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Risk, discourse and identity work: what we do and how we could do it differently

Dr Michael Coffey

Inaugural Mental Health Nurse Academics UK Lecture

23rd International Mental Health Nursing Research Conference, Cardiff, 15th September 2017



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Risk, discourse and identity work: what we do and how we could do it differently

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Annual Mental Health Nurse Academics UK Lecture
23rd International Mental Health Nursing Research (MHNR)
Conference, Cardiff 2017
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Introduction

In this lecture I will talk about risk, the language we use and the possible consequences of risk discourse. I will base my analysis on my observations over the last 30 years as a mental health nurse and as a researcher. I will show examples of discourse on and of risk from some studies I have been involved in and what I think this means for people receiving care and the profession itself. I will contrast our professional focus on the therapeutic relationship with evidence for what seems to be happening in risk practices and argue for approaches that work to achieve more justice in assessments. In 1994 Tony Butterworth's review of mental health nursing argued for a central focus on working in partnership with people using mental


health services. My view is that we have still some distance to travel on this journey and it is in risk assessment practice that we can most clearly see a lack of partnership. Risk practice itself has generated its own requirements that have worked to downplay trust in expertise and to create distance in the therapeutic relationship (Szmukler and Rose, 2013).

Therapeutic relationships are claimed as fundamental to the work of our profession. It therefore seems inconsistent to withhold or deny involvement of people in discussions about their safety, especially given the limitations assessments and the possible consequences arising from them. My argument is that new forms of involvement and engagement in discussions about risk are required that more directly align with claims of what it is to be a mental health nurse and that by doing so we will enable people using services to build and sustain agency.

In this lecture I will argue that how we talk about risk says something important about how the mental health system operates, how work gets done and how people delivering and receiving care make sense of themselves in the context of that care.

For example, as I have found previously (Coffey, 2012) forensic mental health nurses refer to their primary function as public protection then how are we to understand their work and how does this work fit with being a health or social care professional? What are the likely effects upon individuals using our services of talking in this way about the work we do?

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A risk worth taking? Value differences and alternative risk constructions in accounts given by patients and their community workers following conditional discharge from forensic mental health services
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Patients leaving forensic psychiatric settings on conditional discharge face the challenge of achieving successful community integration, which involves not re-offending, adjusting to the local community and building support networks. Aftercare and monitoring of patients by workers inevitably assists with integration, but is often dominated by concerns about risks to the public. Risk is seen to emanate from individuals, with steps taken to ensure intensive monitoring and, if necessary, swift return to hospital. This article shows that workers and conditionally discharged patients have distinct views about risk in community living which are driven by contrasting values and priorities, and that some of these differences are associated with the provision of care itself. A discursive analysis of accounts, drawn from 19 interviews with patients and workers, demonstrates that fears about deviant status weigh most heavily for the individual leaving hospital. Aftercare, with its focus on intensive regular visits by nurses, social workers, police and voluntary agencies, works to 'summit' the patient to the wider community, setting them apart to enable supervision. Discharged patients express anxiety that this unmaking undermines their attempts to begin new lives. Their concern suggests that significant idiosyncratic risk arises from aftercare. Workers are not indifferent to this issue, but are themselves subject to public safety imperatives which require surveillance and control of individuals deemed risks. Community integration has the potential to be an important mediator in future risk behaviours. However, managing intensive aftercare without allowing for its wider visibility may jeopardise its achievement.

Keywords: aftercare; deviance; forensic psychiatry; users' views; risk; idiosyncratic risk; risk; values

P: What you've done in the past sticks with you all the time, you know umm. I'm still classed as a dangerous person cause if I wasn't dangerous I wouldn't have anybody with me would I? So it just shows along that way that people still don't trust me like.

quote from HRS 'A risk worth taking' paper – For some they come to see themselves as embodying risk as in this example from my study of people discharged from forensic mental health care settings.

P: What you've done in the past sticks with you all the time, you know umm. I'm still classed as a dangerous person cause if I wasn't dangerous I wouldn't have anybody with me would I? So it just shows along that way that people still don't trust me like.

Risk Thinking

“the primary task for mental health professionals is now less about therapy and treatment, and much more about the administrative management of potentially problematic persons”

Nikolas Rose (1998:263)

For others such as the sociologist Nikolas Rose (1998:263) it furnishes a claim that there is a focus on risk thinking such that “the primary task for mental health professionals is now less about therapy and treatment, and much more about the administrative management of potentially problematic persons”

Almost 20 years later can we say that there is much improvement in this situation?

Organisations appear more than ever to be focused on reputational risks and our processes purely administrative and not particularly helpful.

I am starting from the position that how risk assessment is practiced in mental health services is little more than a fable. It is a fiction and it is unjust in that the way it is perpetrated works to deny people using services the possibility of contributing their expert knowledge to possible solutions.

In many instances risk assessment has become an interactional accomplishment to deal with uncertainty and reassure us all that something is being done to manage what may be largely unknowable.

I think we can do better than this and want to use the opportunity today to discuss what might be done differently.



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When I walked through the doors of this place in 1984 the word 'risk' was rarely if ever uttered and may have largely been concerned with risks to staff for failing to follow the many rules both formal and informal of the institution.

In institutions like this there was much 'doing to' rather than 'working with' people in mental distress and I think this legacy is partly responsible for problems in achieving meaningful involvement today.

Therapeutic relationships

- Strong evidence base
- Valued by service users and professionals
- Necessary but not sufficient
- High relationship scores associated with high recovery scores
- Workers score higher


INTEGRATIVE LITERATURE REVIEWS AND META-ANALYSES
Therapeutic working relationships with people with schizophrenia: literature review
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Abstract
Cross-national mixed-methods comparative case study of recovery-focused mental health care planning and co-ordination: Collaborative Planning Project (COCAPP)
 Alan Simpson, Ben Atkinson, Michael Coffey, Alan P. Fowler, Cathy, Julia, Stephanie and Alison Lydenham

Abstract
 Cross-national mixed-methods comparative case study of recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings (COCAPP-A)

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As students we did learn a lot about relationships and listening as key mental health nursing skills and today we can be fairly certain that therapeutic relationships remain fundamental, have a reasonably strong evidence base (Hewitt and Coffey, 2005), are valued by workers and service users alike and remain a necessary if not sufficient condition for achieving change with people in mental distress.

In our COCAPP study (Simpson et al, 2016) we found significant associations between scores for relationships and recovery among service users and in the COCAPP-A evidence that workers rate this more highly than service users (Simpson et al, 2017 in press).

We of course do need to understand how to keep people safe in a way that fits within the bounds of our knowledge, and we must respect individual rights and the law. So I am definitely not suggesting that we abandon risk assessment processes entirely. But we should not do this based on fallacious assessments that limit involvement of the people most affected.

Risk assessments have tended to foreground worker and system priorities while accepting weak evidence for their efficacy, excluding or side-lining knowledge from the person and their families with little transparency or scrutiny of the conduct of the actual assessments. The way these are conducted appears to me at least to be contrary to claims made on behalf of honest and respectful therapeutic relationships.

Why focus on risk?

- * Approximately 5,600 suicides per year in the UK
- * 30% known to mental health services
- * Increases during economic austerity
- * Policy and legal requirement
- * Moral and professional obligation
- * Handling consequences e.g. blame

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Harm does occur

When I walked through the front door of the hospital in 1984 I had a sense of stepping into a world which hadn't much changed over the past half a century. Soon things did change and quite rapidly. The 1990's seemed to prompt a series of concerns about dangers arising from behaviours of people in mental distress and in the UK at least these were to an extent crystallised with the killing of Jonathan Zito by Christopher Clunis and the nationally broadcast video of Ben Silcott climbing into the lion's den at London Zoo. Risk and the failure of mental health services to manage this was very much on the agenda and government policy (see the DoH 10-point plan and later the insertion of risk assessment into requirements of the CPA) was quick to locate the responsibility for handling all of this with the professions.

Why focus on risk?

We are appropriately worried about preventing harm and promoting safety because of course harm does occur

It is a real issue because for instance there are about 5,600 suicides each year in the UK 30% of which are known to mental health services and recent increases among men in particular associated with economic austerity (Cavanagh et al, 2016; Coope et al, 2014; NCISH, 2015). Recent concerns about rises in suicides in university students and benefit claimants also point to worrying new trends.


We know there are other types of risk too including the less obvious risks of loneliness, neglect and wider vulnerability though these attract less attention and are rarely estimated. Risk and working with people to manage their safety is an integral requirement of care co-ordination approaches but even if it were not I think we would agree that there is a moral and professional obligation to pay attention to safety of vulnerable people in mental distress.

The introduction of risk assessment has also understandably led to concerns about blame and where it might lie, for in tallying up the risk of untoward events we are also (and perhaps inadvertently) identifying who might be blamed for not spotting and managing the events that later unfold (Annandale, 1996). This has an immediate effect on the work that gets done and perhaps more potently on what gets counted so that wider impacts are felt in the system of care.

Effects of risk judgements

- Implications for people receiving care
- Implications for professionals
 - ❖ You try to (take positive risks), but it's backfired on me once or twice, you tend to take a step back. I'm all for positive risk taking but it's hard to do that when you think you're on your own, when no one else is going to support you. And lots of people are risk averse, and yeah, it makes it difficult
- Implications for how care gets done
- Implications for how we think about people

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Effects of risk judgements

To me it seems that risk assessment is a wholly expected response to trying to figure out the negative outcomes arising in the context of mental distress and as a precursor to attempting to address these. An expected response for sure but how risk assessments actually work in practice remains largely a mystery too but there are concerns that practice is becoming more defensive.

It seems to me that our profession has become concerned with what Paul Godin ruefully notes as 'ticking the boxes on the form' both metaphorically and literally. Rose (1998) noted that this form of 'risk thinking' seeks to bring the future into the present and make it calculable. Risk determinations become the means by which professionals think, act, and justify their actions.

This is worrying because there are potentially serious implications from processes of making judgements about levels of risk for injurious behaviours towards self and others in that for patients they carry significant weight in determinations of continued liberty and for workers in that they represent the means to avoid or apportion blame for untoward events.

This can lead to a tension between outcomes that promote independence say and those that shield workers. Even where workers are truly focused on the person in their risk assessment practice there remains significant anxieties that they may be held accountable for events that are largely unpredictable.

"You try to (take positive risks), but it's backfired on me once or twice, you tend to take a step back. I'm all for positive risk taking but it's hard to do that when you think you're on your own, when no one else is going to support you. And lots of people are risk averse, and yeah, it makes it difficult" Care Co-ordinator in COCAPP study

It seems that in the midst of this emphasis and the obligation to measure and predict we may be guilty of losing sight of the effect our changing discourses are having on the practice and identity of mental health nursing itself. If we see everyone we meet as potential risk objects, that is everyone experiencing mental distress as embodying risk, then this changes how we understand people and orient towards them as human beings.

In focusing too intently on the possibility of risk we may be in danger of forgetting too what it is to be human, to make mistakes, to learn from these. A consequence is we deny people who use services the same rights we all enjoy. Indeed we deny each other as fellow humans both delivering and receiving services, the opportunity to learn.

Safe places to talk?

- In the mental health system, the emphasis is more on stopping the act rather than creating an accepting atmosphere where these tortuous feelings can be understood and possibly lived with. The danger is we attempt to keep people alive not by helping them find meaning, but by submitting them to tactics of control and surveillance.

Rufus May 2017

<http://compassionatementalhealth.co.uk/safe-spaces-talk-suicide-rufus-may>

Safe places to talk – our focus on preventing and controlling it has been argued takes us away from engaging with people and their distress so that perhaps we are ultimately less helpful?

More worrying still is that this very discourse of risk, harm and blame is also having an effect on the people our profession are meant to be helping. Language is important, words do things and they can be extremely powerful, be helpful or devastating and can show resistance or have convincing effects. If you are in any doubt then perhaps you'll remember the persuasive effect of these words?

Language matters



<http://nowweknow.co.uk/lets-give-nhs-350-million-eu-takes-every-week/>

The £350 million a week for the NHS was persuasive it seems but also turned out to be illusory and our talk about judging risk may have a similar fate.

The language of risk assessment as we know is negative, it references difficult, distressing and unpleasant events or possible outcomes.

Rights, risk and choice

- ❖ “It is a risks and rights balance, risks are certainly far more focused on than rights.”
- ❖ “And we’ve got very vulnerable service users, ...there are some who are aggressive and have got risk history, forensic history, it might be one area as well, actually where the service user does not get a choice in what is implemented”

How we talk about risk implicates how we understand ourselves and orient towards each other.

New slide – quotes – we may end up in situations where risk trumps rights or where choice is removed as implied here

☐ “It is a risks and rights balance, risks are certainly far more focused on than rights.”

☐ “And we’ve got very vulnerable service users, ...there are some who are aggressive and have got risk history, forensic history, it might be one area as well, actually where the service user does not get a choice in what is implemented”

The implication may be that individual identity is fixed and immutable. Once we have labelled something it must remain forever labelled. If we have had a mental health problem we are forever mentally ill. If we once stole a bottle of milk we are forever a thief. If we once got involved in a physical fight we are forever violent. If we have been irrational we must be forever considered irrational.

How we do risk assessment and how we talk about it is relevant to how we understand people as people. Identity, or how we are known to ourselves and to others, is a critical element of everyday impression management (Goffman, 1959). We are all engaged in this identity work much of the time. How we come to know who we are is for the most part created in interaction with others, we are validated or disregarded by others, we are held in high esteem or dismissed, what we tell ourselves about ourselves helps formulate our identity but an important further ingredient is what others tell us about ourselves. For this there are multiple cues in our interactions and how we are treated by others. Sue Estroff (1989) noted that people with enduring mental distress have often come to know themselves as embodying a diagnostic label and it appears we have now added the burden of various risk labels.

We know from Goffman (1963) that mental illness is a discredited and discreditable identity. What happens when we add in information derived from probably dubious assessments of risk behaviour? Mike Slade (2009) correctly hit the nail on the head in his book on personal recovery when he noted that the focus on risk was quickly becoming a new source for creating stigmatised identities.

What is happening in CMHTs?

❖ “whilst they may be engaged in the care plan, and that’s debatable, with risk assessment, it’s, that’s one thing we never, you never discuss with service users just in case it alarms them.” (Senior Manager Participant)

33 care plans reviewed

12 = included person’s views in risk assessments.

4 of these 12 = no views included in risk management plan.

21 care plans showed no evidence of involvement.

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A., Barlow, S. 2017. Ordinary risks and accepted fictions: how contrasting and competing priorities work in mental health risk assessment and care planning. *Health Expectations* 20(3): 471–483 DOI: 10.1111/hex.12474

I think at some level many mental health professionals have an intuitive grasp of the unreliability of risk assessments and perhaps too a fear of the effect of the language used in discussing safety and risk? I wonder if this explains why some care co-ordinators appear to avoid discussing risk assessment and approach it with a stealth that leaves many service users largely unaware of any effort to deal with potential and untoward risk behaviours. We know this from data arising from our study of care planning in community mental health teams in England and Wales (Simpson et al, 2016).

This quote from a senior manager in one CMHT summed up a general view among our participants that risk assessment is something that is not talked about or shared with service users. The assumption being made is that such a discussion will upset service users. “whilst they may be engaged in the care plan, and that’s debatable, with risk assessment, it’s, that’s one thing we never, you never discuss with service users just in case it alarms them.” (Senior Manager Participant)

From a total of 33 care plans reviewed for this study, we found 12 showing individuals’ views were considered in risk assessments. However, four of these 12 did not show evidence of extending this to the risk management plan. So 21 care plans showed no evidence of involvement. Our more recent study of inpatient mental health services in England and Wales shows a similar picture (Simpson et al, 2017 in press).

In our studies people using services were largely unaware of risk assessments being conducted. In some cases they assumed that staff took their safety into account but for the most part they were not involved in whatever happened. This finding has been noted in others studies in different mental health settings (e.g. Langan, 2010, Dixon, 2012) so I believe we can take it with reasonable confidence that it is a stable finding.

Some limits of risk assessment

- Overly weighted towards historical factors
- Risk training is limited and fails to account for drift
- Evidence for many scales is weak
- False positives are high
- Practice is variable
- Process suggests they act as fictions

It might be useful too to remind ourselves of some of the limits of risk assessment work. Many services have non-standard forms for recording assessments that are often conducted in highly variable ways.

Where there is use of scales these are heavily weighted towards historical factors (HCR-20 is an example), largely concerned with risks that services or individuals will be held accountable for, often come with no training or fail to account for drift once workers are trained (although not a risk scale there is evidence of drift in using other standardised scales such as the BPRS, Ventura et al, 1993). Evidence for risk assessment scales is weak (Swanson, 2008) and more recent evidence shows that they may be no better at predicting risk than individual clinician or patient opinion (Quinlivan et al, 2017). The most recent recommendation is that these scales should not be used for individual clinical assessments (Carter et al, 2017).

A consistent finding first highlighted by Pokorny (1983) is 96% of high risk predictions of suicide were false positives and more than half of suicides occur in groups rated as low risk. Indeed risk assessments are so unreliable that it has been suggested that we cannot continue to use risk as a decisive in determining the need for psychiatric treatment (Szmuckler and Rose, 2013) and instead we should aim for providing an adequate standard of care to everyone who needs mental health services (Nielsen et al, 2017).

Attempts to do risk assessment at street level in mental health services suggests that much of what is claimed to occur in risk assessment is little more than fiction; fables for dealing with the terrible uncertainty that both the person and the nurse experience (Coffey et al, 2017).

The notion of accepted fictions recognises that risk status is ambiguous, outcomes uncertain and consequences significant. Accepted fictions therefore centre on the ambiguity of risk assessment practices that are either transparently ineffective or for which the contested knowledge about them is known but largely ignored. These fictions appear to operate to legitimate practices that cause moral unease. In this sense all parties in an interaction may be aware that a proposed approach is known to be largely for administrative purposes and has little or no scientific validity.

What is happening in risk assessment work?

- Information is not shared with the person and their family
- Person not involved & knowledge is not used
- Unclear that assessments are evidence based
- Unclear reliability or validity of assessments

Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning

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Abstract

Background: Communication and information sharing are essential to recovery-focused mental health services. Effective mental health care planning and coordination includes assessment and management of risk and safety.

Objective: Using data from our cross-national mixed-method study of care planning and coordination, we examined what patients, family members and workers say about risk assessment and management and explored the content of care plans.

Design: Thematic analysis of qualitative research interviews (n = 117) with patients, family members and workers, across four English and one Welsh National Health Service sites. Care plans were reviewed (n = 75) using a structured template.

Findings: Participants have contrasting priorities in relation to risk. Patients are fearful in discussions about risk, but see the process as a worker priority that may lead to loss of liberty. Relationships with workers are key to family members and patients; however, worker claims of involving people in the care planning process do not correspond to risk assessment and management procedures (or fear of causing upset). Workers focus risk on coming from the person rather than social or environmental factors, are risk averse and appear to prioritise the procedural aspects of assessment.

Conclusions: Despite intentions, risk assessment is treated as legitimate work by professionals. Risk assessment practice operates as a type of fiction in which their predictive ability and fear of consequences are accepted in the interests of normative certainty by all parties. As a consequence, risk adverse options are encouraged by workers and patients steered away from opportunities for ordinary risks thereby hindering the realisation of their strengths and

New slide- What is happening in risk assessment work?

So what it is that is happening in risk assessment work?

What we do see is;

Information is not shared with the person and their family

Person is not involved and their knowledge is not used

It's not clear that assessments are being conducted in evidence based ways, and because there is no transparency of scrutiny it seems there is...

Little evidence for reliability or validity of assessments

Outcomes of risk assessment

- Maintain safety
- Restricts or removes liberty
- Changes how the person is seen
- Denies access and contribution to solutions
- Lack reciprocity

The consequences of risk assessment require us to act in ways that are fair and just for individuals. If you need persuading on this then consider what are the likely outcomes of risk decisions?

At best they might keep someone safe for long enough for them to get better and this is largely welcomed, though we must remember the high rate of false positives and recognise that how safety is achieved is also important.

At worst it denies people liberty on the basis of providing a range of treatments of contested and doubtful efficacy, based on assessments of questionable validity and which may cause them harm. Loss of liberty or other social restrictions can strain the social fabric for individuals, it disconnects them from family, friends, community, employment and sometimes even a place to call home. It is likely too to have a more fundamental effect on how the person sees themselves and are seen by others.

It has been suggested too that a focus on predicting and managing risk may paradoxically lead to less assessment and management of actual risks because workers are fearful if suicide risk is identified that they will then have to eliminate it (Cole-King and Lepping, 2010).

What worries me though is that people using services are subjected to the potential negative effects of risk assessment for little apparent benefit and without any means to participate or contribute their knowledge to the solutions. This lack of reciprocity is problematic and unacceptable but even more fundamental injustices are at play.

Epistemic injustice

“a wrong done to somebody specifically in their capacity as a knower”

Testimonial injustice – where prejudice causes a hearer to give a deflated level of credibility to what someone else says

Hermeneutical injustice – a gap in collective interpretive resources placing someone at a disadvantage in making sense of their social experiences

Fricker, M. 2007. *Epistemic Injustice: power and the ethics of knowing*. Oxford University Press, Oxford.

These include what Miranda Fricker refers to as the concept of epistemic injustice which she defines as wrong done to someone in their capacity as a knower (2007:1). She highlights two types of epistemic injustice, testimonial and hermeneutic injustices. The first of these ‘testimonial injustice’ is relevant I believe to what has been happening in risk assessment practice itself and the second ‘hermeneutic injustice’ is more broadly relevant to the experience of mental health care.

Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to what someone else says or excludes or fails to seek their views based on some prejudice.

Hermeneutic injustice occurs where a gap in collective interpretive resources places someone at an unfair disadvantage in making sense of their social experiences.

In conducting risk assessments without the knowledge and involvement of people we are in danger of creating testimonial injustice, viewing what people say as somehow less valuable than our own knowledge. By failing to share this knowledge we create wider hermeneutical injustice within the group of people using services.

Not being listened to or having one's views downplayed or treated as not credible is crucial for service users estimations of positive or negative experiences of care. Our evidence suggests that most people experiencing mental health care are not involved in risk assessments and are actively denied the opportunity to participate in finding solutions to maintain their safety.

This may be for apparently laudable reasons but we have to remember that Risk practices that ignore patient views and fail to engage them in the process work to distance individuals from decisions that are of critical importance to their wellbeing.



Risk assessment and its management in contemporary mental health services places all the cards with one group of people and successfully keeps another group of people largely in the dark about what is going on. This isn't fair, it isn't just and it is not how to build a modern, forward-looking and collaborative mental health care system. Mental health nursing can do better.

Addressing the democratic deficit in risk assessment?

- Find ways to talk about difficult things
 - “[risk has been discussed and considered]... because when I went out they were concerned about how I would cope and how I would deal with things and contingency plans... we had contingencies in place for things going wrong and that I would be safe no matter what because I wouldn't be on my own and we'd all discussed how things would be dealt with if there was a problem”
- Pay closer attention to language
- Mobilise resources
- Respect service users as knowers
- Build a new evidence base

Find ways to talk about difficult things

People in mental health care value relationships. It seems an odd thing to have to say because we all intuitively know this. In a sense we have all self-selected for valuing relationships. Workers value relationships and people using services value those relationships too. In forming meaningful relationships we can be honest with others, have trust in what they say and develop a sense of shared understanding about what is at stake and how best to deal with issues. In our COCAPP (Simpson et al, 2016 and Simpson et al, 2017 in press) and Plan4Recovery (Coffey et al, 2016) studies we found many people saying all of this but also we found service users telling us that they barely knew their worker, could not confide in them and had no sense of sharing decisions. Even in the most pressured of circumstances making the time for establishing and maintaining relationships should remain the priority and in some cases it's not happening.

We need to focus on dealing with distress with empathy and compassion and recognise that meaningful engagement is the core work of our profession and may have inherent protective qualities (Cole-King and Platt, 2017). We can communicate that we are concerned about safety and interested in working with the person to manage this. We could begin to do this by simply having conversations about risk and safety with people using mental health services. There are some potentially fruitful avenues to explore for example, by making use of open dialogue approaches (Seikkula et al, 2006).

"[risk has been discussed and considered]... because when I went out they were concerned about how I would cope and how I would deal with things and contingency plans... we had contingencies in place for things going wrong and that I would be safe no matter what because I wouldn't be on my own and we'd all discussed how things would be dealt with if there was a problem" (Service User)

Pay closer attention to language

In building relationships we need to pay closer attention to the language we use. Boardman and Roberts (2014) have noted that risk assessment language is negative and inclined towards distressing outcomes. Participants in our recent study of inpatient mental health care (Simpson et al, 2017) noted that a barrier to participating in care planning was that the content was upsetting, focused on negative experiences, emphasised limited resources or was simply 'dark'.

How we talk about risk has important implications for how we see people with mental health problems and also how they see themselves.

If workers orient towards individuals as risky and take steps to limit or restrict opportunities then over time whether this is openly stated or not, it is likely that these same individuals will come to see themselves as people who are unsafe, must be watched and must endure limits on their personal liberty. The contradiction inherent here is that these ways of seeing oneself emphasise dependence rather than the independence we claim is the focus of recovery oriented services. We need a new language that is instead strengths-focused, builds hope and facilitates skills for seeking help and support.

Mobilise resources

We need to move from a focus on control to one in which we work with people to address their safety issues. Our position has been to place professional knowledge above lay

knowledge as somehow carrying greater weight and being immune from contamination of non-empirical or cultural influences. I think this is in part prompted by anxieties derived from organisational concerns about reputational risk. An alternative is to maximise and mobilise available resources towards learning more about risk and its management. This will help people and their families build their confidence and knowledge about what can be done to address risk concerns.

Power (2004) has noted that the burden of managing unknowable risks can lead organisations to focus on the easier task of what can be successfully reported as being addressed. In a sense this is a root cause of fictional risk assessment work. Not being able to be certain of future risks we invest in approaches which meet organisational needs for reporting so a façade of risk management can be erected. Organisations mostly focused on reputational risks arising from negative events may influence or pressure workers to reassure the hierarchy that all is well. Workers buy into claims that actuarial tools do what they say they do and become overly focused on the individual as the problem at the expense of the more difficult structural problems that contribute to an environment in which risk behaviours appear. Being open with others about the limits of risk assessment but also the possibilities would make a change

Respect service users as knowers

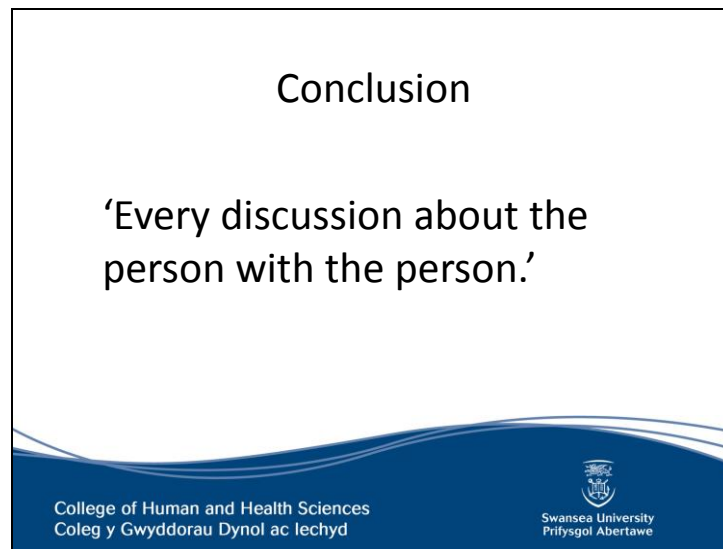
A key element of these resources is knowledge from the person and their family. There is some good evidence that service users' evaluations of their own risk are prospectively significant (Roaldset and Bjorkly, 2010).

There is expert knowledge but there is also lay experiential knowledge. Adopting a multiple perspectives approach we can engage people in risk assessments not simply as the provider of responses to set questions which will be judged later by experts but as valued knowers with contributions to make to understanding and addressing concerns over safety. Risk assessments need to be obvious not hidden, they need to be open, they need to be shared and most importantly they need to include the knowledge brought by the person themselves. Mental health nurses have the skills to facilitate this involvement and in not doing so we neglect these skills and the opportunity to demonstrate our specialist knowledge as relational experts.

Build an evidence base

If we want better risk assessment and management approaches then we need to do more than simply pay lip service to involvement and we need to build an evidence base of the best ways to engage people in decisions about their safety and the safety of others. This needs to value their experience and involve them in decisions on the best ways to mitigate risk and promote safety. The project of risk prediction has failed in mental health care. We need an evidence base of what works and why and how it works. Now we must move to focus the practice and research of mental health nursing on what can be known and in doing so create partnerships with the people that are central to the process to develop shared solutions.

There are a number of examples of risk assessment and mitigation approaches that place the person at the centre of the process and require professionals to engage and involve people in the assessment, e.g. Suicide Assessment Framework e-tool SafeTool application (Connecting with People)



Conclusion

To borrow and slightly subvert the well-known phrase, we could ensure that when we talk about risk that ‘Every discussion about the person is with the person.’

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