other descriptions included documents that did not meet the inclusion criteria for the review.

Policies and procedures

There were 21 documents submitted classified as policy/protocols, representing 17% of the 123 total documents received. The majority (N= 10) of these were generic risk management policies, with a smaller number (N=7) focusing on specific issues such as suicide, self-harm or substance misuse. Four of the documents received were categorised as protocols that were related to risk and safety planning (see table 5.1).

Table 5.1 Frequency of policy/procedure documents (N=21)

Category	Frequency (%)
General risk management policies	N=10
Policies that focused on specific risk areas Illicit drugs and alcohol use Management of self-harm (2) Management of violence and aggression (2) Management of serious adverse events Management of suicide/homicide/ sudden death	N= 7
Policies/protocols that focused on elements of care with a risk focus Protocol for use with risk management plans Protocol for observation Protocol for reporting critical incidents Recovery care planning	N= 4

In terms of language used within these documents the words policy, procedure, protocol and strategy appeared to be used interchangeably with some documents titled 'Risk management policy', while others were titled 'Clinical risk management strategy or procedure'. The majority of the policies reviewed were developed with the multidisciplinary team in mind, including administrative and support staff. Some were written in a principle based manner, while others although titled a policy were more procedural in orientation.

All of the policies acknowledged that risk assessment and risk management was a crucial component of mental health service provision. However, various definitions of the terms risk, risk assessment and risk management were used, drawing on different international literature and policies for the definitions used. While each policy included different risks, the focus was clearly on the service user as a source of risk – both to themselves and others, who must be managed at the organisational level. Policies tended to categorise risks into: risk to self (suicide, self-harm, self-neglect), risk to others (including children), risk of relapse, which was defined as non-compliance with medication, non-engagement, or absent without leave, while other risks included were termed vulnerability and exploitation, without clear explanation of the meaning. Risk from others, risk of social exclusion and iatrogenic risks were not evident as categories of focus within the documents received.

While the language of risk management and risk elimination dominated, there was an acknowledgment that 'clinical risk' could never be totally eliminated; however, it could be minimised by assessment, intervention and training of staff. Risk assessment was not viewed as a once off event but an ongoing process that was integral to all interactions, and required particular attention at what was termed 'critical points', such as first contact with service, change or transfer of care, change in legal status, change in life events, significant

change in mental state and discharge. Within the policies emphasis was placed on collecting information from multiple sources, regular review of plans of care and clear documentation. In addition, the policies were often cross referenced to other policies (see table 5.2 for examples), with the majority making explicit reference to staff education and training.

All the policies viewed risk assessment and management as a collaborative process between members of the MDT and the service user where possible. While the language of positive risk taking or safety planning was minimal throughout the policies, it is interesting to note that when positive risk taking was mentioned the policies indicate that decisions regarding positive risk taking should be taken by the lead clinical consultant within the shared expertise of the MDT.

Table 5.2 Example of policies cross referenced

Aggression and violence Management of patients who undertake self-harm Searching patients property Risk occurrence policy	Critical event policy Use of locked doors Management of staff injured on duty Absent without leave	Special nursing observations Medical emergency Incident/ accident reporting Safe guarding vulnerable adults

Types of assessment tools

Of the 67 assessment tools received in total, 36 (53.7%) were validated tools for the assessment of various mental health issues. The remaining 31 (46.3%) were general risk screening tools which were not found to contain any empirically validated scales.

Validated assessment tools

A total of 36 (53.7%) validated assessment tools were received. Multiple versions and editions of some tools were received from different organisations, with no consistency being noted with regard to why certain versions or editions were being used. The majority of the tools focused on violence assessment (N= 17, 47.2%), general mental health screening (N= 7, 19.4%) and depression/suicide assessment (N= 6, 8.3%). A full list of the seven themes into which the validated assessment tools were categorised is shown in table 5.3.

Table 5.3 Empirically validated assessment tools according to theme

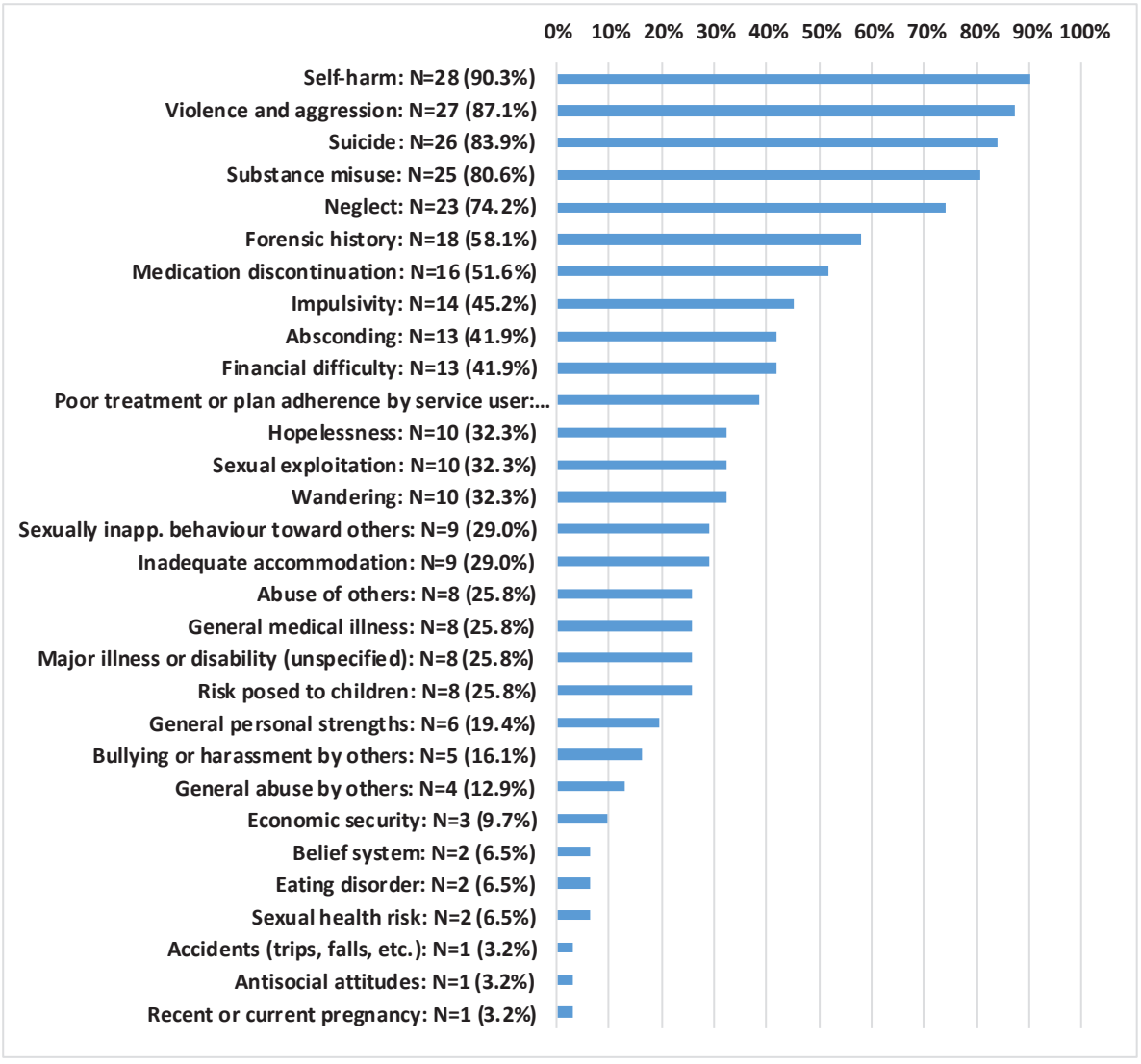
Violence Assessment Tools (47.2% of total 36)	
Tool Name	Frequency (within-group %)
Functional Analysis of Care Environments (FACE)	7 (41.2%)
Historical, Clinical, Risk Management-20 (HCR-20)	4 (23.5%)
Risk of Violence Assessment (ROVA)	4 (23.5%)
Brief Psychiatric Rating Scale	1 (5.9%)
Screening Tool to Alert Doctors to the Right Treatment (START) tool	1 (5.9%)
TOTAL Violence Assessment Tools	17 (100.0%)
Mental Health Screening Tools (19.4% of total 36)	
Tool Name	Frequency (within-group %)
Mini Mental State Examination (MMSE)	2 (28.6%)
Depression/Anxiety/Stress Scale (DASS)	1 (14.3%)
Insight Scale in Psychosis	1 (14.3%)
Krawiecka, Goldberg and Vaughan (modified) (KGVM) Symptom Scale	1 (14.3%)
Psychotic Symptom Rating Scales (PSYRATS) Delusion Subscale	1 (14.3%)
Psychotic Symptom Rating Scales (PSYRATS) Hallucinations Subscale	1 (14.3%)
TOTAL Mental Health Screening Tools	7 (100.0%)
Depression and Suicide Assessment Tools (16.7% of total 36)	
Tool Name	Frequency (within-group %)
Beck's Depression Scale	2 (33.3%)
Beck's Hopelessness Scale	1 (16.7%)
Estimate of Suicide Risk (ESR-20) [Revised]	1 (16.7%)
Montgomery and Asberg Depression Rating Scale	1 (16.7%)
TOTAL Depression and Suicide Assessment Tools	6 (100.0%)
Alcohol Assessment Tools (5.6% of total 36)	
Tool Name	Frequency (within-group %)
Clinical Institute Withdrawal Assessment of Alcohol State, revised (CIWA-Ar)	1 (50.0%)
Short Michigan Alcoholism Screening Test (SMAST)	1 (50.0%)
TOTAL Alcohol Assessment Tools	2 (100.0%)
Living Skills Screening Tools (5.6% of total 36)	
Tool Name	Frequency (within-group %)
Camberwell Assessment of Need (CAN)	1 (50.0%)
Social Functioning Scale	1 (50.0%)
TOTAL Living Skills Screening Tools	2 (100.0%)
Medication Effect Screening Tools (5.6% of total 36)	
Tool Name	Frequency (within-group %)
Drug Attitude Inventory (DAI) 30	1 (50.0%)
Liverpool University Neuroleptic Side Effect Rating (LUNSER) Scale	1 (50.0%)
TOTAL Medication Effect Screening Tools	2 (100.0%)

General screening tools

A total of 31 general screening tools were counted, representing 25.2% of the total 123 documents received.

Each tool contained a number of 'risk' areas and appeared to have been developed by the organisations themselves, with no apparent consistency in the risk area identified, the number of risk areas included or the language used to describe the risk area. An in-depth coding and analysis of the 31 documents indicated that the risk areas identified fell into 30 areas, with the overwhelming majority addressing the risk of self-harm (90.3%), followed by violence and aggression (87.1%), suicide (83.9%) substance misuse (80.6%) and self-neglect (74.2%). Figure 5.1 displays all 30 types of risk areas identified within the documents.

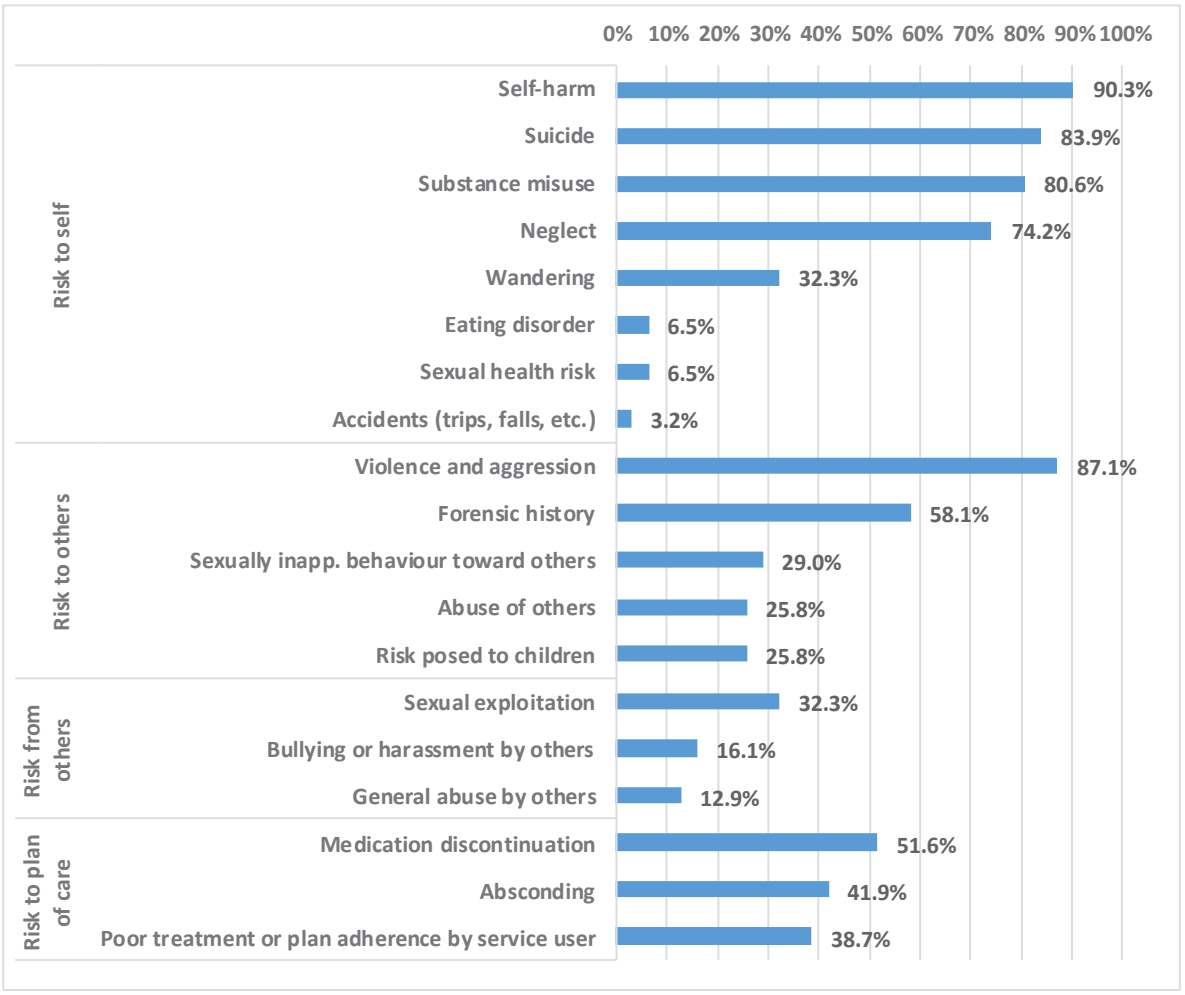
Figure 5.1 Frequency of risk type occurring within general screening documents (N=31)



Using an adapted version of Taylor's (2001 cited in Cordall 2009) model of risk categorisation, a further analysis of the 30 items was performed. 19 items were categorised

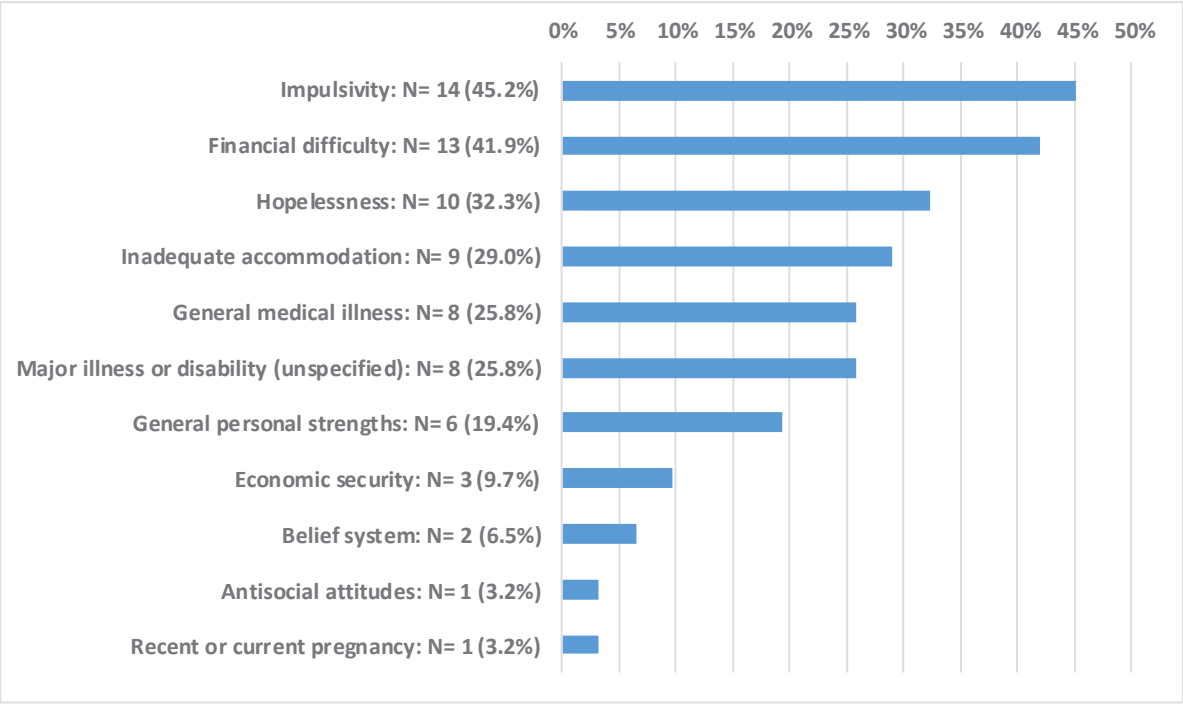
under the following headings: risk to self; risk to others, risk from others, and risk to plan of care (see Figure 5.2) and the remaining 11 items were categorised as contextual risk factors (see Figure 5.3). The pattern identified indicates that risk to self and risk to others is afforded most consideration in the screening process, with risk from others and risk to plan of care given less consideration.

Figure 5.2 Frequency of risk type (by category) occurring within general screening documents (N=31)



With regard to the contextual issues which impact on a service users' risk factors, impulsivity (N=14, 45.2%) featured most frequently, followed by financial difficulty (N= 13, 41.9%), hopelessness (N= 10, 32.3%) and inadequate accommodation (N= 9, 29.0%). Figure 5.3 below displays the frequency values of all 11 contextual risk factors occurring within the 31 general screening tools.

Figure 5.3 Frequency of contextual risk factors occurring within general screening documents (N=31)



In addition to the risk and contextual areas, the screening tools had space for recording some or all of the following items: service users' personal information (e.g., date of birth, ward, admission date, medical/psychiatric history/diagnosis, reason for admission).

In terms of how the screening tools were to be completed, a combination of space for open-ended comments by the practitioner (n=22, 71.0%) and a tick-box style or a Yes/ No/Do not know to indicate the presence or absence of the risk (N=27, 87.1%) was used. Only 8 (25.8%) of the general screening tools included numeric scales, such as scales to rate the severity of risk on a 1-3 point basis (e.g., low, medium, high). The space provided in the comment section of screening tools was very limited in the majority of cases.

There was also wide variation in guidance on how to interpret the meaning of the 'risk areas' identified. While the vast majority did not provide any guidance for the practitioners, no doubt leading to different interpretations, two screening tools provided descriptive prompts, including possible questions to ask, to assist the clinician in interpreting the meaning of the term used, while two others gave a list of what they termed risk indicators. There was also a difference in the focus of the tools in terms of current and past history of risk. While two tools specifically prompted the practitioner to indicate both past and current history, there was a predominant emphasis on past history of risk behaviour, as opposed to current behaviour.

Care plans

Care plans are integral to mental health nurses' work, both in terms of recording assessments, interventions and outcomes. Not only are they a means of recording the decision making process but are central to communication and information sharing with others, including members of the multidisciplinary team, service users' family members and carers. Each of the 123 documents received were reviewed for the presence of care plan templates. A total of 24 care plan templates were received, which were to be used in conjunction with the general screening tools submitted. In some cases the risk screening tool and risk care plan was integrated into the overall plan of care, whereas other 'risk plans' appeared to stand independent of the overall plan of care. The 'risk plan' templates were quite variable in name, format and focus. Titles varied from risk management plan, clinical risk management plan, risk management intervention plan, to risk and recovery plan. In addition, there was variation in format with the plans falling into two broad categories: service user focused and practitioner driven plans.

Those classified as service user focused plans worked from a strengths model and provided the practitioner with prompts to explore with the service user their warning signs, triggers, protective factors and strengths and resources. They also appeared to be modelled on a Wellness Recovery Action Planning (WRAP) philosophy with one plan including a section for 'service user narrative'. The practitioner driven plans, which were the majority, tended to come with a list of recommended interventions including listening to relaxation tape, praying, walking, exercise, observation, prompting compliance, carer/family support, and a list of outside agencies that could be used.

Very few of the templates acknowledged the dynamic nature of risk and had a space to document for ongoing review of the person's situation, with only three documents including a space to document a multidisciplinary review. Further analysis indicated that while all 24 care plan templates had a sign-off option, only 50% (n=12) included a space for the service user to sign off their care plan or indicate that the plan had been discussed with them (see table 5.4).

Table 5.4 Signatures requested by care plans

Signature Requested	Frequency (%)
Nurse only	N= 9 (37.5%)
MHSU only	N= 8 (33.3%)
Doctor only	N= 3 (12.5%)
MHSU & Nurse	N= 3 (12.5%)
MHSU & Doctor	N= 1 (4.2%)
Nurse & Doctor	N= 0 (0.0%)
MHSU, Nurse & Doctor	N= 0 (0.0%)
TOTAL Care Plans Received	N= 24 (100.0%)

Summary of key findings

- Of the 123 documents analysed, the majority were classified as assessment tools (54.5%), followed by risk management and safety planning documentation (18.9%), policies/ procedures (17%), and other/miscellaneous documents (10.6%).
- The policy and procedural documentation (n=21) analysed tended to focus on the service user as a source of risk both to themselves and others (suicide, self-harm or substance misuse and violence). Several risk categories were notably absent, including risk from others, risk of social exclusion and iatrogenic risk. Within the documentation, there was wide variation in how risk, risk assessment and risk management were defined, with the language of positive risk taking or safety planning being minimal. The policy documentation reflected a multidisciplinary team focus and emphasised the importance of collecting information from multiple sources, regular reviews of care plans and clear documentation.
- Just over half (53.7%) of assessment tools received had been validated with a variety of editions and versions being put forward without any apparent rationale for the variation. The majority of the validated tools focused on violence assessment (47.2%), general mental health screening (19.4%) and depression/suicide assessment (8.3%).
- The general screening tools which contained no validated scales (n=31) appeared to have been developed by the organisations with no apparent consistency in the risk area identified, the number of risk areas included or the language used to describe the risk area. There was wide variation in guidance on how to interpret the meaning of risk areas identified and an emphasis on past history of risky behaviour over current behaviour predominated. Risk to self and risk to others featured most in these tools with risk from others and risk to plan of care given less consideration. The focus was overwhelmingly on the risk of self-harm (90.3%), followed by violence and aggression (87.1%), suicide (83.9%) substance misuse (80.6%) and self-neglect (74.2%).
- Care plan templates for safety planning were mostly focused on practitioner-led interventions while some were service user orientated with the strengths model being used as a basis for planning. An acknowledgement of the dynamic nature of risk was largely absent within most documentation as there was a notable absence of space for ongoing review of the persons' situation. While a sign-off option was included in all plans, only half (n=12) included a space for the service user to sign off their care plan or indicate that the plan had been discussed with them.

6. Discussion and Recommendations

Introduction

This is the first study in Ireland that explored practices, policies and processes around risk and safety management within mental health nursing and within a number of mental health services. Data for the study were collected using a mixed method design involving an anonymous, self-completed survey and documentary analysis. In total 381 surveys were received from mental health nurses and 123 documents were analysed. Ethical approval to conduct the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. This chapter discusses the key findings from both data sources, and concludes with the limitations of the study and recommendations for policy, practice, research and education.

Risk categorisation and risk assessment

How people select and decide on what risks to focus on, or what Kelly and McKenna (2004:379) term 'risk selection', is a crucial issue. In their view because it is not possible to worry about all possible risks, 'risk concerns become culturally organized as well as contentious political issues'. The literature reviewed highlights the narrow conceptualisation of risk adopted by policy makers and mental health service stakeholders with the focus almost exclusively on the risks that mental health service users pose to themselves and others (Ryan 1998; Busfield 2004). Similarly within this study as reflected in the practices of nurses the emphasis is on risk to self (suicide and self-harm) and risk to others (violence). This emphasis on risk to self and risk to others is no doubt facilitated by the policies available within the services, as the documentation submitted (policies and tools) also appeared to concentrate on what Ryan (1998) describes as the high-consequence/low-frequency end of the risk spectrum. Notwithstanding the importance of issues such as suicide, self-harm and violence, the emphasis on extreme types of risk, is driven by organisational and practitioner fear of being accused of and blamed for malpractice, which in turn 'reinforces a narrow, professional perspective on risk' (Boardman & Roberts 2013:8). The focus on '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. Although critical in mental health, an approach that is centered on events such as suicide, self-harm and violence creates a dominant discourse on risk which is inappropriate to the majority of service users who do not face or experience such risks (Morgan 2007). In addition, it tends towards viewing the person as the 'problem' or source of blame (Slade 2009), thus missing out on the most 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. If in mental health we continually emphasise high impact or dramatic risks that occur for a few, we lose the opportunity to think about risk in a positive manner and lose the opportunity to explore the idea of risk as part and

parcel of the growth and development of all people who use mental health services (Slade 2009). From the service users' perspective the right to be supported to make challenging and difficult choices even if they are not in agreement with professional opinion is a key variable underpinning recovery (Deegan 1996; Higgins and McGowan 2014). In Watts's (2014) Irish study on service users' recovery journeys through peer support, one of the aspects they valued most about peer support was the manner in which their peers challenged and supported them to move outside their comfort zone and risk engaging with new tasks, roles, and opportunities thus enabling them to grow and develop as a person.

The narrow perspective on risk is also reflected in the fact that the risk of people experiencing mental health problems being victimized and abused by others (Goodman *et al.* 2001) was missed out by the majority of respondents in the study. This is not surprising as those developing policies to guide nursing practice also appeared not to consider these types of risks. Yet research study after research study over the past 20 years indicate that people with mental health problems experience high levels of victimisation and harassment from the general public, both in their own home and on the street including name calling, having objects thrown at them and having offensive graffiti written on the walls or doors of their accommodation (MacGabhann *et al*. 2010; Kelly and McKenna 2004). Kelly and McKenna (2004) also cite examples of people with severe and enduring mental health issues being financially exploited by neighbours and acquaintances, and being reluctant to report such issues to the police in the belief that their word would be doubted, or they might be thought of as 'becoming ill again'.

The trend within this study to miss out on the wider context of peoples' lives is also evident in relation to issues such as employment and housing, as they were rarely considered in the risk assessment or safety management process. Despite the problems which people with mental health problems encounter in their daily lives around employment and housing and the difficulties that these pose for social inclusion and recovery, just over a third of practitioners always considered the risk of homelessness (31.2%), and 15% always considered the risk of losing employment. Yet evidence clearly indicates that people who experience mental health problems are at high risk of being treated unfairly in the workplace, being forced to resign from a job or make a decision to resign because of harassment. Indeed, two fifths of the mental health service users in MacGabhann *et al.*'s (2010) Irish study reported experiencing unfair treatment related to employment, with approximately a quarter reporting discrimination in relation to housing.

While prescribed medication continues to dominate the care of people accessing mental health services, there is growing evidence of the negative impact of side-effects on peoples' quality of life (Moncrieff 2009; Higgins *et al.* 2006), yet just 45% of the respondents reported always considering the risk of the person developing a 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. Another issue which 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 and Holt 2004) and obesity (Citrome and Vreeland 2009) reported. In addition, adverse drug reactions are also implicated in poor physical health (Nash 2011). However, despite this physical health profile, only 49% of respondents reported that they 'always' consider physical health issues as part of their risk assessment. Similarly the area of self-neglect, an under researched area in risk assessment and management, was not seen as integral to risk and safety planning. Yet some service users face challenges to social inclusion, such as poverty and deprivation (Nash 2014), that may increase their risk of self-neglect.

There was also little emphasis on sexual vulnerability with approximately a third of respondents in this study always considering this issue or the risk of intimate partner violence. Yet research has consistently reported high levels of sexual victimisation 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 in Victoria, Australia (2012) for acute inpatient units emphasise the importance of including the assessment of a persons' 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. In the context of assessing sexual vulnerability the findings of this study also reveal a gender difference in relation to this aspect of assessment, with men being significantly less likely to include sexual vulnerability within their risk assessment practices. While it is not possible to state the reason for this difference, studies into other aspects of sexuality have reported a reluctance among male nurses to raise and discuss issues of sexuality with female service users for fear of being accused of 'inappropriate behaviour' (Higgins *et al.* 2008, 2009).

Respondents who were older (over 50) and were longer qualified were found to consider risk factors related to social exclusion and vulnerability such as risk of homelessness, risk of losing employment, and risk of losing contact with family more often than less experienced and younger age groups, suggesting a more holistic approach to risk assessment is acquired over time and with experience. Conversely less experienced respondents reported a greater frequency in putting a person on a level of observation, removing items of risk, identifying anti-absconding strategies and identifying de-escalation strategies, suggesting less experienced respondents practice more conservatively/restrictively than their older counterparts. However, younger and recently qualified staff were more likely to be working in acute inpatient services, where these practices occur, which is a likely explanatory reason for this association.

Safety planning

Developing a safety plan is consistently identified in policy and research as a core dimension of quality safety practices (HSE 2009). In terms of safety planning within this study, there also appears to be the presence of what Woods (2013) terms a 'fragmentation' between risk assessment and risk management 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. Several other studies also highlighted this disconnection between completing a risk assessment and safety plan, or having assessments that are either divorced from the development of safety plans or poorly related to them (Godin 2004; Gilbert *et al.* 2011; Delaney *et al.* 2011). While assessment is an important cornerstone of safety planning, it is of limited utility for services users and practitioners if practitioners simply conduct a risk assessment as a data collection exercise and do not follow through with a safety plan.

Overall, nurses' risk and safety management practice in this study was characterised by taking actions to minimise 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. Over 25% of respondents 'never/rarely' included positive risk taking opportunities in safety planning while 22.5% 'never/rarely' recorded a long-term safety plan with the person. 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. Indeed respondents' confidence was also lower with tasks related to safety planning such as formulating a risk assessment profile, developing a safety management plan, and working with positive risk taking opportunities. Notable differences emerged with respondents working in acute inpatient settings in this study wherein their risk assessment and safety management strategies concentrated on absconsion, de-escalation, and observation with minimal attention paid to the persons' family and social context. Those working in acute settings were more likely to perceive that the emphasis on risk reinforces risk aversion. Risk aversion practice appears especially problematic for inpatient services as reflected by some studies of inpatient mental health services, which highlight the challenges of working in a recovery orientated way in this setting (Chen *et al.* 2013; Hyde *et al.* 2014).

Risk tools and care plan templates

The evidence from this study indicates that many of the risk assessment and screening tools which exist in mental health services have not been validated while those that have are inconsistent in terms of editions being used. The variability of screening tools may be deemed a necessary departure to avoid a 'one-size fits all approach' which some writers caution against (Clancy *et al.* 2014). However, one would have to question the value of the tools and care plan templates as decision aids and communication mechanisms to other

members of the team as many of the templates reviewed only included space for the practitioner to tick yes or no, or indicate with an X the presence of the risk. Little space was provided to include context, service users' perspectives or describe the triggers, which are fundamental to the development of a safety plan.

The study findings also suggest that survey respondents are receptive to using validated risk assessment tools as a means of supporting clinical judgements. This preference among nurses for using validated tools to aid clinical decision-making was reflected in the literature (Godin 2004; Muir-Cochrane *et al.* 2011; Woods 2013; Gerace *et al.* 2013) as were some of the reservations held by a significant proportion of survey respondents in this study in relation to tools not being conducive to service user engagement (Godin 2004). The challenge going forward is to incorporate the use of tools in a way that supports and compliments the processes and approaches to clinical decision-making which currently operate in mental health nursing and to use tools which promote rather than marginalise service user involvement (Langan 2008). Furthermore, Boardman & Roberts (2013) advocate the use of standardised risk assessment tools as part of a broader systematic assessment in which peoples' personal narratives and circumstances feature strongly.

Positive risk and recovery

Evidence from this study illustrates a lack of knowledge and confidence around positive risk taking opportunities with respondents' reporting least confidence with this aspect of risk assessment and safety management. This lack of confidence and knowledge was also reflected in respondents' practice, with only around 20% routinely providing service users with opportunities for positive risk taking. Similarly, research has shown that mental health professionals in Ireland are unfamiliar with the role of positive risk taking and place greater emphasis on symptom management and compliance with treatment (Cleary & Dowling 2009). Despite positive risk taking being advocated as best practice in international and national guidelines (Higgins 2008; MHR 2012; HSE 2014), positive risk taking appeared to be absent within the organisational policies reviewed. While national and international policies advocate positive risk taking and promote self-determination, practitioners are constrained by the emphasis on risk control within local policies, and are possibly unsure how best to implement positive risk taking in a way that reconciles demands for personal, professional and public accountability (Raven & Rix 1999; Robertson & Collinson 2011). In addition, they also have to resolve the tension created between a recovery ethos that is espoused within a service with safety management procedures that emphasise risk and control or as Cleary & Dowling (2009:543) note an ethos that '*On one hand is [about] the promotion of choice and freedom, and on the other, the endorsement of control is evident'.*

Service user involvement

Despite the high level of self-reported involvement of service users in risk assessment and safety management processes, other indicators of involvement such as person-centred approaches to risk assessment and safety planning suggest a lack of meaningful engagement with services users in planning their care. Effective safety management is predicated on building on a persons' strengths and protective factors (HSE 2009), yet on the basis of the evidence of this study, less than half of respondents routinely focus on these in practice. Person-centred safety planning which focuses on a person's strengths, resources and capabilities is deemed integral to the recovery process as it fosters a shared responsibility for safety and planning among service users and enhances 'their capacity to develop self-directed plans to manage risk in the pursuit of valued life goals' (Boardman & Roberts 2013). In addition, while some of the policies submitted espouse the ideal of service user involvement, there is little evidence within the tools or care plan templates of a real commitment to service user involvement, with just 50% having a space for service users to sign, which is often the only documented evidence that service users have been consulted about the safety plan developed.

Some contradictory findings also emerged in relation to communication with services users about risk. While respondents reported a relatively high level of confidence in speaking to service users about safety management strategies, just half reported 'always' communicating risk level to the service user. One possible reason for this is that service user involvement may be viewed as more relevant to the risk management stage when service users' mental health status has improved. 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 stigmatisation and disempowerment of service users by applying the discourse of risk (Langan 2008; Clancy *et al.* 2014).

Training/Education

The importance of education and training in the area of risk assessment and safety planning is central to all policies in the area, and is reiterated in the local policies reviewed for this study. However, just over half (51%) of the respondents indicated that they received education on safety planning, with less than a third of respondents (30.3%) reporting that they had access to ongoing education in risk assessment and management within their organisations. Therefore, it is not surprising that similar to other studies the participants requested further education in the area (Cusack and Killoury 2012; Cleary & Dowling 2009; Jelinek *et al.* 2013). The educational priorities identified by respondents in this study reflect the same knowledge and skills deficits highlighted within Cusack and Killoury's (2012) recent study. Respondents in both studies requested education on the skills and strategies for

effective safety management, in particular education in the use of risk assessment tools, how to involve service users in the process and how to work within an ethos of positive risk.

The centrality of education in improving risk and safety practices is evidenced in this study as findings suggest that those with training in risk assessment and safety planning were more likely, than those without, to conduct risk assessments and develop safety plans. In addition education and training was positively associated with a number of safety management practices including developing a shared responsibility with the service user for safety and identifying how the persons' strengths can support the safety plan. The findings also suggest that training together with confidence in one's ability to complete a risk assessment and safety plan may influence respondents' practice, with training being linked to increased confidence. However, what is evident from this study is the need for education to adopt a much more holistic conceptualisation of 'risk' and 'embrace the concept of dignity of risk, and the right to failure' (Deegan 1996: 28) if practitioners are to be enabled to become more supportive of service users.

While no other research on the impact of training on risk practices could be located, research is available that demonstrates the positive impact of training on staff knowledge, skills and competencies to practice in a recovery-orientated manner (Gudjonsson *et al.* 2010). Having said this, any approach to risk needs to be organisationally mandated with responsibility held by the service rather than the practitioner, therefore policies, guidelines and management support are also required to create a climate that is receptive to positive risk taking (Stickley & Felton 2006).

Limitations

The results of this study need to be interpreted in light of the following limitations:

- Nurses' practices and behaviours are self-reported and not observed, therefore the data is limited in that it is impossible to determine whether the nurses' behaviour is the same and/or different in their actual clinical practice.
- There is potential for a response bias with those more positively disposed to risk assessment and management more likely to complete the survey.
- Throughout the survey, the terms 'safety planning' and 'safety management' were used to ascertain respondents' views and practices. It is possible that mental health nurses are more familiar with the term 'risk management' and may not have equated their risk management practice with safety planning practice thus underrepresenting the true extent of risk management/safety planning practice.
- The estimated response rate of 28.9% is quite low although this is not unusual in survey research.

- There is no way of knowing how representative the documentation received is of the overall documentation on risk within the services. There may also be selection bias in the documentation submitted.

Recommendations

In light of the findings, the following recommendations are proposed:

Recommendations for policy

- National guidelines or recommendations are required to inform the development of evidence based policies and strategies for risk assessment and safety planning at organizational and clinical practice levels.

Recommendations for practice

- A HSE wide mental health service approach to risk assessment and safety planning is required which incorporates recovery and positive risk principles. Managers within local service, in conjunction with service user panels, need to review their policies on risk and safety to ensure that they have a recovery and positive risk focus, as well as ensuring that the policies reflect a comprehensive definition of risk.
- A common language of risk is developed so that both professionals and service users have at least a rough idea of what is meant by terms such as risk assessment, risk management, safety planning and positive risk. This might be underpinned by the adoption of a best practice guide to assist nurses to work with risk and safety in a recovery oriented manner, and a risk glossary that can be given to clinicians, service users, families and carers.
- A coherent approach to the development of documentation, including risk screening and other risk tools is required. This may involve the selection and adoption of named, validated instruments throughout HSE mental health services which will require detailed discussion to arrive at a consensus on which tools should be employed.
- A risk screening tool and care plan template be developed that can be used across all services and evaluated from all stakeholder perspectives. Any tool/template should be multi-disciplinary in nature, as many of the issues will require multidisciplinary input, and incorporate a space for service users to sign off on the plan.

Recommendations for education

- Risk assessment and safety planning education and training be developed and delivered to mental health practitioners to enable them to develop skills to work with and respond to service users presenting with risk issues in a competent, creative and compassionate manner including the knowledge, skills, and attitudes to discuss protective factors and positive risk taking opportunities.

- Service user and family/carer input be incorporated into such training in order for professionals to see the potential impact on service users and family members of decisions made regarding risk and safety planning.
- Service users' capacity to formulate self-directed plans be built-up through educational interventions as well as ensuring training focuses on the requisite knowledge and skills practitioners need to engage in the process of person-centred planning.

Recommendations for research

There is considerable gaps in our knowledge on all aspects of risk and safety therefore we recommend that further studies are undertaken to:

- Explore service users' perspectives of risk and the strategies they use to maintain their own safety.
- Explore family members' views and perspectives on risk including their perspective on how services are responding to their needs and concerns.
- Explore how nurses engage with service users around risk assessment and risk management, including how they resolve tensions between working in a recovery oriented manner and a culture that is risk averse.
- Explore how organisational practices foster or hinder nurses learning of risk assessment and risk management, including how they resolve tensions around working in a recovery oriented manner
- Explore current multi-disciplinary team working in risk assessment and safety planning to elicit different team members' views as to effectiveness and potential barriers in practice.
- Examine nurses' clinical supervision needs as a means of supporting effective practice in risk and safety planning.

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