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Negotiating Risk on the Frontline: Community Mental Health Workers’ Experiences of Risk Management Policies

Abstract

As a consequence of deinstitutionalisation and the shift to models of community care, mental health practice has become increasingly focused on the risks posed by service users. The rise of risk management, as it intersects with the growth of community care and discourses of human rights, normalisation and client-centred service delivery, generates potential tensions between protection and control on the one hand, and support and empowerment on the other. How, then, do workers feel about the obligation to assess and manage risk? British research suggests that the emphasis on risk gives rise to greater monitoring and administrative supervision of workers and a focus on managerial rather than therapeutic skills (e.g. Munro 2004; Rose 1998; Webb 2006). However, the impacts of risk management on workers’ professional subjectivities have not been studied systematically in Australia. This paper reports on some emerging findings from an ARC-funded research project that explores how risk management policies have been translated into practice by community-based services. Drawing on in-depth interviews with frontline workers from three community mental health agencies, the paper discusses how workers feel about these tensions and how they negotiate risk management policies in their day-to-day work.

Key Terms – mental health, risk, community care, frontline work, risk management policies

Word Count – 3,218 (paper plus references); abstract 192.
Introduction

Since deinstitutionalisation was initiated two decades ago in Victoria, mental health practice has become increasingly focused on assessing and managing the risks posed by service users. Indeed, ‘risk’ has become the dominant organising principle for managing service delivery and demand in the post-deinstitutionalised era (Healy and Renouf 2005; Rose 1998). In mental health practice, ‘risk’ refers to an individual’s vulnerability to self-harm and/or likelihood of inflicting violence on others as a result of mental disturbance (Ryan 1996: 93; Titterton 2005: 74). ‘Risk management’ can be defined as ‘organisational and professional strategies for responding to perceived risks, including the processes of identification, analysis, assessment, prevention, and reduction of risk’ (Green 2007: 401). The growth in these strategies has occurred in the context of intensified levels of risk arising from community-based care as opposed to institutional care, increased demands for accountability from various bodies (e.g. governments, funding agencies, insurers and consumer groups), and increased regulatory control via audits, quality assurance and external reviews, along with increased demand for health and welfare services.

Admission to hospital is now available only to patients with the most severe psychiatric symptoms and high levels of risk to self or others (Sawyer 2005: 284). Community mental health workers are therefore required to deal with increasingly high levels of acuity and need, whilst at the same time ensuring the safety of their clients, themselves and the broader public. Because of increased demand, particularly for acute services, collaborative and ‘healing’ work with clients tends to be passed over in order to meet the more pressing demands of the moment – the obligation to identify, monitor and manage risk, as exemplified by medication compliance (Healy
and Renouf 2005: 43-45). Often, as a consequence, mental health clinicians are not able to work with all clients in ways that they would wish (Healy and Renouf 2005: 45). Tensions between care and healing, and safe management and control have thus come to characterise the professional and ethical dilemmas at the heart of contemporary community mental health work.

Several British academics have argued that risk management re-shapes the professional identities of community health and welfare workers through increasing administrative monitoring and supervision, and diminishing professional discretion and autonomy (Garland 1997; Munro 2004; Stalker 2003). Demand for greater efficiency and transparency in public sector services has generated a preoccupation with performance indicators, which are geared to quantitative measures of service outputs; e.g. monitoring the completion of assessment forms, rather than ‘measuring’ how accurately and comprehensively they have been filled in (Munro 2004: 1086). With managerial concern directed primarily to paperwork protocols and organisational procedures, little consideration is paid to the effectiveness of direct service provision for clients and the quality of relationships between workers and clients which, it may be argued, have been pivotal to workers’ professional and ethical concerns. Munro (2004: 1093) notes that audit, and risk management in general, ‘creates a paradoxical experience’ for frontline workers:

Their work is now subject to closer monitoring and judging than ever before but surveillance is directed at the paperwork attached to the work, not at the intricacies of their actual practice with people. Indeed, for many, the most difficult aspects of their work and where they would most appreciate input from their seniors – in the specific details of working with
human beings – is now getting less attention than before (Munro 2004: 1093; see Webb 2006).

Drawing on early findings from in-depth interviews with Victorian community mental health workers, this paper discusses how these workers feel about the tensions inherent in their work and how they negotiate risk management policies in their interactions with clients.

**Methodology**

The data discussed here are drawn from interviews with frontline workers from three Victorian community mental health services: a public mental health service administered by a health care network and two PDRS (Psychiatric Disability Rehabilitation and Support) Services, namely a residential rehabilitation program and an outreach-support program. The interviews were semi-structured; researchers asked workers about their interpretations and experiences of ‘risk’ in their day-to-day work, organisational responses to adverse incidents, occupational health and safety regulations, and the impact of risk management policies on their work with clients. Participants were interviewed one on one for one-two hours. All interviews were tape recorded and later transcribed.

Most participants were qualified social workers; one was a clinical psychologist and another had a teaching qualification. Several had recently entered the mental health field, in each case as a ‘second career’, whereas others had extensive experience of at least ten years in the field. Pseudonyms were used in order to protect the identity of participants.
The larger project involves case studies of twenty-four Victorian community service organisations across three sectors – disability, aged care and mental health. All organisations were not-for-profit. In Stage 1, interviews were conducted with Chief Executive Officers and senior-level managers and in Stage 2, with program managers, frontline workers and clients. This research is supported by an ARC-Linkage grant that runs for three years (2006-2009), funded by the Australian Research Council in conjunction with the Victorian Department of Human Services and the Victorian Office of the Public Advocate.

Findings
This section discusses three of the concerns raised most frequently by frontline workers in relation to their experiences of risk management: increased paperwork, the negative impacts of ‘high risk’ labels on clients, and constraints to practice as a result of occupational health and safety legislation (e.g. ‘no smoking’ rule).

Increased Paperwork
Increased demands for accountability and auditing have led to an increase in paperwork and record-keeping across all services (Munro 2004: 1091; Rose 1998). Marissa, a clinical psychologist from a public mental health service, expressed concern about the potential effects that a major audit of documentation and forms may have on their workloads and interactions with clients. Like several other workers, she identified risks that had been inadvertently created through organisational initiatives to heighten accountability:
So what they’re talking about is every time you have a new client we need to fill out a whole battery of forms and that will happen at three, six months and every time they go in for an admission, and the clock will restart again, so that will be quite a bit of documentation and not necessarily driven by clinical significance… I suppose the thing that I’m mindful of working with people long term is if we’re needing to assess and document risk all the time, how that impacts on your longer term work and the message that you give a client around that. And a lot of our clients have chronic suicidal ideation, so if you’ve just spent that time assessing that and focusing on that, they could miss out on actual therapy (Marissa, clinical psychologist, public mental health agency).

‘High risk’ labels

Increased attention to the identification and assessment of risk has engendered an emphasis on classifying and documenting a client’s level of risk, whether ‘high’, ‘moderate’ or ‘low’ (Rose 1998). Most participants reflected on the potential negative consequences that ‘high risk’ labels may exert over clients’ lives. A ‘high risk’ classification in an official file often means that a client is marked as a threat to society even after the label ceases to have any relevance. These labels are especially disadvantageous if the assessment was formulated in response to an isolated crisis event and has not been reviewed. Effectively, the label may become the client’s major defining characteristic, prejudicing health and welfare practitioners across time. As Mark, a social worker from an outreach-support program, explained:
[The client] might have just had a really bad day on one day and one worker says, “Oh I thought he was going to punch me” and that goes on that file, “risk of violence”, and it might not have even been real - but once it’s in writing and on that file… it is going to follow that person around forever… and there’s a lot of Chinese whispers that happens when people are handing over information. So something that’s been around for six years can really turn into something that it’s not and I suppose it’s a risk in terms of - it might cost people access to services that they might desperately need and yeah, depending on how you unpack it could be a risk to them.

Mark also argued that a client should be assessed over a number of weeks in order to produce a reliable assessment. Part of the problem, he noted, is that assessments are often made in urgent circumstances when the service is under pressure to make a decision about what should be done:

Until we’ve had a degree of time to work with that person we’re not going to be able to assess those risks. All mental illness work is about assessment, and the longer the period of time the better the assessment is going to be. It’s unrealistic to think you’re going to have a good assessment done in the space of two hours.

Another social worker discussed the introduction of a new filing system into his workplace whereby ‘high risk’ clients are designated by a red dot on the front of their files. He disputed this practice, asserting that he would prefer to ‘work with the person’ to ‘address the issues underlying the risk rather than just labelling them… so
yeah I work with the clients to identify when they are going to be become unwell and at risk to themselves or others’ (Richard, residential rehabilitation program). He described the labelling process as a ‘vexed question’, emphasising that he aims to build empathy and trust rather than alienate the client with numerous questions about risk, especially when he/she first enters the program: ‘the last thing you want… is saying “we don’t trust you”… in regard to risk [that]… should be negotiated further down the track’. Richard also surmised that a client-centred approach was not only therapeutic for the client, but risk reducing as such: ‘a lot of it stems… back to you, the rapport between the worker and the client… And kind of working in conjunction with the client… That’s one way of eliminating it’.

In a similar vein, Gillian, a senior support worker from the same residential rehabilitation service, articulated the potential dilemma generated by a ‘high risk’ label, noting that their service attempted to counter the long-term negative effects of these labels on their clients’ sense of self and recovery:

Once a client’s been you know kind of branded as a significant risk to society, it can be very often difficult for them to have any kind of leeway to move out of that… the extent to which we perpetuate that inability to move… I feel like that’s always the really kind of delicate balance…

Because to cover their arses they [services and professionals] will say…this client poses a long term threat and always will, do you know what I mean? Because if they don’t say that and he ends up doing something, then it comes back to them. So they will always kind of err on that side. [So there’s] not a lot of scope for people to feel like they’re actually moving along… and might be in quite a different place than they were five years
ago… I think something that our service tries to do is really reflect that back to the person because it may not be being reflected back to them from any other places (Gillian, residential rehabilitation program).

**Occupational health and safety**

Increasingly, occupational health and safety regulators require that services demonstrate how they have taken precautions in planning, delivering and managing services. Several workers noted that occupational health and safety policies could, in some instances, restrict the range of interventions available to use with clients. Michael, a social worker from an outreach-support service, admitted that he had breached the ‘no smoking’ policy in order to work therapeutically and safely with clients – he argued that this was a more effective way to manage potentially volatile situations:

A cigarette can prove to be one of the most successful engagement tools when you’re working with a client. It’s also one of the most successful diffusion tools of working with a client with escalating behaviours [that] may put yourself or other workers or clients at risk. While I understand why the policy is there to protect the organisation from litigation, the litigiousness shits me because you know we break the rules in order to, I do, I readily admit I use a cigarette, I’ll quite often put myself into a situation that’s not one of my clients but it’s an escalated client, where it can become quite volatile and I’ll use deflection, I’ll use humour, I’ll use a cigarette to get them out of that environment.
Discussion

The interviews discussed here suggest that mental health workers actively resist and critique the practices and subjectivities shaped by risk discourse. It seems that these workers have adapted to risk regimes and managerial imperatives to control risk – not through internalising managerial aims and priorities but by maintaining strong identities as frontline workers. For these workers, ‘the intricacies of their actual practice with people’ (Munro 2004: 1093) were critical to their professional subjectivities. The upholding of specific risk management regulations often seemed adverse to clients’ needs, giving rise to the creation of a range of new risks associated with reduced quality of service provision (e.g. the emphasis on assessing risk may impede the process of therapeutic engagement between client and worker). Most significantly, they questioned and critiqued organisational policies and procedures to manage risk, along with the notion of ‘risk’ itself. Although the structural context of their work has been altered by a range of risk management strategies (e.g. labelling ‘high risk’ on client files, greater managerial control over the way clients are represented in formal case notes), these workers articulated clear ideas and ideals of ethical practice and expressed a strong commitment and sensitivity to their clients’ needs. Though preliminary, the findings presented here call into question claims made by British research that risk thinking is ‘transforming’ the professional subjectivities of frontline workers (Rose 1998: 184; see Culpitt 1999; Webb 2006), and that clients’ needs are sidelined at the expense of assessing their risks (Kemshall et al. 1997: 227).

Most participants expressed concern about the potentially negative and constraining effects of specific risk management policies on their work with clients. Whilst they recognised the rationale for such policies, their commentaries point to a dysfunctional
interaction between the values and objectives of community-based service delivery and those of risk management, which often seemed directed to protecting the organisation. Marissa offered the most explicit illustration of this tension. She feared that additional paperwork, driven by organisational aims to heighten accountability, would encroach on valuable therapeutic time with clients thus reducing service quality. She noted that the additional assessments being proposed had no specific clinical meaning and were antithetical to the reality of clients’ lives – in short, the imposition of procedures from above to fulfil accountability criteria. Green’s (2007: 406) observation, drawing on the work of Kemshall, is pertinent here: ‘As the demands for administrative accountability and documentation increase… the more service providers… feel the necessity to build conservative, controlling, and defensive procedures against risk. This process is “resource intensive and results in an over-emphasis upon identification and assessment” (Kemshall 2002: 84)’. Similarly, in discussing the possible negative consequences of ‘high risk’ labels, Richard alluded to the divergence between two opposing practice orientations – one aimed at therapeutic, client-centred interactions in which the worker attempts to build empathy and trust versus risk-focused interactions where the worker’s main aim is to assess the client’s level of risk.

The data discussed here suggest that workers attempt to resolve these tensions through developing ‘risk rationalities’ - particular ways of interpreting and acting within the context of risk management policies whilst striving for ethical practices with their clients. These risk rationalities are both individual and contextual, and appear to be shaped by the worker’s professional background and training, his/her personal ethical stance, and the organisation’s ethos, function and culture and its formal rules and
regulations. Data analysis is still in progress. Differences may yet emerge between workers employed by public ‘clinical’ services and those employed in the PDRS sector, and between different disciplinary backgrounds (e.g. nursing versus social work). Through further analysis, we aim to develop an interpretive framework of the multiple meaning systems underlying mental health workers’ risk rationalities (see Adams 2003, for an example of such framing devices).

**Conclusion**

Given the tension between organisational imperatives to manage risk and workers’ therapeutic endeavours within mental health services, it is also important to consider possible effects on retention of staff - itself identified as a major issue across all human services - and its particular impact on clients. How might these tensions be eased? Are there lessons to be learned from other service sectors, namely disability? Can the concept of ‘dignity of risk’, central to the philosophy of many disability services, be usefully integrated within mental health, notwithstanding the different needs associated with mental illness? To reiterate, the findings reported here are preliminary. We are yet to analyse interviews with clients, and therefore we hope to shed light on such questions as data analysis proceeds.

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**References**


