Talking about risk, doing risk assessment

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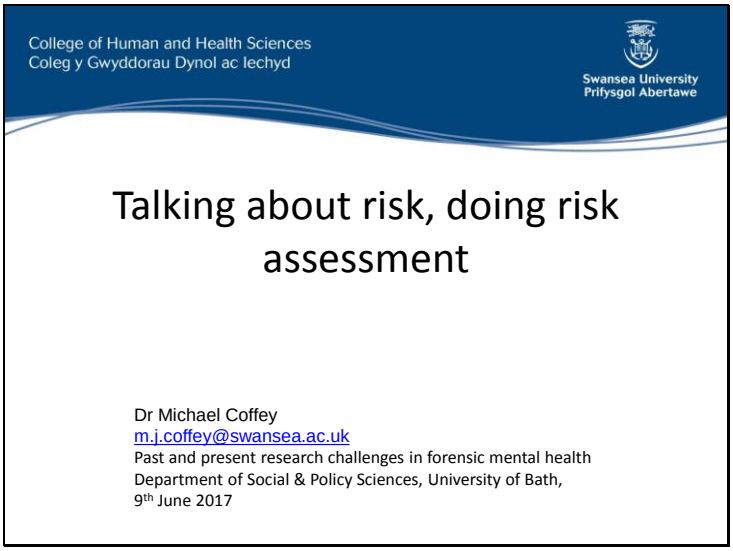

In this seminar I want to bring to the fore how we talk about risk in mental health care. I will argue that how we talk about risk says something important about how the mental health system operates, how work gets done and how people delivering and receiving care make sense of themselves in the context of that care. For example, if workers refer to their primary role as public protection then what might we then understand about their work and how does this work fit with the work of being a health or social care professional.

This is a short seminar so I am going to be a provocative straight off the bat. I am starting from the position that much of what occurs in risk assessment in mental health services is little more than a fable, an interactional accomplishment to deal with uncertainty and reassure us all that something is being done to manage what is largely unknowable. I will show the basis for this position and want to use the opportunity today to discuss what might be done differently.
We of course need to understand how to keep people safe in a way that fits within the bounds of our knowledge, and that respects individual rights and the law. So I am definitely not suggesting that we abandon risk assessment processes.
My argument is that how we talk about risk implicates a division in which professionals are positioned as knowledgeable experts while the priorities of service users and their families are side-lined in favour of a focus on what is reportable and blameable.

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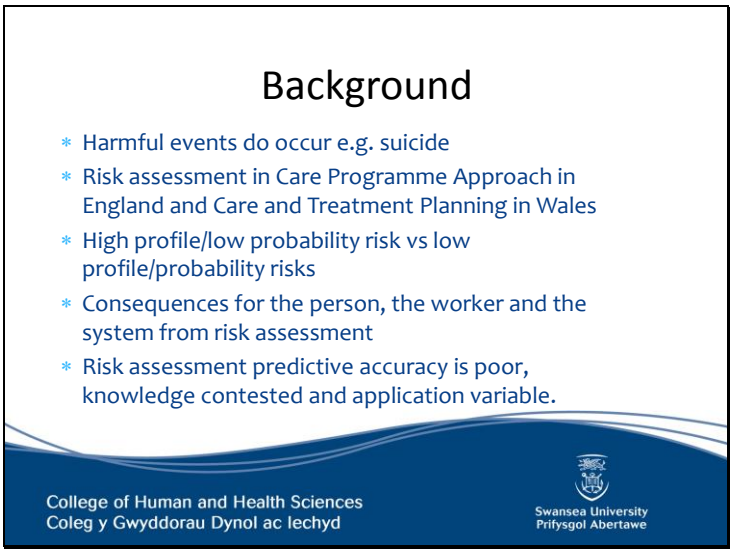

- What is knowable
- Can we measure it
- How
- What are the effects of risk thinking on practice

Risk – its assessment and management and to some extent its measurement is a recurring issue for mental health services. It is a real issue because of course harmful events do occur, for instance there are about 5,500 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.

Risk assessment is also a key requirement of care co-ordination in the CPA in England and in the Welsh CTP. There is little doubt that some form of risk and safety process is needed in mental health care. However risk assessment procedures are rarely consistently applied and the uncritical adoption of existing risk processes in care planning raises a concern so that attempts to support safety may amount to little more than a thin façade.

Within the mental health system like society more broadly there is a contrast between perceptions of high profile / low probability risks that lead to calls for intervention and low profile / high probability risks that are seemingly accepted without concern such that judgements about risk tend to highlight certain risks and downplay others. The high profile/low probability risks however are at the limits of our knowledge, we have few data and they are therefore difficult to manage. They generate therefore significant uncertainties for all involved.

Common, every day or ordinary risks that the person experiences are rarely considered in mental health assessments so that there is a mismatch between worker and patient concerns.

There are potentially serious implications from risk assessment processes 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. So there may be a tension here between outcomes that promote independence say and those that shield workers. Even where workers are truly altruistic in their risk assessment practice there remains significant anxieties that they may be held accountable for events that are largely unpredictable.

In this sense then Risk assessment is itself a contested area of mental health care. Significant efforts continue to add knowledge to the practice of risk assessment with a great deal of the focus placed on developing actuarial and hence supposedly more scientific mechanisms for identifying and predicting future risk behaviours (Boardman and Roberts 2014, DoH 2007, Gray et al, 2011). Swanson (2008) however has noted that the predictive accuracy of risk assessment in mental health care is fraught with problems such that even the best actuarial tools perform substantially below that which is commonly acceptable in other branches of medicine. More recently Quinlivan et al (2017) and others have shown that standardised tools for assessing risk of suicide performed no better than clinician or patient assessment and the wider conclusion is that these scales should not be used in individual assessments.

Evidence also shows that patients are often unaware of risk assessments taking place (Langan, 2008), and that assessments overplay individual factors at the expense of structural, social or interactional issues (Langan 2010). It has been argued too that for workers it seems that risk is embodied in the mentally ill person who is seen as chief actor in creating dangerous events. More rarely the risks the person themselves are presented with are considered. These risks include iatrogenic risks, meaning those linked with the provision of care. The more obvious of these are posed by psychotropic medicine such as irreversible side-effects (Busfield, 2004; Whitaker, 2004). Kelly and McKenna, (2004) further noted those risks presented by the community itself in the form of discrimination, stigma and possible physical attack. Risks presented by intense scrutiny and follow-up by workers has also been shown to be a concern for people using services (Coffey 2012). Current risk assessment practice seems to reinforce a type of professional knowledge elitism in the sense that risk practice prioritises professional judgement over lay judgements often with the claim that lay judgements are prone to subjective influences which professionals are considered to be somehow immune to themselves. We have found too that practice of risk

assessment in community mental health services is variable despite claims that risk assessment is central to the work of these teams.

This presents a significant problem in contemporary mental health care where the concept of recovery is trumpeted as a new paradigm in service provision. Recovery requires involvement and participation in an attempt to gain control and self-manage your own condition. Services we are told are providing care co-ordination and care planning in recovery focused ways, some services have even renamed themselves as forms of recovery teams. So the question arises, if services are indeed recovery led as claimed how are they handling risk discussions given that determinations of risk have a significant role in gaining and sustaining liberty and presumably have a role as part of the means to achieve or maintain recovery?

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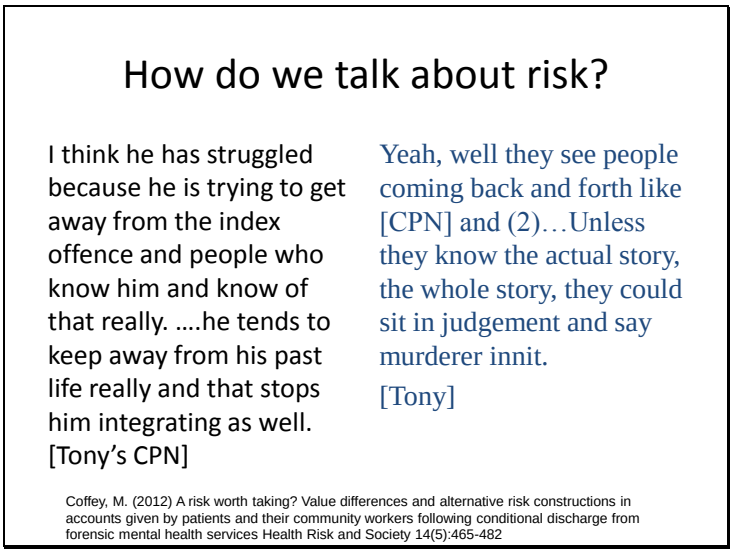

How we talk about risk implicates how we understand ourselves and orientate towards each other. The implicit assumption being made is that identity is fixed and immutable. Once we have labelled something it must remain forever labelled. So if we have had a mental health problem we are forever mentally 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.
For people using services like Tony here, there is an awareness of the weight of social judgement that can come to bear down on the individual. There is fear of what this might mean and this can lead to strategies for handling this. The fear of being unmasked and the consequences of this are not imagined, they are a very real day to day risk that services are aware of but perhaps have a lower priority. They are not something for which services will be blamed.

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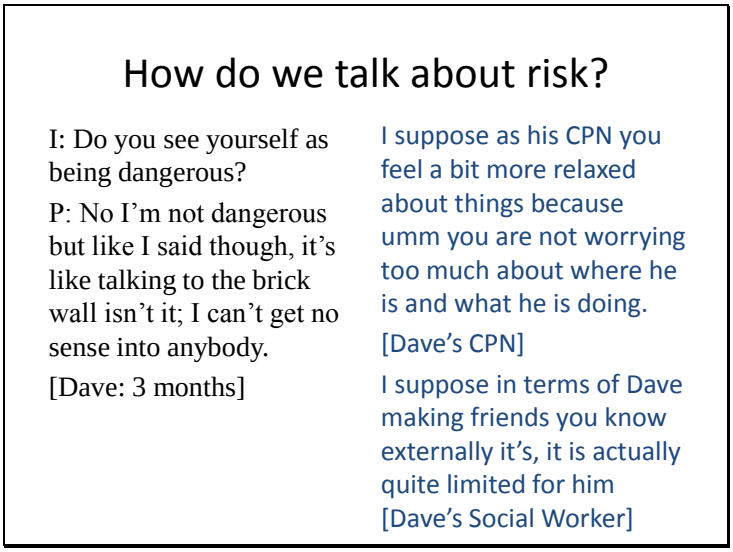

Dave as introduced the word 'dangerous' just before this part of the data presented here. His rationale was that service must see him as dangerous (a label he disputed) because otherwise why would be on 24 hour supervision in the community. For Dave his concern was that the supervision he was subject to was limiting his social opportunities (it was also limiting his offending opportunities for sure). The CPN sees the decreased possibility of blame arising out of something that Dave might do because for the most part Dave will have limited opportunity to offend. The Social Worker here perhaps inadvertently highlights a new risk, social isolation. This is in line with Dave's concern.
For workers the concern is with limiting and restricting opportunities at all costs, for Dave who is accompanied everywhere he goes this is perhaps a price that in the short term he willing to pay.

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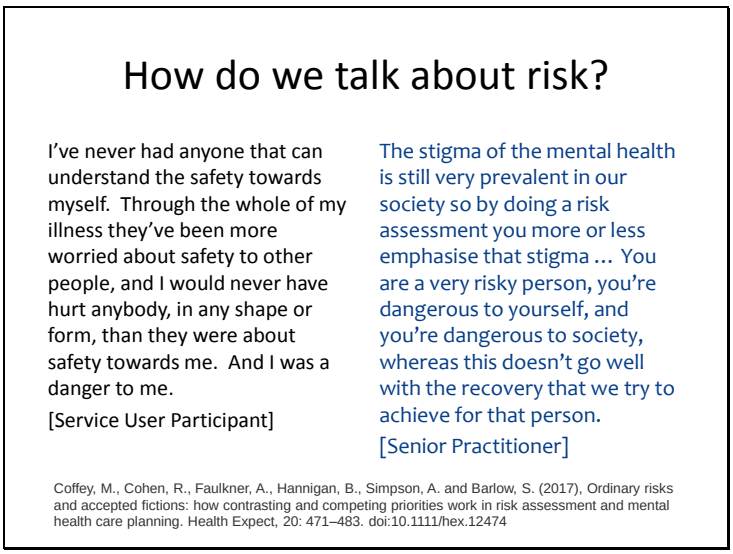

Risk language has been noted to be largely negative and inclined towards unpleasant outcomes; hence workers (and perhaps service users and their families too) appear to buy into or create a set of fables which may work to preserve working relationships which would otherwise be challenged by a focus on assessments that limited value in themselves (Boardman and Roberts, 2014).
The problem that can occur however is that service users and their families worry that their safety is not being actively considered or that workers are only concerned with risk that implicates potential blame.
In our COCAPP study we found that only about a third of care plans showed some involvement of the person in care plans but a further quarter of these did not show involvement of the person in the management plan.
Here the service user participant expresses a concern that his safety is not being addressed and that this might be a lower priority for services over harm to others while the worker implies that identity is very much implicated in the outcomes of risk assessment. We found that many practitioners of all types did not share risk assessments with service users thus denying people the opportunities to participate and show agency in attempts to address safety issues.

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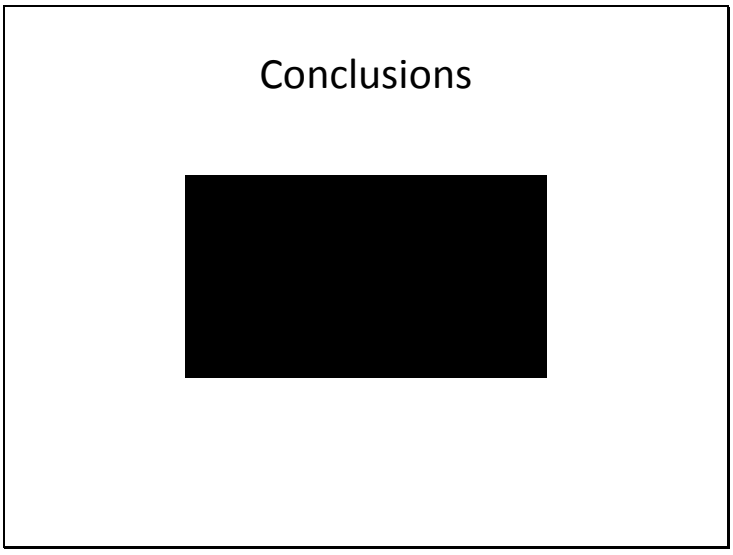
People in mental health care value relationships. It seems an odd thing to have to say because we all intuitively know this. Workers value relationships and people using services values those relationships too. In forming meaningful relationships we can be honest with others, have trust in what they say and develop a sense of shared understanding about what is at stake and how best to deal with issues. In our COCAPP and Plan4Recovery 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 remains the priority.
How we talk about risk has important implications for how we see people with mental health problems and also how they see themselves. Identity is an ongoing accomplishment that is worked up interaction with others. If workers orient towards individuals as risky and

take steps to limit or restrict opportunities then over time it is likely that these same individuals will come to see themselves as people who are unsafe, must be watched and endure limits on their personal liberty. These ways of seeing oneself emphasise dependence rather than the independence we claim is the focus of recovery.

Moreover our positions in relation to the person is one in which we claim specialist knowledge. This is despite knowing that this knowledge is limited and limiting. We know that risk assessment cannot predict with any accuracy and yet we present it to others as a high value currency. 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. An alternative is to maximise and mobilise available resources. 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.

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 person at the expense of the more difficult structural problems that contribute to an environment in which risk behaviours appear.

If we want better risk assessment and management approaches then we need to stop simply paying 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. The project of risk prediction has failed in mental health care and now we must move to focus practice on what can be known and involve the people that are central to the process in any solutions we develop.



Murmurations suggest that people involved in risk work might be engaged in a sophisticated dance in which any change of position is mirrored by others, causes ripples through systems and while presenting as a mesmerising or even beautiful display it might be ultimately purposeless. An alternative might be that these displays reinforce links between people and that although risk assessment are not predictive they instead do different types of work. This might be that in engaging with people we communicate a sense of valuing that person and a wish to help. Perhaps we could then develop our connections with people so that there is more direct involvement in the assessment and the management of safety.

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