Emerging Themes *are a series of papers drawn from the work of the National Development Team*

Modelling risk management in inclusive settings

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Introduction

Over the past few years, the National Development Team has been assisting a number of services for people with mental health issues or learning disabilities to promote socially inclusive lifestyles. The most common difficulty that is raised during staff training sessions is how risk is managed in ordinary community locations. While staff are generally well intentioned in their concern, the modernisation agenda that highlights the importance of social inclusion has also highlighted weaknesses in the culture and management of risk.

This paper identifies three different models in relation to issues of risk that we feel staff have adopted in their practice. For each one, through an analysis of their deficiencies, we point the way toward a more sophisticated approach that attends to the person, the specific community and the needs of the organisation and its staff.

Using Models

The models that we describe in this paper are of our own making and based on years of delivering training on both effective risk management and social inclusion to staff, service users and carers. We have not consciously borrowed these models from other publications or heard others discuss them openly. Instead, we have detected them hidden within the stories we have been told, unconsciously shaping the decisions people make and directing the opportunities offered to people using services. In each case, the model is used at two places: firstly to decide who is involved in the ongoing process of managing risks for current service users, and secondly to navigate the process of discharge from services.

Providing Too Much

In this model, people who are known to present high profile risks are placed in situations where there is limited or no opportunity to engage in high-risk behaviour. Containment keeps the community safe in the short term, staffed residential, nursing or hospital care aims to avoid the possibility that a person with dementia will get lost, and accompanied outings prevent the person from engaging in potentially risky exchanges with community members. Too much may consist of excessive care packages or cheap but excessive restriction of freedom, which can have legal consequences as shown by the European Court of Human Rights' decision of HL vs. United Kingdom, known as the Bournewood

judgement. Similarly in the proposed Mental Health Bill there will be a stipulation to, "have an independent assessment that deprivation of liberty is necessary in their best interests to prevent a person from harm." (Mental Health Bill, pending).

People using this model believe that risk can be managed by taking away or limiting the person's ability to engage in opportunities that may result in harm. The intended outcome is to avoid risk and maintain the reputation of the organisation rather than viewing risk management as a dynamic, messy and imprecise process. It is a common feature of risk-averse or overly bureaucratic organisations and fearful, poorly led staff working in a blame culture. For example, one service refused a learning disabled man permission to use garden machinery – solely on the basis of his diagnosis.

The point of discharge simply disappears from sight in services that provide too much, as they assume that the person will need them for life.

Providing Too Much leads to poor risk management for the following reasons:

- It is based on the label or diagnosis rather than a detailed understanding of the person as an individual with strengths, interests and areas of vulnerability and risk.
- The excessive control or intervention can feel oppressive and damaging to the person as it restricts opportunities and independence.
- It does not take account of the risks that this level of intervention may create for the person or their situation – the attempt to avoid risk is mistakenly assumed to eliminate it all together and intervention is wrongly seen as always beneficial and never harmful.
- It rejects any potential for the person to change.
- It is sometimes more expensive than necessary and leads to misallocation of resources.

The Mental Health Act Commission in its Tenth Biennial Report (2003, para 9.3) indicated that,

> *"The risks that need to be considered in any comprehensive risk assessment as a part of a patient's care plan must not be limited to risk behaviour shown by the patient in the past, but should extend to consideration of the risks of interventions designed to meet the patient's healthcare needs.…..there is a danger of 'risk' being interpreted as relating only to potential harm that a patient might do to themselves or others, with no consideration being given to the harm that interventions might do to the patients they are designed to help. These risks encompass physical risks from, for example, control and restraint interventions or from the side-effects of medication or other treatments, to psychological or social risks, such as the alienation of a patient from services and from seeking help when needed, or the isolation of a patient within their home community through heavy-handed interventions."*

Any service can *provide too much* and so increase the risk of harm. For people who live the whole of their life surrounded by other service users and staff, the social inclusion agenda can feel like an invitation to swap the safety of familiar services for the

uncertainty of community life. The option of providing too much by continuing to surround the person with services can be a seductive way of attempting to manage risk.

The Binary Model

Whilst *Providing Too Much* has little to do with active engagement over the management of risk, the *Binary Model* moves a step closer. Risk assessments are conducted, decision-making is shared and care plans are formulated. But the *Binary Model* is used to distinguish colleagues who are 'in' - and therefore share responsibility for decisions and are entitled to receive information - from other citizens who are 'out' and so cannot receive any information due to the duty of confidentiality owed to the person using services. Service users are similarly seen as either 'in', in which case they are subject to all the duties of care, observation, information sharing and protection, or 'out' in which case they are ineligible or entirely discharged from that particular service which then behaves as though it has no further responsibility for them.

For example, we met a worker who had conducted an informal mental health assessment of a person who appeared at the duty desk. The worker knew that their service had an information-sharing protocol with primary care and so felt obliged to pass information to the person's general practitioner. Since there was no similar protocol with further education, he had no intention of breaching the person's rights of confidentiality by sharing information with her college tutor. Thus primary care was counted as 'in' while education was 'out'. At the duty desk the person had seemed paranoid, made threatening statements and admitted to carrying a weapon.

This model may be in use by services that work with a defined caseload and operate strict 'border controls' by the use of clear admission and discharge processes that allow for little or no subtlety as cases are deemed to be either 'open' or 'closed'. It is also used when, for example, inpatient staff judge that day service, community team or supported living staff are 'out' and exclude them from access to information or fail to include them in the assessment and management of risk.

The *Binary Model* has some appeal, as it tidies up risk management into a clear framework and is simple to use, but it may lead to poor risk management decisions for the following reasons:

- There is a clear duty of care laid upon staff to assess the risk that service users may pose to all citizens, not just those staff who fall within the group of professionals identified within a service's information-sharing protocol.
- There are many circumstances where family members or other people who might be classed as 'out' will be at much greater risk than members of the 'in' group. For example, Reith (1998) reports that of the homicides committed by people with mental health needs throughout the 1990s, the most common identity of the victim was that of carer. A more recent report (DH 2006) found that in 31% of homicides committed by people with mental illness the victim was a family member or former spouse or partner.

- It provides no help to people attempting to reduce their involvement in the service or move towards discharge. People are viewed as either entirely 'in' or discharged and the model permits no half-measures, gradual withdrawal or transition from the role of care user to citizen.

By promoting opportunities for social inclusion, services increase the likelihood that service users will spend more time with people considered to be 'out' of the risk assessment and management process, and it is thereby assumed that risk increases to (and from) them. Most people who have used services have also been in contact with members of the public. However, in promoting social inclusion, services get more actively involved in promoting people's access to ordinary community facilities. Staff may not have thought through the implications of this beyond making a general assumption that risk and responsibility will increase as their control over the person's life decreases. This in why the *Binary Model* fails as service users mix with people and facilities that are 'out' of service control.

The Tapered Model

The *Tapered Model* can be developed by stacking a number of *Binary Models* together. In this formulation, the inpatient team who provide 24 hour care have the opportunity to exert the most control over the person and so they are seen as being closest to them. The community team have comparatively less control over the person's life and therefore have a correspondingly lesser role in risk management. Beyond the community team might be primary care, housing staff and others working for statutory agencies, such as leisure centres. Then comes people in responsible posts in community organizations (an employer, college tutor, paid volunteer organiser or the manager of a voluntary sector agency) and finally, people who co-participate with the service user in community activities (co-workers, fellow students, other members of the darts team), who are so far down the list that they probably have no rights or involvement in managing risk.

This model seems to be in common use where people simultaneously use services and maintain informal roles in the community. Although it may not be made explicit, a version of it (sometimes summarized as 'need to know') can subtly guide staff behaviour.

When it comes to planning discharge, the *Tapered Model* seems a vast improvement on the *Binary Model*. It offers the possibility of developing a framework in which care workers gradually 'hand over' areas of life to ordinary community arrangements so that the span of control and supervision is gradually reduced until the person is finally discharged or lives with state intervention in as few life areas as possible.

Again, at first appearance, this model has appeal. It captures something of the relationship between the person's right to confidentiality and society's expectation of 'public protection' since people with few formal duties towards the person have access to proportionately less information about them and less opportunity to affect their lives.

However, using the *Tapered Model* may lead to poor risk management, for the following reasons:

- However people line up from the closest to the person to the most distant, their place in line will change from one circumstance to another. The Consultant psychiatrist may have the most formal power, but spend the least amount of time with the person; while family members or friends at the pub might be more engaged with the person but less likely to be part of the formal risk management process.
- The very idea of this ranking suggests that people have a fixed position and discourages staff from considering the nature of involvement of every person involved in each distinct situation.
- By creating an (albeit) tapering boundary, this model divides the world in two – the service side of the boundary and the community side. While staff may have a greater accountability for the risk management processes in which they are directly engaged, a model is needed that spans boundaries and harnesses the same values and approaches whoever is involved.
- It is further distorted by resource rationing decisions. On one occasion, a supported living service received an application that contained no reference to violent offences. When these came to light, it became clear that a decision to withhold that information was taken out of fear that the application would have been rejected if the full story was known. The 'need to know' principle was used improperly as a justification.

When the *Tapered Model* is just used to manage relationships between statutory agencies, staff can be comforted that everyone shares a common accountability. In contrast, social inclusion promotes opportunities for service users to build connections with informal groups outside statutory services, with whom there are few or no inter-agency agreements, protocols and sanctions. Thus the promotion of social inclusion highlights the inadequacy of the *Tapered Model.*

Auditing Risk Management Models

Each model has been described and its deficiencies explained. None of them are wholly adequate for managing risk, but their deficiencies are particularly revealed when a social inclusion perspective is promoted. We believe that a good quality risk management culture, protocol and practice will need no revision as services modernise to focus on inclusion, but, if any or all of these things are weak, then the inclusion agenda will expose their weaknesses. Local services may be showing signs of this weakness if:

- Once in the system, people receive high levels of intervention and control and there are few convenient ways of detecting a growth in independence or greater use of informal supports and making a corresponding reduction in provision. If there is a lack of step-down care from hospital, if residential care staff believe that they have to continually chaperone all people in their care, or if there is a lack of personalised services such as Direct Payments, Supported Living and Supported Employment then the organisation may be caught in *Providing Too Much* as a way of managing risk.

- Information-sharing protocols make reference to formal organisations (health, social services at a minimum; under 'robust CPA' the police, criminal justice agencies and voluntary sector providers were also included) but not informal supports (such as the priest, neighbours, publican and friends or co-workers). This sends the incorrect signal to workers that the 'in and out' concept of the *Binary Model* may be acceptable.
- Staff are unable to explain how their service gradually reduces its intervention in the lives of service users. This suggests that workers are operating on a *Binary Model* of discharge.
- Frequent references to 'need to know' are made, but staff have no clear explanation of how they create risk-sharing partnerships with informal community members. Meanwhile, people who have been excluded complain that their insights, safety needs and contribution to risk management have been ignored. These are signs that the *Tapered Model* is shaping staff attitudes and those who may have the greatest knowledge of the service user are seen as being at the furthest end of the service 'taper' and therefore outside of the risk management process.

Effective Risk Management

If *providing too much* avoids robust risk management, and neither the *Binary Model* nor the *Tapered Model* is satisfactory, what is to replace them? The answer can be nothing more or less than thorough, professional, personalised risk management. This is not a precise formula; it is based on a number of different processes that should be integrated, shared and made as transparent as possible.

Whilst innumerable publications have been written on '*effective risk management'* and it has perhaps become the 'holy grail' of mental health and other care services, guidance documents continue to reflect the challenge of integrating seemingly contradictory issues. So for example, December 2006 saw the publication both of *Making Choices, taking risks* (CSCI) - that largely supported autonomy, independence and positive risk taking – and *Avoidable Deaths* (Appleby et al 2006), that emphasised protecting the public, the 'vulnerable adult' and minimising harm.

In order to try and integrate the best from both positions and offer something helpful to staff, service users and carers, we offer below a summary of some of the key features that need to be thoughtfully explored together in managing risks. Such a process includes:

- Involvement - of service users and their relatives in risk assessment and management. Staff must understand what service users and others want, how they view their own risks and what responsibilities each person has in managing risks effectively.
- Positive and informed risk-taking – so that quality of life is maximised while people and communities are kept as safe as can be reasonably expected within a free society.

- Proportionality – as risks become more severe, so the amount of detail and the number of people who may become involved correspondingly increases. The management of the risk must match the gravity of potential harm.
- Contextualising behaviour – why did this person behave in this way? At this time? In this situation? Is it likely to happen again in similar circumstances? What influence does culture, religion or gender offer to understanding the behaviour? Can you distinguish between the static and dynamic risk factors?
- Defensible decision making – there is an explicit and justifiable rationale for the risk management decisions, based on adopting a proactive and investigative approach to gathering and evaluating information in respect of risk – what has worked and failed in the past.
- A learning culture – so that organisations avoid fear and blame and learn from mistakes of the past in order to continually improve. There is a culture that acknowledges rather than hides early warnings or near misses and openly explores explanations through the sharing of risk between team members.
- Tolerable Risks – "*To tolerate a risk means that we do not regard it as negligible or something we might ignore, but rather we need to keep under review and reduce still further if and as we can".* (Royal Society, 1992)

Conclusion

The challenge to promote social inclusion is an opportunity to evaluate the health of risk management processes. We have identified a number of approaches or models that can be used to describe how staff operate in their struggles to manage risk effectively. We have tried to show that each of these models may offer something to staff in terms of clarity and direction, but don't actually manage risks effectively. Each one turns out to be inadequate and pushes us on toward further improvements in the culture, procedures and processes for more transparent and engaging risk management.

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If you wish to discuss the inclusion aspect of this work, please contact the first author at pbates@ndt.org.uk or if you are interested in the risk management aspect, then please contact the second author at integritas.r@gmail.com. We will both, of course, discuss the interaction between these two elements!