MANAGING RISK IN COMMUNITY SERVICES
A PRELIMINARY STUDY OF THE IMPACTS OF RISK MANAGEMENT ON VICTORIAN SERVICES AND CLIENTS

An ARC Linkage Project
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Judith Brett, Anthony Moran, David Green
PART ONE
BACKGROUND, CONTEXT AND DESIGN

CHAPTER 1
INTRODUCTION – THE ORIGINS AND CONTEXT OF THIS PROJECT

1.1 Risk and Community Services
Increasingly the day-to-day operations of governments, the helping professions, businesses and individuals are being managed through the frameworks and technologies for the management of risk (Ayres and Braithwaite, 1992; O’Malley, 2004; Power, 2004a, 2004b, 2007; Rose 1999). The expectation that governments and their services will identify and control risk represents a growing political imperative not only for public agencies but also for the businesses and organisations they contract to deliver services to the community. As a consequence policies, programs, practices and procedures are being shaped not only by service goals and program technologies, but also the need to regulate risks.

Community services and workers in front-line health, protective and community care programs, their clients and patients, families and carers are in the thick of this change. The demand on them to manage and control risks has become a powerful factor in their work and lives, but little is known of the impacts and consequences of these changes, especially from the viewpoints of the major stakeholders in community care. Recognising this reality, late in 2005 the Australian Research Council funded La Trobe University, in partnership with the Victorian Department of Human Services and the Victorian Office of the Public Advocate, to undertake an exploratory study of risk in the state’s community services. The project commenced midway through 2006.

This project is timely because it comes after two decades of major changes in public policy, which have in turn radically altered the scope and role of community services in Australian society. Many of the protective, healing, rehabilitative and caring functions of hospitals and institutions have been transferred to non-residential community-based services (Australian Institute of Health and Welfare, 2001). Services once delivered in bed-based facilities, outpatient departments and specialised clinics have been packaged into a vast range of community health, community care, support, and protective programs, and contracted to a wide range of public, private and not for profit service agencies. Longstanding community-based services, such as domiciliary care of the aged, disability support, and home nursing have been joined by many more recent programs such as hospital in the home, post-acute home care, intensive aged and disability care and support, community-based mental health care, complex case management and assertive outreach.

For over three decades all incumbent federal and state governments have had bi-partisan support for the expansion of community care. While some deinstitutionalisation programs have been criticised on the basis of inadequate planning and/or limited transfer of resources, these changes have generally been supported by all major stakeholders. However, it has been found in this project that few government agencies or the advocates for reform fully anticipated the complexity of the governance, management and practice changes required for delivering increasingly complex community care. By the late 1990s it also became evident that most authorities had underestimated the impact of the changes on families, communities, local services, and the individuals at the centre of these changes (AIHW, 2001; Duckett, 2007; Green 2003).
All of these new programs bring what Rose calls ‘a new pluralisation of “social” technologies’ (1996a, p. 56), including those designed to manage the risks that were previously contained and controlled within the walls, routines and infrastructure of institutions, hospitals and specialised treatment facilities. Institutions had shut out the dangers of community life, and managed most, although not all, internal hazards through their highly regulated regimes. Community services now have to develop the procedures and practices to manage these risks.

At the same time that Australian governments were embracing community care, a number of quite different but related changes were in train, which had major implications for community services and the management or risk. In the context of the ‘reinvention of government’ in advanced capitalist societies (Alford and O’Neill, 1994; Osborne and Gaebler, 1992; Power, 2007), the roles, organisation, responsibilities and governance of community services were to also undergo extensive change. Five related transitions are of significance: (i) a radical program of contracting public health and welfare services to local public, private and non-government agencies; (ii) the implementation of complex tendering and contracting business systems to manage these changes; (iii) the consequent requirements of service providers to reform their governance arrangements in the interests of accountability, service standards, efficiency and effectiveness; (iv) the introduction of a range of quality assurance programs and requirements for service providers; and (v) formal requirements through contracts and standards processes to manage risks.

This powerful set of changes, often referred to as ‘new public management’, represented a new regulatory regime for a wide range of public health services, businesses and community services, all directed not only towards the goals of improving the efficiency, quality, and performance of community care, but also toward the management of risks (Alford and O’Neill, 1994; Braithwaite, 1982, 1999; Hood, 1991, 1995; Webb, 2006).

Later in this period emerged the growing endorsement of ‘individualised services’, based on what Yeatman (2009, p. 27) identified as the need for the new services ‘to shape what they have to offer in relation to what is of subjective significance to the client’.

Community care also became central to the way governments managed major emerging systemic risks such as population ageing, the escalating costs of hospital and residential care, rising community expectations, and the growing complexity of the care needs of people with disabilities and mental illness. As a consequence, service providers now have to manage an increasingly complex range of performance requirements, relating not only to efficiency and effectiveness but also to the management of new operational and secondary risks (Braithwaite, 1999; Rothstein, 2006).

An added complication arising from these changes is the perception, supported and sometimes fuelled by the media, that the community is becoming a ‘zone of high risk’ (Rose 1998, p. 183). This view that the community is becoming more dangerous also escalated the projection of risk from the periphery of community services to a central role in the day to day operations of contracting departments and their service providers (Culpitt, 1999; Douglas, 1992; Garland, 2001; Kemshall, 2002; Kemshall, Parton, Walsh and Waterson, 1997). As a result of all these changes risk and risk management have become ‘increasingly embedded in organisational rationales and procedures for the delivery of services and relationships with users and clients’ (Kemshall et al, 1997, p. 214).

These issues set the context for this project.

1.2 The objectives and a brief description of this ARC Project

Whilst there is an extensive overseas literature on the impact of risk management on community-based health and welfare services, particularly from the United Kingdom (e.g. Aleszewski, Harrison, and Manthorpe, 1998; Carson and Bain, 2008; Godin, 2004; Kemshall, 2002; Rose, 1998; Stalker, 2003; Titterton, 2005), there has been no systematic study of the subject in Australia. To address this gap, late in 2005 the Australian Research Council awarded a Linkages Project grant to La Trobe University to undertake an exploratory study of how risk management
policies have been interpreted and translated into practice by community-based mental health, disability and aged care services in the state of Victoria. Specifically, the study investigates how service providers and professionals adopt and adapt risk management in the context of their service goals and ideals, and the impacts of risk management on clients, patients and carers.

Entitled *Managing Risk in Community Services: A Preliminary Study of the Impacts of Risk Management on Victorian Services and Clients*, the project (which commenced in 2006) is a joint collaboration between the School of Social Sciences and the School of Social Work and Social Policy with the support of two major public agencies, the then Victorian Department of Human Services and the Victorian Office of the Public Advocate, identified as “industry partners” by the Australian Research Council.

**The following objectives were defined for the project**

1. To document the recent history of risk management in Australian public administration, commencing with the identification of risk as a major imperative for public and private organizations in the late 1980s. This historical account will focus on the development of risk policies and practices at national and state levels.

2. To investigate the processes by which the practices and technologies of risk management have been taken up and translated into the practices of community service organisations. This part of the project will focus on Victoria.

3. To test the contention that there are dysfunctional interactions between the values, objectives and practices of community services and values, objectives and practices of risk management.

4. To examine the ways community services, professionals and clients have adopted and adapted risk management to service goals and ideals.

This report will address each of these objectives. The historical background, which looks at the rise of risk management in public and community sector services, is outlined in Part Two, Chapter 3. The other three objectives are discussed in detail in Chapters 4-8. The final chapter in Part Three addresses possible implications of our findings for community care.

The project commenced with a systematic review of the literature informing contemporary theories of risk, the recent history of risk management and risk regulation, particularly in the United Kingdom and Australia, and the more specific literature regarding risk, human services and community care. The investigators and the industry partners formed a reading group which met regularly for six months before the formal investigations commenced in 2006.

These readings and discussions have contributed to the way we have designed the project and analysed and explained our principal findings.

In Part One, Chapter 2 ‘Design and Methodology’, we explain in detail how we conducted the project, and the character of the agencies and people involved. Initially a total of 24 service provider agencies or organisations participated. Of these, nineteen were based in the metropolitan regions of the Department of Human Services and five were rural agencies operating out of two regional centres. Fourteen of the twenty-four were not-for-profit community service organisations and ten were public agencies, including one local government council, two regional offices and a specialist service of a government department, and six public health agencies. It was clear from the interest in the project more could have been recruited but it was agreed that the sample met the design requirements.

The project was planned in two stages. In Stage One we conducted 24 interviews, lasting between two and three hours, with 52 Chief Executive Officers and senior-level managers. In Stage Two we conducted a further 126 interviews, lasting between one and two hours each, with program managers, frontline workers, clients and carers. Of the original 24 participating services two public agencies did not proceed to the second stage because of their specialised forensic functions, and three did not continue to the second stage for reasons of pressure of work and new contracts.
Finally, in early 2008, the design of the project was amended. A new category of research participants was added to those already involved in the project, namely a sample of chief executive officers/senior managers and family carers/members from six advocacy/support organisations. These included three mental health organisations, one disability organisation, one multi-sector organisation with a disability focus, and one aged care organisation.

A total of 166 people and 30 organisations participated in the project.

This is a qualitative rather than a quantitative research study. We did not, for example, conduct a representative survey about risk and risk management. Thus our discussion and findings are interpretative rather than expressed as percentages of 'who said or did this or that'. The interviews for both stages of the project were wide-ranging, in-depth discussions about risk, risk management and related dilemmas of providing safe high quality care in the community. The findings from these interviews are discussed at length in Part Two (Chapters 4, 5, 6, 7 and 8). We make use of extensive quotations from the interviews to allow readers to experience the often complex reasoning about risk and care engaged in by our participants. This, we believe, reveals a powerful and mainly positive story about the capacities and commitment of those working in the front line of community care.

Part 3 of the report represents our observations on what we consider the most significant findings and their possible implications for the future management of risk in community services. We do not make firm recommendations, as this was an exploratory study, but we do make suggestions for the consideration of the industry partners and other authorities involved in the shaping of community care and its management.

1.3 ‘Risk and Rights’—the role of the Office of the Public Advocate

The Office of the Public Advocate, in its role as Victoria’s guardian of last resort, has for many years considered its advocacy and guardianship responsibilities in the context of the need to balance respect for individual freedoms with the duty to provide protection to vulnerable clients. For many years advocacy services for people with disability have argued, from a number of perspectives, that risk was an essential component of a ‘normal’ life, and to over-protect people was to deny the ‘dignity of risk’. Inevitably, when advocacy or guardianship cases are concerned, any decision to privilege the recognition of individual freedoms over the provision of protection carries with it risks: usually to the well-being of the person involved, and sometimes to the broader society. Conversely the decision of a guardian to place a represented person in protective accommodation will inevitably result in that person having less freedom to choose how to live their lives.

The language and practice of this ‘risk versus rights’ balancing act has been given further shape with the adoption of the Victorian Parliament’s Charter of Human Rights and Responsibilities Act, 2006, which holds that decisions which result in limitations on the enjoyment of human rights can only be made after ‘taking into account … any less restrictive means reasonably available’ (S.7(2)(e)). Guardianship decisions now have to be the ‘least restrictive’ ones possible in the circumstances.

In addition to assessing the ‘risk versus rights’ calculus in individual guardianship cases, the Office of the Public Advocate has sought to place this debate in a broader policy discourse. The Office, for instance, hosted a ‘Risk and Rights’ forum in 2005 that presented papers from a range of policy experts and practitioners in the disability sector. Its support for, and participation in, this ARC project is further evidence of the Office’s belief in the importance of this debate.

1.4 A brief review of definitional issues—‘risk’ and ‘uncertainty’

Risk

One of the initial tasks of this project was to undertake a general review of the literature relevant to a contemporary understanding of risk, as well as its impacts on community services. As a consequence this report will briefly explore relevant understanding and constructions of risk; the
so-called ‘rise of risk’ in public policy, regulation, and new public management; and in the world of service provision.

There is a vast literature on the construct of risk, across a wide range of disciplines, particularly medicine, public health, engineering, economics, commerce, project management, public administration, law, criminology and the social sciences. This literature has been dominated by the scientific, technical and actuarial study of risk. For example, in all of the above disciplines there is extensive research on risk prediction, risk assessment and risk management in activities as diverse as building and construction, banking and financial services, transport, water supply, food services, tourism, disaster management, general health, mental health, addictions and child protection.

Not surprisingly in this technical literature on risk it is possible to see that there are major differences in the approach to risk taken by different disciplines. Alaszewski (1998, p. 5) defines four general but different constructions of risk in research, as follows:

- Epidemiology - in which the main emphasis is on identifying and measuring the negative consequences of events;
- statistics and actuarial science—in which the emphasis is on measuring and predicting the probability or chance of specific events;
- engineering and operational research—in which the chief emphasis is on the relationship between positive and negative consequences of events;
- social science - in which most of the emphasis is on studying the ways that individuals and groups identify and respond to risk.

The study of risk in community services is more recent and less extensive than in fields such as engineering, market economics, and medicine. As will be demonstrated, risk management only became a major force in community and welfare domains in the last two decades of the twentieth century (Kemshall, 2002; O’Malley, 2004; Power, 2007; Webb, 2006). Today, however, there is a growing focus on risk identification, risk assessment and risk management in services such as child protection, corrections, drug and alcohol services, mental health, disability care and aged care. However, according to Stalker (2003, p. 212), in a very useful and comprehensive literature review, much of the work on risk and human services was ‘largely opinion based’, descriptive and lacking in systematic inquiry and methodological rigour. More recently there has been a rapidly growing body of work that raises major issues and questions about the impact of risks on community services, to which we hope this project makes a contribution.

As with many constructs used regularly in daily life, such as ‘community’, ‘identity’ and ‘development’ the term ‘risk’ also has many different meanings. Alaszewski (1998, p. 9) states that within a wide range of definitions it is generally possible to identify two key and constant elements—chance (or probability) and consequences (or impact). Within both these elements, risk can have both positive and negative consequences.

This understanding of risk is demonstrated in the definitions of risk used in the Australian public agencies, most of which favour both a positive and negative view of the consequences of risk. Generally public documentation on risk acknowledges that risk arises out of uncertainty and represents our exposure to a wide range of possible positive, neutral and negative events or outcomes of our actions (Standards Australian and Standards New Zealand, 1999; UK National Audit Office, 2000). In practice, however, as we shall report later, the substantive focus is generally on negative risk.

Bernstein (1996), in his work on the history of risk, demonstrates that the meaning of risk has changed over time. Original conceptions of risk did not focus on negative meanings, rather opportunities. By the late nineteenth century, however, risk was increasingly used to refer to only adverse events or bad outcomes, and that interpretation of risk now prevails. For example the Chambers English Dictionary (1990, p. 1268) adopts the following definitions:
Hazard, danger, chance or loss or injury, the degree of probability or loss: a person, thing or factor likely to cause loss or danger: to expose to hazard: to incur the choice of unfortunate consequences by (doing something).

This approach to risk, representing the possibility of harm or danger, has significant consequences for community services. It can lead to a denial of the value of risk-taking activities in the achievement of client goals and service goals. It sets the stage for negative and defensive practice. A number of writers on community services, including Carson (1995, 1997); Carson and Bain (2008); Manthorpe, Walsh, Alaszewski and Harrison (1997); Kemshall (2002) and Titterton (2005), are now calling for a different approach to risk, which allows for the possibility of both positive and negative outcomes.

**Risk and uncertainty**

Another issue of definition, which is of significance for this project, is the relationship between risk and uncertainty. Some influential writers (Marris, 1996a; O’Malley, 2004; Parton, 1998, 2003, 2004; Reddy, 1996) consider that a declining tolerance of uncertainty in the twentieth century is critical to explaining the rapid emergence of risk in its last two decades. Early in the twentieth century, modern economics initial approach to uncertainty established a distinction between the predictable and calculable on the one hand, and the unpredictable and the incalculable on the other (Keynes, 1937; Knight, 1964, originally published in 1921). The former events were designated as risks, given that they could be identified, subject to definition, measurement, and the estimation of probabilities. The latter, such as investor behaviour, were understood as ‘radical uncertainty’ (Keynes, 1937). Lupton (1999, p. 7) puts the distinction quite simply—risk can be understood as ‘conditions in which probability estimates of an event are known or knowable’ and uncertainty as conditions in which ‘probabilities were inestimable’.

Keynes and his followers ‘rejected theories that ignored uncertainty and argued that uncertainty rather than mathematical probability is the ruling paradigm in the real world’ (Bernstein, 1996, p. 228). Supporting this view Reddy (1996, p. 223) points out ‘a large degree of uncertainty is immanent in nature’, and further ‘uncertainty is also rooted in the unpredictability of social life, or in short, in human agency’.

However, by the late twentieth century, according to Parton (1998, p. 22), ‘our contemporary conceptualisations of risk have predominantly assumed that the world can be subject to prediction and control, and that rational systems of accountability should be constructed in case things go wrong’.

Kemshall (2002), Garland (2001), Marris (1996a) and Rose (1999 all argue that by the end of the twentieth century risk and uncertainty were more than abstract concepts about the future, for they had assumed great political significance and power. In order to demonstrate command and control of events, particularly threatening events, certain risks had to be made calculable, subject to probabilities rather that random chance. The protection of children and the protection of the community from sex offenders are examples of these priorities. As a result they became the subjects of exhaustive inquiries and research, directed to eliminate uncertainty and chance. Many researchers see this demand for predictability and control as central to the rise of risk.

However Bernstein (1996), Hammond (1996), Moss (2002) and Reddy (1996) argue that Keynes and Knight were right about irreducible uncertainty, not only in the domain of economics but also in the natural and social worlds. Bernstein goes further, claiming that risk probabilities become straitjackets on innovation and creative endeavour. Rather, he claims a ‘tremendous idea lies buried in the conclusion that we simply do not know’ (1996, p. 229). Bernstein concludes his extensive history of risk by claiming that ‘(r)ather than frightening us, Keynes’ words bring great news: we are not prisoners of an inevitable future. Uncertainty makes us free’ (1996, p. 229). This argument may be music to the ears of the entrepreneur, but not for the politician responsible for community services, or for professionals whose reputations depend on their ability to predict and control events.

While this largely dualistic debate is limited in its value for understanding risk, it serves to highlight that in most fields of endeavour the reality is that some risks can be reliably predicted,
some partially so, and some cannot be predicted at all. Hammond (1996) considers that in the realm of social policy, while research evidence will inform most decisions, conditions of irreducible uncertainty will also prevail, and human judgment will be required. He defines irreducible uncertainty as ‘uncertainty that cannot be reduced by any activity at the moment action is required’ (1996, p. 13). Practice researchers such as Parton (1996, 1998), Titterton (2005), and Houston (2001), and some socio-economic theorists such as Reddy (1996), also support this view. They make it clear that within the limitations of our existing knowledge, and in complex, unregulated and variable environments such as community care there will always be elements of irreducible uncertainty and therefore error.

Further, once we move outside the modern factory, the planned hi-tech office and the regulated clinical environments delivering intensive and technological medicine, as Reddy (1996) demonstrates, the social world is becoming more uncertain, not less. This world is subject to ‘an unprecedented and unpredictable complex of contingent events’ and that ‘(t)hese circumstances combine to make risks both increasingly unpredictable and unmanageable’ (Reddy, 1996 p. 243). For Hammond ‘judgment under uncertainty is one of the most pervasive and difficult aspects of life’ (1996 p. 35). Douglas (1992) and Macdonald and Macdonald (1999) also argue that a risk management policy that either denies or suppresses this reality of irreducible uncertainty sets the stage for unachievable expectations, the inevitability of failure, defensive practices, and constant inquiries to find retrospective explanations of what went wrong and who is to blame.

Some may believe that almost all risks can be eliminated with sufficient resources, exhaustive predictive testing, rigorous procedures, adequate surveillance and, if necessary, coercion. However, for Reddy, the enormous costs of these measures require us to find approaches to risk which will ‘recover alternative and more humane conceptions of indeterminacy to substitute for the dominant scientistic approach to uncertainty’ (1996 p. 224). To writers like Kemshall (2002), Parton (1998) and Parton, Thorpe and Wattam (1997) this alternate view appears far more realistic given that community based human services have to confront increasing and deepening community problems such as family violence, child abuse, homelessness, exploitation of the disabled and the elderly, addictions and mental illness.

Finally, with respect to this brief overview, Culpitt (1999), Hammond (1996) and Rose (1998, 1999) all point out the many problems that can arise as a result of exhaustive strategies to control risk and error, especially in the realm of the community. When risk management sets out to minimise selected risks they may both heighten the probability of other risks and adversely impact on key goals and activities (Hammond, 1996, p. 22).

Reddy concludes his analysis claiming that ‘the fantasy of prediction and “control”, on which modernist constructions of the world, and risk science in particular, are based, is bound to give way, in the conditions under which we currently live to an increasing realisation of the irrepressible ubiquity of radical uncertainty in the modern world’ (1996, p.244). In this vein it is proposed by practice oriented researchers such as Houston (2001), Houston and Griffiths (2000), and Parton (1998) and theorists such as Hammond (1996), Reddy (1996) and Rose (1996a, 1996b, 1999) that the process of making decisions about the future should be open to a much broader discourse than one based on the narrow definition of low frequency high profile dangers and hazards. The research and analysis of these writers suggest that the reality of professional practice with troubled people in the community (as distinct from the regulated environment of institutions) is volatile, sometimes chaotic, genuinely complex and contingent. Both the present, as well as the future, are genuinely more complex than many risk management frameworks suggest.

Notwithstanding this analysis most contemporary governments are reluctant to acknowledge that the outcomes of some of their policies and programs are uncertain. On the contrary, they are more inclined to claim increased capacity to predict and control the fields of their operations.

Herein is one of the most significant aspects of this study.
1.5 A brief review of the rise of risk in the late twentieth century

There appears to be widespread support for the view that the impact of risk on government, business and human services has increased significantly over the past two to three decades. There are a number of significant and usually interrelated explanations for this change, and they help inform not only the context of our research, but also our understanding of impacts and possible responses. The following theoretical explanations are influential, although their relative validity and significance are contested. They will be summarised very briefly.

The ‘Risk Society’ Thesis

One explanation for the rise of risk is that late industrial society has produced a frightening array of new risks, some of which are global in their nature, such as climate change, pollution, infectious diseases, inequality and terror; and some of which are local and relate to our social lives, such as addictions, community violence and crime. This approach is known as the ‘risk society’ thesis, originally the work of Ulrich Beck (1992, 1999), and also Anthony Giddens (1990, 1991). According to Beck we are in the process of change from the modern society to the risk society. The era of modernity was identified by our confidence in science and its capacity to solve problems, deliver progress, and ensure that everyone has a stake in society and a fair share. The risk society, however, is characterised by ‘a loss of faith in science, knowledge and various hierarchies of truth and power’ (Kemshall et al, 1997, p.224). and thus our futures seem much less certain. The normative or moral basis of the risk society is not the triumph of progress and continual improvement, but rather the growing dominance of safety and security. As a consequence we are absorbed with a ‘culture of fear’ and apprehension (Furedi, 1997). In fact, in the risk society the ‘axial principle is the distribution not of “goods”, or access to quality of life, but of “bads” —the distribution of hazards, dangers and risks’ (Kemshall et al, 1997, p. 223, citing Beck, 1992).

While the reality of risk has always been present in our daily lives, Beck (1992, 1999) argues that our understanding of risk has been reconstituted, and the consequences are profound. Traditionally risk was perceived to be random, personal and governed by chance. Life was fragile and dangerous and one could only take precautions, and with respect to some risks insure against the possibility of disaster. With the progress delivered by industrialisation and advanced technologies, however, came the belief that science could eventually eliminate or control most of the risks which alarmed us.

But this optimism was, in the context of late modernity, short lived. For Beck (1992) the processes of modernisation and technological change have produced new hazards and dangers that are essentially of our own making. Contemporary risk represents the unintended or unforeseen costs of progress, distinguished by their sources of production and their global nature (Beck, 1992, p. 21). Life in ‘high modernity’ as Giddens prefers to name it, involves constantly confronting and living with more risks and dangers, not less (1990, 1991). As a consequence we have to confront a new consciousness of the dangers and hazards created as a by-product of the great modernist project.

Beck (1992) further suggests risk is both pervasive and ubiquitous. We are increasingly conscious of the significance of risk in the management of our daily lives, not only in the protection of our health, assets or safety, but with respect to an increased consciousness about the pervasiveness of risks in so many areas of the social world, the economy and the environment.

It is in this sense that Beck describes risk as the manifestation of a genuine reflective and critical awareness of ourselves and our world, which awareness represents a different understanding of the transition from the modern era to the post-modern era (1992, 1999). Culpitt (1999) observes that risk ‘cannot be construed just as a potential threat to the self. Risk perception also involves the ways in which the self is able to perceive the self. Because risk constitutes that consciousness, as well as threatening it, it becomes reflexive’ (1999, p. 23).
So according to Beck and Giddens we all experience risk and we accept that we need to respond in some way. Not only do we insure against natural and unnatural hazards, but also we are, as described by Donzelot (1991), constantly confronted with information that alerts us to new and emerging risks. Because we have been warned we are also constrained to take preventative action and assume new responsibilities for our safety and well-being (Kemshall 2002, O’Malley 1992, and Rose 1999). This new understanding about risks requires individuals to adopt preventative health measures, travel safely, take more responsibility for their own occupational health and safety, address financial planning and management, and take precautionary behaviour with respect to crime. All these actions are seen as intrinsic to our safety and well being.

**Risk and Actuarialism**

Castel (1991), Gordon (1991), Garland (1997, 2001), Kemshall (2002), O’Malley (1992, 2004) and Rose (1996a, 1996b, 1998, 1999) all suggest that as the risk society leads to increased demand to control risk, new or existing technologies emerge to identify risk, measure it, predict it, prevent it and manage it. The growing need to control risk and the means adopted to deliver this control, are central to Foucault’s argument (1991, originally 1972) that the late twentieth century would see a transition from the disciplinary society to the control society. Deleuze (1995) identifies the new modes of control in the post-industrial society as spearheaded by the capacity of actuarial power to manage risk.

In this analysis managerialism, contracting, demand management and harm minimisation join actuarialism as approaches which radically change the recognition and approach to risk in community services.

Garland makes this transition from the disciplinary society to the control society more explicit:

> The discretionary power of the clinical experts is being displaced by central management decisions based on central actuarial expertise. New diagnostic practices apply risk factor analysis to the ‘profile’ of a case rather than engage in face-to-face examination of individual patients. Strategies of care or control fix increasingly upon ‘population flows’ rather than individual cases, ushering low risk into low cost care in the community, reserving institutional care for groups defined as high risk (Garland, 1997, p. 182).

Robert Castel (1991) also identifies this change in his well-known article on risk and actuarialism. Based on the work of Foucault on governance, Castel focuses on the profound significance of risk in the role and function of psychiatry. He goes on to identify a significant innovation in clinical services, particularly in the United States and France, which ‘dissolves the notion of a subject or a concrete individual, and puts in its place a combinatory of factors, the factors of risk’ (1991, p. 281).

As a consequence:

> [The] essential component of intervention no longer takes the form of the direct face to face relationship between the carer and the cared, the helper and the helped, the professional and the client. It comes instead to reside in the establishing of ‘flows of population’ based on the collation of a range of abstract factors deemed liable to produce risk in general (Castel, 1991, p. 281).

Castel’s analysis does not embrace all practice in community services, but it does describe the increasing role of actuarial tools in practice in many fields of community services—child and youth protection, mental health, forensic services, disability support and aged care.

Actuarial technologies in public health, mental health, crime and corrections, road safety, occupational health and safety and child development have allowed governments to focus on the behaviours of populations at risk, an approach which is clearly more efficient than disciplining, treating, correcting and rehabilitating individuals. And the focus of interventions could also be relocated from expensive institutions to the home, the community and the streets. Influential theorists, such as those above, identify the increasing relationship between risk and actuarialism in what Rose (1999), drawing on the work of Foucault, calls ‘the conduct of conduct’.

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Further, in the context of this analysis, argued by Culpitt (1999), Kemshall (2002), O’Malley (1996, 2004), Rose (1999) and others, risk management can capitalise on the advances in knowledge made possible by epidemiological studies, economics and actuarialism. This new knowledge opens up opportunities for broad population based responses to social problems. Managers are able to enlist this new knowledge to map and track social problems and guide their future program responses (Kemshall, 2002). Thus the role of government becomes even more rational and increasingly efficient. It is scientific evidence, rather than subjective and individualised judgements about needs, which becomes the principal driver of governments’ interventions. On the basis of objective evidence, governments can select narrow and precise definitions of problems, and focus on the consequences, or behaviours, rather than causes. As a result costly investment in curative and rehabilitative problem-solving programs can be curtailed in favour of harm minimisation interventions which are benign, realistic and pragmatic (Alaszewski and Manthorpe, 1998, pp. 142-3).

**Risk, Governmentality and Neoliberalism**

Other theories about contemporary risk would give more emphasis to the increasing dominance of neoliberalism in the realm of politics, giving rise to policies that set out to unpick public and collective welfare programs for managing risk, in favour of shifting the responsibility for risk to local communities, families and individuals (Culpitt, 1999; Mitchell, Braithwaite and Gatens, 2000; Marris, 1996a, 1996b; O’Malley, 1992). Aligned with the culture of fear and the political manipulation of anxiety (Furedi, 1997), the future becomes more uncertain, not less. In this political context we, as individuals, become more and more conscious of our responsibility to confront and deal with risk.

Peter Marris (1996a, 1996b), in his work on the politics of uncertainty, argues that the changes to the welfare state, which commenced in the 1980’s, have profound consequences for the distribution of uncertainty and risk. While the relative significance and role of risk in the contemporary dominance of neoliberalism is contested (O’Malley, 1992, 1996), the argument that ‘de-collectivising’ risk has been a major lever and rationale in the reform of the welfare state is central to the analysis of Culpitt (1999), Kemshall (2002), Mitchell, Braithwaite and Gatens (2000), and Rose (1999). For Culpitt the ‘concept of risk has now been used to reinforce and generate the power of an all-pervasive colonising of our self-consciousness, such that the “solitary”, “self-regarding” individual is the dominating symbol of our times’ (1999, p. 24). So as well as offering governments the opportunity to reduce their role in responding to some risks and elevating others (particularly those which focus on security and safety), Culpitt argues that risk offers a new framework for identifying public policy priorities and goals. Public choice theory, as the normative and political rationale “for massive social reconstruction, has in fact valorised the concept of individual risk to reinforce the “whittling away of the state”” (Culpitt, 1999, p. 32).

Marris (1996a) also bases his analysis on the unfair distribution of uncertainty, which means that the risks once held by governments and corporations are now shifted to individuals through the familiar strategies of privatisation, welfare reform, contracting, and labour market reforms. As a consequence, Marris states ‘the power to control uncertainty is unequally distributed, the greatest burden of uncertainty tends to fall on the weakest, with the fewer resources to withstand it, and in trying to retrieve some sense of autonomy and control they often compound and confirm their weakness’ (Marris, 1996a, p. 1). And the subjective experience of casual employment, welfare reform and rapid change in transitional labour markets, creates a significant burden for those now destined to carry this load (Green and McClelland, 2003; Marris 1996a).

O’Malley summarises the significance of this change to the welfare state as follows:

> Better understood as prudentialism, it is a construct of governance that removes the key conception of regulating individuals by collectivising risk management, and throws back upon the individual the responsibility for managing risk. This may be advocated by supporters as ‘efficient’, for individuals will be driven to greater exertion and enterprise by the need to secure against adverse circumstances—and the more enterprising they are, the better the safety net they can construct (1992, p. 261).
So in this new era of ‘responsibilisation’ (Rose, 1999), ‘reflexive modernisation’ (Beck, 1992; Giddens, 1991), and Giddens’ new democratic Third Way (1998, 2000), a defining feature is that ‘every individual must manage and take responsibility for the risks inherent in social life’ (Culpitt, 1999, p. 15). As a consequence, argues Kemshall (2002), the ‘order and control delivered by collective welfare and its disciplinary techniques is replaced by individualised risk management, self–management towards the preset prudential aims of advanced liberal societies. The state’s role becomes that of facilitator and educator toward “good” risk choices: through education, training, health campaigns etc’ (p. 121). Therefore ‘in respect of risk, individuals should bear more and the state should carry less’ (Culpitt, 1999, p. 15).

Contemporary governments see themselves as most vulnerable when they are unable to control, or appear to control, uncertainty. However the definition and assessment of risk shifts the focus from irreducible uncertainty to predictable risks. Every future event, particularly adverse events, can be subject to actuarially determined probabilities, thereby reinstating control. Further, the identification of risks, and their assessment and management allows them to be distributed (Marris, 1996a; O’Malley, 1992, 1996; Rose, 1999). Rather than deal with problems through interventions that expose them to unpredictability, cost and the possibility of failure, governments are now moving to limit their exposure. Bessant, Hil and Watts (2003) in their work on ‘discovering’ risk illuminate this process by identifying the shift from a structural and collective understanding of risk, to a focus on risk as a series of empirically tested and actuarially defined factors firmly located within the biological, social and psychological attributes or deficiencies of the individual (2003, p. 26). At the level of policy this can be seen in the general shift from collectivising responses to social problems to relocating them within families, individuals and localities; and from interventions based on treatment and rehabilitation to those based on harm minimisation (Culpitt, 1999; Garland, 1997, 2001; Rose, 1999).

Further, Bessant, Hil and Watts (2003), Kemshall (2002) and O’Malley (1992, 1996), in the exploration of risk and crime prevention, all suggest that risk research, at the level of the individual and the community, has joined forces with the push to early intervention to keep the focus of the action on the individual. This research continually defines and refines risk as factors located within the world of the individual, rather than the complex, powerful and unpredictable systems that surround them. As a result outcomes are more and more carefully crafted, individually focused, time limited interventions targeted at critical points in the lives of the person designated to be at risk (Bessant, Hil and Watts, 2003).

Reddy concludes that while public programs such as community services are so focused on ever more sophisticated and detailed risk analyses and assessments, they are less and less able to deal with the impacts of rapid change on our fragile social relations, increasingly fraught by the distribution of risks (1996, p. 242). Hood and Rothstein (2000) in the UK National Audit Office report on risk to the UK Parliament, also take the view that these approaches to risk management seriously weaken governments’ capacity to deal with systemic risks, a view which is supported by the findings of this project.

**Institutional and Secondary Risk**

Mike Power in *The Risk Management of Everything* (2004b), and later *Organised Uncertainly* (2007), takes a different approach to those perspectives discussed above and arrives at a different conclusion. He appears to be sceptical about ‘the risk society’, believing that we are safer now than ever before. Basing his analysis on the incredible expansion of the risk industry, he argues this phenomenon reflects ‘a number of different but convergent pressures for change in organisational practices in dealing with uncertainty’ (2004b, p. 12). Significant scandals in businesses around the globe, new expectations of corporate responsibility, new models of regulation, and the capacity of technology to deliver new risk management opportunities, have all combined to drive a focus on risk as never before.

Power considers it is these institutional responses to risk that should be the centre of our attention. The nature of this response is to focus on internal controls of secondary as well as operational risk in organisations. This approach, however, itself provokes significant risks. Increasingly professionals and operatives with responsibility for delivering services are becoming
more and more preoccupied with risks to their reputations, security and liability, thereby diverting their attention away from their principal responsibilities and the risks incurred by their clients or customers. Driving these processes is an anxiety, even obsession, with ‘killer events’ (Power, 2004b, p. 31), leading to the belief that highly unlikely, catastrophic and radically unpredictable events can be brought under control.

In all this risk management has ‘become synonymous with being a well-governed organisation, which is internally and externally accountable for how it “handles” uncertainty’ (Power, 2004b, p. 40). The major problematic consequence for this risk management of everything phenomena is the ‘increasingly defensive mood of agents who previously absorbed risk on behalf of others’, leading to ‘a potentially catastrophic downward spiral in which expert judgement shrinks to an empty form of defendable compliance’ (Power, 2004b, p. 42).

Colleagues of Michael Power at the London School of Economics, Rothstein, Huber and Gaskell (2006) and Rothstein (2006) take up this analysis, arguing that alongside direct operational risks in business and service delivery are a range of secondary or institutional risks, arising out of the complex matrix of regulations, contracts, service agreements, accreditation requirements, quality assurance systems and performance reviews, required of today’s businesses and community services. These have been defined as institutional or secondary risks, risks which arise out of the measures taken to increase accountability, improve quality and manage dangers and hazards arising from action. Other researchers addressing these issues include Fine (2005), Kemshall (2002), Munro (2004), and Webb (2006).

We can conclude this brief overview with the observation that the literature consistently supports the view that the pressure to identify, control or transfer risk has come to represent a growing political imperative at many levels for governments, their contracted agencies, and the professions (Fine, 2005; O’Malley, 2004). Politicians and policy makers are intensely interested in risk, as are contracted service providers, their employees, clients and other stakeholders. The consequences for community care are the subject of this report.

CHAPTER 2

DESIGN AND METHODOLOGY

2.1 Introduction

As noted in the introduction, in order to develop a background knowledge of the rise of risk in the late twentieth century the project commenced with a systematic review of the literature informing contemporary theories of risk, and in particular the changing role of risk in public policy, the regulation of business and the regulation of public services. We looked at the recent history of risk management and risk regulation in the United Kingdom and Australia, and then explored the more specific literature regarding risk in human services and community care. To facilitate this process the investigators and the industry partners involved in the development of the project formed a reading group which met regularly for six months before the structured investigations commenced in 2006. We report on the outcomes of this research in Chapter 3.

In 2006, a Partnership Group was established to oversee the detailed design of the project and in particular to finalise the interview schedules, data collection and data analysis. After data collection was well underway a Reference Group was established in 2008, made up of additional representatives from the Victorian Department of Human Services and the Victorian Office of the Public Advocate. This group advised the research team on policy and practice issues arising from the findings and provided directions to guide the preparation of the final report.
The project design was initially a two-stage, qualitative study of 24 Victorian community services across three sectors – mental health, aged care and disability. Our main research tool was the in-depth, semi-structured interview. In analysing the findings from the extensive interview data collected for this phase of the project, we aimed to provide insights into both the workings of risk management and perceptions of risk at different levels of organisations (through the eyes of chief executive officers, program managers and front-line workers), and experiences of risk and risk management among service users. After this work was largely completed the design was modified to include six carers’ advocacy organisations, their chief executives, and some of their members.

In this chapter we explain how we recruited our sample, describe the number and types of agencies and interview participants involved, and discuss our interviewing method and how we analysed the data. Then, in Chapters 4, 5, 6, 7 and 8 we interpret what people told us about risk and risk management. Our participants provide many insights into how risk management works at the coalface of community services, and we have quoted extensively from the interviews in order to better convey these insights. Finally, in Part 3, Chapter 9, we will deal directly with some of the issues and problems which emerged from our background research, and which became relevant and instructive to the Victorian context as we analysed the data from our interview research.

2.2 The Sample and Interview Approach

In total, 138 interviews were conducted with 166 participants, made up of 52 senior executives (including chief executive officers), 19 program managers and team leaders, 40 frontline workers, 34 clients and patients, and 21 family carers.

Our sampling method aimed for ‘maximum variation’ (Creswell, 1998, p. 119) through inclusion of a diverse range of services in terms of their functions and responsibilities, and location across regional and rural settings and inner and outer metropolitan areas. In recruiting participants, we sought guidance from our industry partners, the Victorian Department of Human Services and the Victorian Office of the Public Advocate. In several cases, we utilised informal networks as two of the researchers had extensive work histories with a number of Victorian health and welfare services.

The 24 organisations comprised public and non-government services. Nineteen were based in the metropolitan region and five were located in provincial cities. Fourteen of the 24 were community service organisations (i.e. non-government organisations) and ten were public agencies, including one local government council, two regional offices and a specialist service of a government department, and six public health agencies.

The 24 participating agencies can be categorised and described as follows:

**Seven mental health agencies, comprising:**
- Three Area Mental Health Services, two PDRS (Psychiatric Disability Rehabilitation and Support) agencies and two specialist public mental health agencies, including a forensic service
- Five were public (government) agencies and two were community service organisations (non-government agencies)
- Two of the seven services, namely an Area Mental Health Service and the forensic service, did not participate in Stage 2

**Seven disability agencies, comprising:**
- A support service for adults with physical disabilities, three support services for adults and children with a range of disabilities, a support service for adults with a range of disabilities, and two specialist disability services, including a forensic service
- Three were public (government) agencies and four were community service organisations (non-government agencies)
- Six were based in the metropolitan are and three were located in regional cities as well as metropolitan Melbourne
Two of the seven services, namely the forensic service and the support service for adults with a range of disabilities, did not participate in Stage 2.

Four aged care services, comprising:

- Two home-based nursing agencies, a service providing support and home care to the aged, and a case management agency providing assessment and home care to the aged.
- One was a public (government) agency and three were community service organisations (non-government agencies).
- Three were based in the metropolitan area and one was located in a regional city.

Six multi-sector agencies, comprising:

- A case management agency supporting aged clients, and adults and children with a range of disabilities; two church-based providers of a wide range of housing, health, disability and welfare services to adults and children; a church-based provider of a wide range of services, including crisis accommodation, aged care, disability and mental health; an agency supporting clients with a range of disabilities from culturally and linguistically diverse backgrounds, and a municipal council.
- One was a public (government) agency and five were community service organisations (non-government agencies).
- Five were based in the metropolitan area and one was located in a regional city.
- One of the six services, namely the agency supporting clients with a range of disabilities from culturally and linguistically diverse backgrounds, did not participate in Stage 2.

Stage 1 involved 24 interviews with chief executive officers and senior managers from the organisations listed above. One or more researchers met with one or more participants for discussions of two-three hours on general issues concerning governance, management of risk and adverse incidents, and managing relationships with other agencies. The interviews were semi-structured with an interview schedule used as a guide (see Appendix 1). A total of 39 chief executive officers and senior managers participated in these interviews. Stage 1 interviews were conducted from May 2006 – December 2007 with most taking place in 2006. These interviews were not audio-recorded; instead researchers made notes during the discussions.

In March-April 2007, we sent letters to the chief executive officers of 22 organisations that had participated in Stage 1, inviting them to take part in the next stage of the project. Two public agencies were not invited to do so because of their specialised forensic functions. In these letters, we outlined a procedure to facilitate the organisation’s participation in Stage 2: each chief executive officer was asked to nominate a program manager whom we could interview; this program manager would then assist in recruiting two frontline workers from the program and two or three clients. If the program manager felt it was too difficult to involve clients in the research process, either for ethical or other reasons (including the capacity to give informed consent), it was emphasised that this would not exclude him/her and the frontline workers from participating in Stage 2.

Nineteen organisations elected to take part in Stage 2. Three organisations, including a public organisation and two community service organisations, did not continue to the second stage for reasons of work pressures and, in two cases, organisational restructuring. Nineteen program managers, 40 frontline workers and 34 clients participated in in-depth interviews in the second stage of the project. Interviews took place from May 2007 – December 2008. These interviews were conducted one-on-one and were semi-structured with an interview schedule used as a guide (see Appendix 1). Interview material from Stage 1 helped to inform the construction of questions for the interview schedules used in Stage 2. All interviews were audio-recorded and transcribed, with pseudonyms used to protect participants’ identities.

Interviews with program managers and frontline workers went for one to two hours; these workers were asked 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 and procedures on their work with clients. Data was analysed in terms of the major themes in each interview. Initially the research team met to discuss
observations and reflections on the interviews. A ‘framework’ was developed to organise within-case and cross-case analyses at the more intensive stage of analysis (Creswell, 1998, p. 63). This framework included such categories as the ‘philosophical base, ethos and function of agency’, ‘practice issues’ (e.g. ‘identification and conceptualisation of risk’), ‘organisational machinery to manage risk’, and perceptions of the ‘impact of risk regulation on service provision’.

Interviews with clients went for twenty minutes to one-and-a-half hours. We asked clients about their day-to-day activities, sources of support, particular ‘worries’ or ‘concerns’, how they felt about the services they used, and whether they had been restricted in any way by these services or had ever been refused service by an agency. In asking about restrictions and refusals on the part of service providers, we hoped to draw out any experiences where an agency had perceived a specific activity as too risky for a client, along with situations where an agency had perceived a client as ‘too risky’ for service provision or not risky enough in terms of its inclusion or eligibility criteria. In short, we hoped to elicit any difficulties that clients had encountered as a consequence of an agency’s risk management policies and practices. Again, a framework was developed to organise and guide analysis of the data. This framework included such categories as ‘major issues, concerns, worries or fears’, ‘desires and aspirations’ and ‘comments and feelings about services’ (including the question of whether the service helped the client to do what he/she wished to do, and reflections on agency policies and practices including risk management policies).

The distribution of Stage 2 participants across the sectors was as follows:

- Mental health agencies: 4 program managers, 9 frontline workers, 9 clients
- Aged care agencies: 4 program managers, 11 frontline workers, 7 clients
- Disability agencies: 5 program managers, 11 frontline workers, 9 clients
- Multi-sector agencies: 6 program managers, 9 frontline workers, 9 clients

In early 2008 we amended the design of the project by adding a new category of research participants to those already involved in the project, namely a sample of family carers and chief executive officers/senior managers from six advocacy/support organisations. This group of research participants was considered in the original design of the project but reluctantly omitted because of the scale of the inquiry. However, we came to review this decision because early emerging evidence from interviews with clients, frontline workers and program managers, suggested that while some clients were active in defining and negotiating their risks and the management of risk, it appeared that families and carers undertook this role for a significant proportion of the clients overall (see Huang and Slevin, 1999; Miller, 2004).

Given the timing of this amendment and the effort and commitment already made by our participating organisations, we decided to approach independent ‘carer’ organisations, rather than carers from our original sample of 24 service providers. Consequently we approached six advocacy/support organisations representing the sectors selected for this project and requested their assistance in recruiting members who would agree to participate on the same basis as the frontline workers and clients. These included three mental health organisations, one disability organisation, one multi-sector organisation with a disability focus, and one aged care organisation. Each of the six organisations agreed to take part in the project. Initially interviews were conducted with chief executive officers and senior managers from each organisation. One researcher met with one or more participants for discussions of around two hours, exploring the nature of family members’ concerns in the context of their caring roles, risks and dangers experienced by families in their caring roles, general observations about the management of risk by relevant services (and how this may have changed over recent years), and whether the organisation was involved in any lobbying or activities concerning the management of risk. A total of 13 chief executive officers and/or other senior staff were interviewed. These interviews were semi-structured with an interview schedule used as a guide (see Appendix 1). The interviews were not audio-recorded; instead researchers made notes during the discussions. Interviews were conducted from April - September 2008.

Through hearing about our study from the advocacy/support organisations, twenty-one family carers elected to participate. These participants were interviewed one-on-one or in a focus group
according to their preference. Three focus groups were conducted comprising two, three and four participants respectively, along with twelve one-on-one interviews. Most interviews went for one to one-and-a-half hours, and were conducted from April 2008 – September 2009. Participants were asked about the major worries or concerns they experienced in caring for their family member; how services responded to these concerns, including issues of safety or risk; and whether they or their family member (identified client) had ever been refused services by an organisation. All interviews were audio-recorded and later transcribed, with pseudonyms used to protect participants’ identities. Since data collection has been completed only recently for this component of the project, the analysis of this data is still in progress, and not fully reported in this document.

The distribution of these participants across the sectors was as follows:

- Mental health advocacy/support agencies: 7 senior staff; 8 family carers
- Disability advocacy/support agencies: 3 senior staff; 9 family carers
- Aged care advocacy/support agency: 3 senior staff; 4 family carers.

2.3 Ethical standards

Ethics approval was obtained from the Human Ethics Committee of La Trobe University and the Human Research Ethics Committee of the Victorian Department of Human Services for the original project and the addition of the carer organisations and their members. Information guides were given to all participants, and we obtained written consent before conducting each interview (see Appendix 2). Participants were assured of confidentiality and informed that pseudonyms would be used in any written and published material relating to the study. Data collected from individuals were stored in a secure locked office at the University, and all computer-based materials were password protected.

Written feedback has been provided to each category of participants according to our progress with data analysis: to participants from Stage 1 (March-April 2007), to program managers and frontline workers (February – March 2009), and to clients (July-August 2009). Analysis of the interviews with family carers and chief executive officers/senior managers from advocacy/support organisations is still in preliminary stages. We aim to provide feedback to these participants in 2010.

2.4 Main Empirical Findings - In Brief

In Part Two, we document and analyse the major findings of the project. Chapter 3 outlines a very brief history of the emergence of late modern risk management, based on our review of the recent literature. This review focuses on major developments in Australia and Victoria, and to a lesser extent the United Kingdom, as many developments here emanated from that country. We give particular emphasis to new public management, the adoption of business models and practices to guide new public management in general and risk management in particular, and briefly review some of the literature on the implications of these developments for public services.

However the major findings discussed in Part Two, Chapters 4 to 8, result from our analysis of the interview data collected for the project. As indicated above 166 people participated from 30 organisations and it has been difficult to do justice to the extent of the insights and perspectives they shared with us during the interviews.

A brief overview of some of the major findings discussed in the following chapters is as follows:

- First, all the different participants defined and understood ‘risk’ according to their roles and responsibilities and the particular contexts that shaped their work and lives. There were differences in how risk was constructed between the different sectors – aged care, disability, and mental health - differences which reflect the histories, disciplines, services and professional ideologies predominant in each sector. We discuss these findings in Chapters 4, 5 and 6.
Second, program managers and frontline workers developed their own ways of thinking about and negotiating ‘risk’ and the risk management policies and procedures of the workplace. We referred to these complex reasoning processes as ‘risk rationalities’ and found three broad types which we classified as ‘positive’, ‘critical’ and ‘compliant’. We discuss this finding in Chapter 5.

Third, the idea of ‘sharing’ risk with other service providers in the context of working relationships as partners, collaborators or members of an interdependent service team was largely an unfamiliar concept to most frontline workers and some program managers, since risks were generally framed within the individual operations of each organisation. We discuss this finding in Chapter 7.

Fourth, the extent to which organisations successfully balanced their service goals and clients’ needs alongside responsibly managing risk depended not so much on the procedures and systems adopted, but on the organisation’s risk culture and the degree to which the organisation and its workers were able to approach the management of risk as part of, and integrated with, their service goals. We discuss this finding in Chapter 8.
PART TWO
THE FINDINGS

CHAPTER 3
THE CHANGING ROLE OF RISK AND RISK MANAGEMENT IN PUBLIC POLICY AND
REGULATION IN AUSTRALIA

3.1 The development of risk management in Australia since the 1980s
While Bernstein (1996) and Hacking (1993) remind us that attempts to control uncertainty and
risk commenced with the Enlightenment, and certain forms of risk management have always
been implicit in the operations of government and business, it is only in the last two to three
decades that Australia has seen the emergence of significant government policies and strategies
to manage risks (Auditor General Victoria, 2003, 2004). The imperatives that drove Australian
governments and all advanced capitalist societies to change their management of risks late last
century were the increasing numbers of collapses and scandals in the globalised banking and
financial markets and major environmental disasters such as Bhopal and Exxon Valdez.

These catastrophic events gave rise to a wide range of regulatory responses. Initially they
focused on greater regulation of the credit industry, through such interventions as the Basel
Accords I and II. This history is well reported elsewhere, and is not the focus of this study. Its
relevance, however, is that these events led not only to increased risk regulation in the financial
world, but in almost all the operations of government and business. In this regard the Victorian
Auditor General (2003, p. 15) reported that ‘as the use of risk management has increased, it has
broadened its scope’. Influential reports such as that of the UK Committee on the Financial
Aspects of Corporate Governance (1992), commonly referred to as the Cadbury Report, and the
US Committee of Sponsoring Organizations Report (1992) both identified the need for
organisational control frameworks and strong governance systems, and emphasised the ‘benefit
of a robust and formal knowledge of an organisation’s risks as a prerequisite for effective control
and governance’ (Auditor General Victoria, 2003, p. 15).

When risk management exploded into prominence as an imperative for both government and
business, it led not only to external regulation, but also to the requirement for agencies,
departments and businesses to build their own capacity for improved governance and self-
regulation (Power, 2004a, 2004b, 2007). By the middle of the 1990s, risk management was given
high priority by governments and their agencies in the UK, USA, NZ, Canada and Australia
(Auditor General Victoria, 2003, 2004; Braithwaite, 1999; Lupton, 1999; Power, 2007).

In addition to the pressures created by corporate disasters, CPA Australia (2002) reports that by
the mid-1990s risk management in Australia was also being driven by major changes to the way
governments of all persuasions conducted their business. These changes included, in particular:

- Public sector reforms requiring shifts away from centralised governments and greater
devolution of control to individual agencies.
- The introduction of a national competition policy which is in turn driving contestability and
much greater contracting out of public services.
- An increased focus on quality services and customer focus, leading to more
individualised services in functions such as health and welfare.
- Increased reliance on contractors to deliver services leading in turn to the need to
manage risks and standards.
• Declining financial resources and the requirement to increase efficiency and performance within existing or reduced budgets.

• Ongoing accountability and public scrutiny of performance and errors.

(CPA Australia, 2002, p. 10)

Throughout this period both the Australian and the Victorian Governments were much influenced by developments in the United Kingdom, where it was accepted that given the diversity of government functions and responsibilities, risk in the public sector needed to be defined very broadly. The UK National Audit Office (2000), in a report entitled Supporting Innovation: Managing Risk in Government Departments, outlined these issues as:

• Anything that poses a threat to the achievement of a department’s objectives, programs or to service delivery for citizens.

• Anything that could damage the reputation of a department and undermine the public’s confidence in it.

• Failure to guard against impropriety, malpractice, waste or poor value for money.

• Failure to comply with requirements such as those covering health and safety and the environment.

• An inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on delivery of public services.

(UK National Audit Office, 2000, p.1)

Central to these publicly stated rationales for risk management, as developed in Australia, Canada, New Zealand and the United Kingdom, are very broad goals such as improving service delivery, enhancing innovation, improving efficiency and effectively managing change.

Such broad and sweeping agendas for risk management in public agencies and services suggest its role is much wider than the traditional function of controlling specified primary risks. Rather, risk management became increasingly identified as integral to general efficiency and effectiveness reforms, and change management strategies.


In 2002 the Commonwealth Government’s insurance body, Comcover released 10 key performance indicators of best practice in risk management to help Commonwealth agencies to benchmark their performance. The breadth of these indicators demonstrates the intention of the government to move away from narrow approaches to risk management, and the strong focus on process and leadership.

• **KPI 1-Integrated risk management approach**
  An integrated approach to risk management, in an organisation, requires that risk management is an integral facet of all of its business processes. Its application is critical to the achievement of organisational objectives and governance responsibilities. Such an organisation has policies, strategies, and a comprehensive system to maintain a risk management culture. An integrated approach is also forward looking, requiring a focus on identifying opportunities, as well as avoiding or mitigating losses.

• **KPI 2-Committed and led**
  The achievement of an integrated risk management approach and culture requires strong leadership and a commitment at the highest level/s within an organisation. There is an active and committed focus by all senior executives to “champion” the practice of risk management to achieve business success.
**KPI 3- Positive and proactive focus**
The organisation maintains a proactive role in the identification, analysis and treatment of potential risks. It positively aims to provide optimum levels of protection, as well as optimising opportunities for the organisation at minimum cost.

**KPI 4- Process driven**
The organisation has a framework capable of implementing risk management processes. The organisation has a clearly defined and documented risk management process, which is seamlessly integrated into all other business processes.

**KPI 5- Planned for continuous improvement**
There is a continuous application of risk management practice with a clearly defined risk planning process. Continuous control, performance monitoring, review and improvement of planning and practices are inculcated into the organisation's culture.

**KPI 6- Audited and documented**
There are developed and applied mechanisms to ensure ongoing review of risks. The organisation has a well-developed audit, reporting and documentation system in place. It monitors and documents all levels within the risk management process.

**KPI 7- Active communication**
Active communication and consultation occurs with internal and external stakeholders (as appropriate) at each stage of the risk management process and concerning the process as a whole. A communication plan has been developed at the earliest stage in the risk management process, with the plan addressing issues relating to the risks themselves and the process to manage it. There is a staff position responsible for communicating risk management policies and the risk management program.

**KPI 8- Resourced**
The organisation has identified and committed adequate resources to support the full implementation of risk management practices and processes on a continuing basis. The business is adequately protected, financially, operationally and contractually, against the risk of losses. Accountability for the management of risks rests with each line manager, with each unit having adequate risk management resources.

**KPI 9- Trained and educated**
The organisation is committed to the training and the education of staff in risk management, and has an ongoing and funded training and education program.

**KPI 10- Value-based decisions**
The organisation's business decisions incorporate a full risk assessment, including cost-benefit analysis of the risks and business value, rather than on assessing the cost of risk alone. It links outcomes to the achievement of goals and objectives. Business decisions are value-based. (Australian Government Department of Finance and Administration, Comcover, 2002)

**The Significance of the Australian Risk Management Standard**
A wide range of related but quite different factors led to the take up of risk management in Australia. In this context it is noteworthy that Australia’s and New Zealand’s insurers and risk managers were responsible for the first ‘risk management standard’, the need for which was raised by the Association of Risk and Insurance Managers of Australasia in 1992. The Association established a Joint Technical Committee (OB7) which was charged with writing such a standard. A discussion paper on risk was released in 1993, and followed two years later by the joint Australian and New Zealand Standard, Risk Management, AS/NZS 4360:1995 (Standards Australia and Standards New Zealand 1995). It was subsequently updated with new editions in 1999 and 2004. In 2001, the ISO adopted the AS/NZS 4360 as a guideline for their standards. When the Australian and New Zealand standard was updated in 1999 it was accompanied by a handbook; Guidelines for managing risk in the Australian and New Zealand public sectors, HB 143:1999 (Standards Australia and Standards New Zealand, 1999). Over the next few years other standards were developed for industry specific aspects of risk management such as Occupational health and safety management systems, AS/NZS 4804:2001 (Standards Australia
and Standards New Zealand, 2001). In 2003 Victoria's Auditor General undertook a performance audit of risk management in this State. The report noted that the risk management standard was 'widely quoted and adopted by organisations in Australia and New Zealand as well as abroad in the UK and Canada' (Auditor General Victoria, 2003, p. 15). Power (2004b, p. 26) identifies this standard as the first of its type, to be followed by similar standards in Canada, the UK and Japan. Significantly this Standard takes a broad and developmental approach to risk, recognising the importance of risk for opportunity, improvement and effectiveness, as well as its relevance to hazards and dangers. The process always starts with the specification of key organisational goals. This framework, or variations of it, is generally the preferred model of risk management adopted by commercial and non-profit organisations, as well as government departments.

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**STANDARD RISK MANAGEMENT PROCESS**

![Diagram of Standard Risk Management Process](image-url)

Late in 2009 SAI Global, which took over the role of development of standards from Standards Australia and Standards New Zealand, announced the release of a new risk management standard ISO 31000: 2009 which supersedes AS/NZS 4360: 2004. The new standard continues to give practical advice on how organizations develop, implement and improve the way they manage risk. The Standard focuses attention on tackling organizational risk by identifying and treating both external and internal influences and factors that give rise to that risk, and claims to give particular advice on how organisations can integrate and embed risk management, and how to improve current frameworks and processes.

3.2 Risk Management in Victoria since the 1980s

In this segment of the overview we report briefly on the main public agencies involved in risk management in Victoria, and make some comments on the significance of the related issues of standards regulation and occupational health and safety.

The Victorian Managed Insurance Authority

In Victoria the principal agency responsible for driving the introduction of risk management in public agencies is the Victorian Managed Insurance Authority (VMIA). The VMIA provides risk and insurance services to protect Victoria's assets and minimise losses from adverse events. Established in October 1996, VMIA is a statutory authority operating under the Managed Insurance Authority Act 1996, and reporting to the Department of Treasury and Finance.

The functions of the VMIA include the following: to assist state government departments and agencies to establish programs to manage risk; to monitor these programs; to act as insurer for departments and agencies; to provide indemnities to officers of State agencies against liabilities they may have incurred in their duties; and to provide risk management advice and training to state departments and agencies.

In the late 1990s the VMIA was a key part of the State Government's financial reform strategy, and one of its critical functions was to lead over 300 public bodies into developing their own risk management strategies. As previously noted, in 2003 the Victorian Auditor General reported on a performance audit of 61 randomly selected state public sector organisations, which had participated in a review. The study found a high level of activity with over 90% of the sample applying risk management processes in all or some of their businesses or operations. However, according to the Auditor General, only 39% had appropriate risk management strategies in place. The rest failed to demonstrate an adequate risk management policy and strategy and failed to demonstrate they could identify and assess their main risks. There were many other deficiencies and as a result of this audit the Government intensified its requirements of all public agencies.

The VMIA responded by focusing on improving performance in the key areas identified as problems by the Auditor General's performance audit:

- **Risk management reporting**—Improving risk reporting to Management and the Board to ensure a high level of visibility was a common issue. Through ensuring the existence of strong processes to identify, escalate and monitor risks, the ability of the organisation to implement effective treatment plans and avoid potential consequences will be significantly enhanced.

- **Development of Key Risk Indicators**—One of the more important aspects of risk management is the development of Key Risk Indicators. These are predictive indicators regarding changes to the risk profile of a business. They can be used to predict areas of increasing risk or “hot spots”, identify control weakness or used to improve behaviour and operational efficiency. VMIA will be working with clients to improve their use of key risk indicators.

- **Business continuity management**—There was evidence from the RFQR that the business continuity management systems, for a number of organisations, require improvement. Business continuity management is seen as a priority area for action.
• **Aligning Internal Audit and Risk Management Assurance**--It was identified that whilst Internal Audit groups provided support to the risk function and in some cases acted as the risk consultant to the organisation, it was evident that the link between strategic and operational risk through to the risk register and risk assurance process was negligible. There was a need to provide support to clients through tools and training, including the use of Control Self Assessment (CSA) techniques and linking risk and audit methods.

• **Risk Registers**--Another general area of weakness was the form and function of risk registers. Whilst registers may have a number of common elements, there were very few exemplar risk registers identified. Common weaknesses included poor risk definitions, lack of depth in risk registers, failure to identify controls or control effectiveness, not allocating risk to accountable individuals, no follow up activity etc. VMIA will be working with clients to overcome some of these shortfalls.

As well as its work with Victoria’s government departments and agencies the VMIA provides some services to non-government community organisations. The rise of risk management was not confined to government and business, and community organisations contracted by government were progressively required to introduce their own policies and procedures. Even community service organisations not publicly funded moved to protect themselves from public liability, risks to their financial standing, and risks to their reputation. The VMIA publishes useful general guidelines and advice to community organisations, such as the Risk Management Guide: For Community Service Organisations (2009), and its website up-dates both non-profit organisations and businesses on important legislative and regulatory developments.

Not surprisingly the guidelines, tools and procedures outlined in AS/NZS 4360:2004 (and now the global standard ISO 31000:2009) have also been adopted and adapted by many non-profit coordinating organisations. For example, the web site of Our Community, a Victorian non-profit organisation, makes available detailed guidelines (using the Australian Standard’s framework) for local groups, non-profit services, co-operatives and other small organisations to assist them implement their own risk management strategy (Our Community, 2003).

In October 2009 the VMIA ran the State’s first risk management conference which reported on global and local risk scenarios and advances in risk management technologies. It was noticeable that while a number of delegates came from health services, very few were from community services.

The VMIA, and contracting departments in their various regulatory roles, are charged to ensure that risk management is seen as a governance responsibility by provider organisations, and that these organisations develop the capacity and systems to manage risks. The result has seen many improvements in a wide range of organisations, but it also produces approaches to risk management which can vary widely across these organisations. This project found that these variations set up tensions between services working collaboratively, and even within individual services. These issues are discussed extensively in our findings.

**The Victorian Department of Human Services**

Victoria’s largest public agency was, until recently, the Department of Human Services (DHS). In 2009 it was split into two separate departments, Health and Human Services. Before the split the DHS planned and funded most health and community services in the state, and had made extensive commitments to risk management planning in its key functions of planning, program development, purchasing, monitoring, and regulation of standards. Risk management was defined as a set of processes for systematically identifying and evaluating risks that may impact on the Department’s ability to deliver programs or achieve departmental objectives. Risk management also encompassed the adoption of strategies to mitigate risk, as well as the monitoring and reviewing of these strategies (Keating, 2005).
The major risks identified by the Department of Human Services in its *Risk Management Framework* (2004a) were as follows:

- Strategic/Planning
- Social/Political
- Demand management
- Duty of care
- Financial/Budget/Commercial/Systems
- Operational
- Physical asset/Infrastructure
- Personnel/Industrial
- Compliance/Legal/Governance.

*(Victorian Department of Human Services, 2004a)*

As for all government agencies in Victoria, this Department was and of course still is in its new structures, required to have a risk management strategy to comply with the requirements of the *Managed Insurance Authority Act 1996*, the *Financial Management Act 1994*, and the Minister of Finance’s directions under the *Financial Management Act 1994*. The Department’s framework at that time also drew upon the Australian and New Zealand Standard for Risk Management AS/NZS 4360:1999 and 2004 *(Keating, 2005)*.

The Department’s Risk Management Framework was based upon the following five principles:

- Management: the aim is risk management, not risk aversion.
- Accountability: risk management is everyone’s business at all levels and in all areas.
- Portfolio focus: risk management takes place in the context of the wider goals, objectives and strategies of the Department.
- Process: the process of managing risk is logical and systematic and should become routine.
- Integration: risk management is part of business as usual.

*(Victorian Department of Human Services, 2004)*

*Risk and contracting in the Department of Human Services*

The extent of this Department’s commitment to risk management was further demonstrated in the attention given to one of its most significant roles, namely the funding of ‘external service delivery’. In a sixty-page document entitled *Risk Management Policy: Framework and User Guide in Funds Allocation of External Service Provision* *(Victorian Department of Human Services, 2000)* over 110 sources of risk were identified in the process of funds allocation to external service providers. Contracting out services is clearly identified as a high risk activity. The risks were identified at each stage of the funding or contracting process—planning, preparing specifications, selection, setting up the contract, managing the contract, reviewing performance, managing legal, contractual and political issues -- and include the possibilities of cultural, community and political problems in the funding of programs.

Two observations could be made about this risk management policy. First, this document validates the significance of the changes to the role of governments as identified by the CPA (2002), Braithwaite (1999), Power (2004b) and many others referred to in this report. As Rothstein, Huber and Gaskell (2006) point out, governments which steer rather than row, become increasingly focused on contracting and risk, seeking to ensure their contracted providers deal with operational risks. Second, it is also significant that every one of the 110 risks listed in this document is a threat or danger. Not even the problem of what to do with success or a winning innovation is mentioned as examples of possible positive risks to be managed.
Risk and child protection in the Department of Human Services

One high profile program within this Department, namely Child Protection, was one of the first to develop its own comprehensive risk framework, the Victorian Risk Framework: A Guided Professional Judgement Approach to Risk Assessment in Child Protection (1999) and updated since this time. This framework spelt out comprehensive guidelines for risk assessment, risk analysis and risk judgement. It reflected the significance of risk in the work of protecting children in their families and the community, and the reality that child protection is one of the most sensitive areas of public administration in Australia. No state jurisdiction has contracted out child protection, demonstrating the complexity and sensitivity of this work. However, the Victorian Government has commenced a process of service innovation, which extends some of the responsibility for child protection to community service organisations and other partners in this jurisdiction (Department of Human Services, 2005).

Developments in standardisation, accreditation and quality assurance

This project did not set out to investigate the relationship between risk management and the parallel rise of standards, quality assurance and accreditation regimes, but a number of the chief executive officers interviewed in the first stage of the project identified these measures as significant risks to their organisations. Braithwaite (1982) originally defined these rapidly growing requirements imposed on publicly funded services, as well as commercial businesses, as the new technologies of ‘enforced self-regulation’. Later he referred to them as “responsive” regulatory techniques to replace regulation through direct command and control’ (Braithwaite, 2000, p. 224-5).

This particular form of regulation aims to enhance efficiency and effectiveness by relocating responsibility for standards and quality, as well as risks, from public inspectors to the contracted organisations. The technologies of this ‘responsive regulation’ include mechanisms to monitor, evaluate and improve service providers’ governance structures, operational performance, financial accountability, and quality assurance, together with procedures to manage potential risks to clients, workers, and community. As a consequence, contracted services had to change their internal processes of regulation and risk management (Kemshall et al, 1997; Power, 2004b, 2007; Rothstein et al, 2006).

In addition the ultimate responsibility of governments for the care of its vulnerable citizens also contributed to shifts away from technical and product oriented regulation to a focus on processes within business and service provider organisations.

Not surprisingly, therefore, in health and community services during the 1990s, the traditional command and control processes of standards monitoring gave way to responsive regulation and continuous quality improvement processes, thereby comprehensively ‘changing the way we look at standards and the accreditation process’ (Skok, Swerissen and Macmillan, 2000, p. 1). The old prescriptive standards and enforcement by inspection were replaced by strategies encouraging services to develop their own quality processes in service delivery, which were tested by internal and external review procedures for the purpose of accreditation. So it was becoming increasingly important for service providers to not only deliver efficient and effective services but to have systems in place which would drive continuing review and improvement.

In this context a number of standards agencies and standards products were established for the different service sectors. In 2000 Skok, Swerissen and Macmillan identified the key agencies and products which emerged out of the 1990s reforms to the way Australian governments carried out their regulatory functions. This report was the first overview of this revolution in addressing the quality and standards of human services. We have selected the agencies and systems listed by Skok, Swerissen and Macmillan which have been the most significant for the community health and care service providers over the past 10 years. For a more detailed discussion of these developments we refer the reader to the full report by Skok, Swerissen and Macmillan (2000).
STANDARDS AGENCIES

- **The Australian Council on Healthcare Standards**
  Established in 1974 ACHS is an independent non-profit organisation funded by service fees with over 300 health sector professionals acting as a voluntary surveyor workforce. It has established a product called EQuIP which develops standards addressing the processes of care in hospitals and mental health services. The public mental health agencies in this project come under the ACHS.

- **The Quality Improvement Council (formerly the Community and Health Accreditation and Standards Program)**
  While originally established for community health the QIC is broadening its role across both government and non-government health and human services.

- **International Standards Organisation**
  The ISO is a world federation of national standards bodies set up to promote the development of standardisation globally and to improve cooperation in advancing quality. The ISO focuses on good management practices (ISO 9000) and quality management (ISO 9001, 9002, 9003). It is not known how many of the participating organisations in this project used the ISO, although several CEOs were aware of its products and had considered adopting them.

- **Australian Quality Council**
  The AQC has developed the Australian Business Excellence Framework which is applicable to all organisations. Again, it is not known how many of the participating organisations used the ABEF, though some CEOs mentioned the Business Excellence Framework as an example of something they had or might adopt.

OTHER RELEVANT STANDARDS PRODUCTS

- **Home and Community Care Standards**
  The HACC National Service Standards were developed in 1991 for Commonwealth/State funded services to frail older people and people with disabilities living in their own home. A significant number of the organisations in this project, as they receive or manage HAAC funding, are covered by these standards.

  - **ACHS Guidelines for Residential Aged Care within ACHS EQuIP**
    A small number of the organizations in the sample were working to these guidelines. There are other modules and standards for aged care.

- **Disability Service Standards**
  National standards developed by the Commonwealth Department of Health and Family Services. A significant number of the sample were working to these standards, as well as various Standards for Disability Services in Victoria and the national HACC standards.

- **National Standards for Mental Health Services**
  Also produced by the Commonwealth Department of Health and Family Services, these standards were endorsed by the Australian Health Ministers’ Advisory Council’s (AHMAC) National Mental Health Working Group in December 1996. Mental health organisations in our sample were working to these standards.

  - **Supported Accommodation Assistance Program (SAAP) Service Standards**
    The Commonwealth/State funded homelessness program SAAP was replaced in 2009 by the National Affordable Housing Agreement, and agencies receiving such funds in Victoria now operate under the Victorian Homelessness Assistance Service Standards. A small number of the participating organisations were reporting on the previous version of these standards, the Victorian SAAP Service Standards.

For service providers working under one system of funding, accountability and accreditation, and a general management quality program such as ISO 9000, these requirements, while perhaps onerous, are accepted as reasonable. For providers delivering services through a number of funding programs in different service sectors, the accumulated and different requirements for
standards compliance and other accountability and accreditation requirements could constitute major and incompatible reporting demands. Some CEOs interviewed for this project identified these demands as significant risks for their organisation.

By 2007 the widespread industry concern about this complex and burgeoning regulatory burden, reached a level sufficient for the State Government to institute a major review of regulation in the non-government services sector.

**The State Services Authority (SSA) Review of Not-for-Profit Regulation (2007)**

In September 2007 the Victorian State Services Authority published a *Review of Not-for-Profit Regulation*, following a commission from the Premier and the Treasurer to examine ‘the impact of Victorian Government regulation and other contractual and accountability requirements placed on not-for-profit organisations by Victorian Government systems, processes, structures and functional relationships’ (Victorian State Services Authority, 2007, p. xi). This review took place during the early stage of this ARC project, and the research team held discussions with the Commissioner responsible for the review. By this time the State Services Authority review had held over thirty public meetings and consultations across the State with many not-for-profit services, including a number providing community services in the aged care, disability and mental health sectors.

The review identified four types of accountability requirements as follows:

- Financial reporting
- Service performance (statistical reporting)
- Compliance with service standards and guidelines reporting, and
- Client data and other reporting

Significantly the SSA identified major problems with the regulatory burden of those provider organisations involved in administering multiple and different contracts or service agreements with the Victorian Department of Human Services, other State departments, and Commonwealth departments funding community services.

The SSA also reported that not-for-profit agencies experienced burdens from changes to the regulatory environment. For example at that time the *Children, Youth and Families Act 2005*, and the *Disability Act 2006* were and still are being implemented, requiring changes in standard reporting and accountability procedures and introducing new measures such as accreditation of provider services. Many of the services participating in the SSA review were delivering services under the *Disability Act 2006* and some were contracted under new programs and developments in housing services, mental health services and new Commonwealth programs arising from changes to family law.

According to the SSA (2007, pp. 51-7) the cumulative impacts of diverse regulatory requirements, including radical increases in reporting requirements, the necessity to introduce different systems to meet new accountability demands, and the associated time and costs were directly impacting on the service capacity of many contracted agencies.

This finding is supported by the evidence of this project. A majority of CEOs from not-for-profit services reported that the rising regulatory requirements had become a major source of risk to their organisation, not only in terms of the financial and staff commitments required, but also in terms of possible risks to reputation arising from poor compliance or failure to maintain compliance with a wide range of demands. Most of these executive managers indicated that the regulatory requirements for individual contracts or programs were generally not unreasonable in and of themselves; rather it was the cumulative burden which posed the greatest risk.

These findings support the analysis of the Centre for Analysis of Risk Regulation at the London School of Economics and the work of Rothstein, Huber and Gaskell (2006) on what they called ‘institutional’ risk. In this ARC project and the SSA review it was clear that risk regulation itself was becoming a major risk—for some organisations participating in this project it was considered their fastest growing risk.
In its final report the SSA (2007, pp. 53-57) clearly identified the importance of these issues for not-for-profit services and for public agencies, particularly the Department of Human Services. As well as reforms to financial regulation the SSA identified three particular areas of regulation which required reform:

- the issue of changes to social regulation
- the integration of quality and accreditation standards
- and data collection and storage requirements

Specific recommendations were made with respect to each of these areas. The SSA, however, did not address the general issue of complexity in the changing nature of community services, or the overall problem of inter-governmental and inter-departmental integration and coherence in regulatory processes. The contracting of public services to not-for-profit and private providers have produced a wide range of community service organisations, many of which do not have the infrastructure necessary to meet regulatory requirements. While some government departments have recognised this reality, in their outsourcing they have continued to focus on sector specific, target group specific or highly prescribed programs and compliance requirements.

**Occupational Health and Safety in Victoria**

All the participating organisations in this study were subject to the Victorian Parliament’s *Occupational Health and Safety Act, 2004*. The employer’s duty of care is defined in the Act as:

> The employer must, in so far as it is reasonably practical, provide and maintain for employees of the employer a working environment that is safe and without risks to health *(Occupational Health and Safety Act, 2004, s.21 (1)).*

The term ‘health’ now includes ‘psychological health’ which includes managing hazards such as occupational violence, stress and fatigue. Employers ‘so far as it is reasonably practical’ are now required to put in place ways of identifying hazards, assessing likelihood and severity of the hazard, and ways of controlling the hazard. Further, employers must have regard to the current state of knowledge about identified hazards, ways of controlling, removing and mitigating them, and the costs of removing or mitigating hazards or risks.

As many of the work sites of community care organisations, such as private homes, housing estates, streets, parks, squats and other public places, are unregulated, the demands on employers with respect to occupational health and safety have become much more significant. In addition, the responsibility for very vulnerable, frail, disabled and sometimes troubled young people and adults has been transferred from highly regulated and controlled institutional environments, to these diverse and unregulated sites. All the senior managers and CEOs participating in this study reported recent changes in their approach to, and governance of, the health and safety of their workers, and most were of the view that recent reforms had seen improvements in their prevention of, and responses to, work hazards. Many of the front line workers in the project also reported favourably on the changes in occupational health and safety over the past decade. Some clients and carers, on the other hand, saw a reduction of services or the quality of service, as a result of new health and safety policies and procedures.

The evidence of this project will show that in community care managing risks, including occupational risks, has become integral not only to the responsibility of employers, but also to the roles and practices of individual professionals and workers, many of whom work in small teams or practice alone. Risk, including occupational risk, frames their assessments, defines their interventions, and demands the detailed documentation of interventions, decisions and clinical information *(Kemshall et al, 1997; Kemshall, 2002; Munro, 2004; Sawyer, 2005; Webb, 2006).*

Risk may also qualify their relationships with their clients and patients.

Notwithstanding the widespread support for a much more sophisticated approach to occupational health and safety in community care, we found some systemic problems which impacted on workers, clients and carers.

- The first was that some service provider organisations had different interpretations of occupational health and safety from other organisations, which meant withdrawal of services.
and/or transfer of clients judged to be of high risk from one service to another. Some services described other services as having what could be called a ‘zero tolerance’ approach to certain hazards, which put more stress on those which were prepared to be more flexible.

- The second major issue to arise was that some carers found that employed workers, particularly support or home care workers, operated under restrictions which effectively transferred certain risks to carers or family members, who may themselves be managing a disability, frailty or other problems.
- A third issue was that workers of all categories, but particularly professional workers, were not permitted to carry out certain tasks which they felt they should do on the basis of their values and professional ethics.

This study did not set out to evaluate or review particular risk regimes, including occupational health and safety provisions, and we do not report on these matters. Our focus was on the experience, perception and problems of the different actors in the twenty four service organisations and the six carer organisations. And while occupational health and safety provisions were contentious in some circumstances, the commitment to keeping workers safe was not, at the end of the day, the major problem identified by the participants in this project. Rather it was the difficulties arising from working interdependently with different definitions, interpretations and rules about the management of risk.

3.3 Business risk management models and their implications for public services

As noted above, during the last two decades of the twentieth century Australian governments, led initially by Victoria, embarked upon an extensive program of reforms to ‘modernise’ government services, government contracting and public sector regulation. In order to understand the relevance of these changes to this project we have drawn on the work of some of the United Kingdom’s foremost authorities on public administration and regulation, authors such as Christopher Hood, Henry Rothstein and Mike Power, their colleagues at the Centre for Analysis of Risk Regulation (CARR) at the London School of Economics, as well as other academic research and numerous UK government policy papers on regulation and risk management. In addition, the work of Professor John Braithwaite at the Australian National University has been central to our understanding of the broader contexts explaining the rise of risk and risk regulation in Australian public agencies.

Christopher Hood (1991, pp. 4-5) identified seven original doctrinal drivers of these reforms, which included ‘explicit standards and measurement of performance’, ‘greater discipline and parsimony in resource use’, ‘hands-on professional management’ and the value of ‘private sector styles of management practice’. Achieving these changes, according to Hutter (2005, p. 2), was seen to be dependent ‘upon adopting private sector styles of management and an almost unthinking acceptance that private sector practice was the benchmark against which to assess public sector activities’. In the late 1990s, the Blair government’s ‘new public management’ program, which had so much influence here in Australia, consolidated the adoption and application of enterprise-based models of management and regulation to the public sector (Hutter, 2005).

As a result, by the end of the twentieth century there was little doubt in the minds of reforming governments in most Western democracies that business practices pointed the way to improved efficiency, innovation and responsible governance. In a short period of time business practices became ‘the benchmark against which to assess public sector activities’ (Hutter, 2005, p. 2), including the management of risk (Braithwaite, 1999). The UK National Audit Office (2000) report on managing risk in government departments identifies close links between its proposals and a number of key inquiries and reports on new developments in corporate governance codes. In particular it identified the UK Committee on the Financial Aspects of Corporate Governance (1992), commonly referred to as the Cadbury Report, and the US Committee of Sponsoring Organizations Report (1992) referred to as the Treadway Commission. In addition Hutter (2005, p. 2) comments that the Turnbull Report (1999) Internal Control: Guidance of Listed companies Incorporated in the United Kingdom, ‘is identified as especially significant as a voluntary code
which adopts a risk based approach to designing, operating and maintaining a sound system of
control in business financial management, in particular it supports a top-down, integrated
corporate risk management policy’. Public sector reform and risk regulation reform were part of
the same package, given that the responsive approach to regulation aligned comfortably with
contracting and commissioning processes, allowing contracting departments to package and
transfer risks into their performance agreements with service providers. The same logic
supported the focus on risk management processes in the development of standards and quality
assurance programs.

Both business and government agreed that what was needed were approaches which
‘incorporated cost benefit analysis, were apparently objective and apparently transparent’ (Hutter,
2005, p. 2). As a consequence it was largely corporate and business risk management practices
which were to shape the state’s regulation of itself, the introduction of regimes of enforced self-
regulation for corporations, and similar measures for public agencies and their contracted service

In some human services, particularly health services, the scientific and technological basis of
some risk technologies meant they were readily accepted as objective tools which complemented
the call for evidence-based practice, quality assurance and improved internal auditing (Webb,
2006). As Scott (2004, p. 157) explains, the central objective of the so-called responsive
regulation is to stimulate regulatory approaches which foster and support the ‘regulatory
capacities which already exist’ within organisations and businesses, and even individual citizens.
In the context of the demands for increasing efficiency, greater accountability, reducing costly
government interventions and improving public sector governance, few voices questioned the
reassuring logic of ‘new public management’. It was not until the end of the century that some
authoritative voices were heard which drew attention to the significant difference between the
needs of business and the needs of government in the management of risk.

Problems arising from the adoption of business risk management models by public
agencies and community services.

By early this century Hood and Rothstein (2000) were arguing that there are distinctive regulatory
issues and problems in the public sector. They acknowledge that while corporate models of risk
management may have been well suited to some functions of government, the question arises
whether they meet the needs of the complex risk sharing relationships and the mutual
management of systemic risks relevant to the responsibilities of government today.

Hood and Rothstein also argued that in the public sector risk is usually systemic, and is allocated
across numerous public agencies and at multiple levels in government. Unlike business,
therefore, the management of risk is complex and must be integrated and possibly shared across
autonomous organisations. Effective management of risk requires public organisations to work
together and develop ‘cross-organisational trust and management craftsmanship of a high order’
(Bardach, 1999, cited by Hood and Rothstein, 2000). We would argue that exactly the same
requirements apply to community services, where the collaborative and shared work also
includes subtle risk sharing relationships with service users, families and other providers. From
the literature and the evidence of this project we have identified five issues which we consider of
importance to setting the context for this project.

(i) Business risk management approaches are driven by the institutional imperatives of
avoiding blame and litigation

Hood and Rothstein (2000) and Hood, Rothstein and Baldwin (2004) drew attention to the critical
difference between the responsibilities of public agencies to manage risk in the public interest,
and the essentially self-protective interests of corporations. Consequently they concluded that
‘bringing business risk management to public services could easily augment the “blame
prevention re-engineering” that is already too well established in public sector organisations
generally and risk regulation in particular’ (Hood, Rothstein and Baldwin 2004, p. 177).
A fundamental principle underpinning modern risk management models is to allocate each risk to
the body or agency best equipped to bear it (UK National Audit Office, 2000, p.3; Hodge, 2004).
However, as Hood and Rothstein (2000) suggest, if public agencies are focused on blame avoidance and their own secondary institutional risks, they are prone to transfer risks to organisations, or possibly service users, that do not have the capacity, resources or infrastructure to manage them. They go on to observe that ‘(s)ystems that put too much stress on limiting downside business risk at organisational level can trigger risk-displacement processes among different organisations that create nil (or negative) “public value” ’ (2000, p. 26).

While no systematic study has been made of this issue in community services, the preliminary findings from this project suggest that this trend is evident in that small provider organisations confront a wide range of risks, transferred through their contracts and partnership arrangements. While large public bodies like hospitals, with significant infrastructure capacity, are well equipped to absorb increasing operational and institutional risks, community-based social care providers may not have the necessary infrastructure to do so, and it may not even be sensible to suggest they should be so equipped.

Small agencies interviewed consistently report that their work is affected by the transfer of risk between providers as a result of risk management strategies that encourage the displacement of risk. The most common practice is the transfer of high-risk clients, or refusal to work with high-risk clients, thus increasing other organisations’ exposure to risk. In some jurisdictions it appears that this process operates in a hierarchical way, transferring risk lower and lower to face-to-face workers or last resort services, such as homeless programs. The lack of sector wide risk definitions and risk responses contributes to the perception and reality of an unequal distribution of risks within a service system or network, usually in the interests of blame avoidance by service organisations.

(ii) Who takes responsibility for systemic risks?

Preoccupation with blame avoidance and organisational risk, that is, the business, reputation and liability risks of the agency, diverts attention from systemic risks, the risks that constitute the ‘real’ problem for the public and the government (Hood, Rothstein and Baldwin, 2004, p. 178). And in their contribution to the UK National Audit Office report, Hood and Rothstein (2000, p. 26-7) said this internal focus can lead to policy inactivity and the use of risk management as a ‘fig leaf’ to hide the failure to address systemic risks.

By adopting corporate models of risk management that are designed to protect businesses or corporations, community service providers are encouraged to focus on avoiding blame and their own specific agency risks. Shared, systemic and ‘whole of industry’ risks are left to someone else to manage, while organisations focus on blame, liability, reputation, the media and their competitive standing. Power (2004b, p. 17) describes these secondary or institutional risks as a ‘site of problematisation’ because they draw attention to issues that are also secondary to the agencies’ core functions, and usually secondary to systemic risks. While traditionally health and welfare providers have been focused on systemic risks as well as client risks, and have not seen institutional risks as their dominating concern, that perception is changing with the adoption of corporate approaches to risk management and the rise of the blame culture in public agencies and services.

(iii) Corporate risk management and its impact on trust between agencies

The corporate thrust of public sector reform in general, and risk management in particular, does not encourage high levels of mutual trust across different agencies. If anything, say Hood, Rothstein and Baldwin (2004, p. 178) it ‘was designed to make public organisations go in exactly the opposite direction’.

Hood and Rothstein (2000) also found risk management accountability measures and the regulation of standards can negatively impact on the readiness of services to innovate and collaborate with other providers to improve outcomes. This problem is significant in terms of trust and working relationships between agencies, and on professionals’ perception of the benefits and hazards of collaboration and partnerships, increasingly shadowed by the apprehension of being blamed if something goes wrong.
According to Douglas (1990, 1992) the centrality of risk is leading to a forensic approach to social problems and the conduct of services. As a result most helping professions now work in a system which perceives ‘every death as chargeable to someone’s account, every accident as caused by someone’s criminal negligence, every illness a threatened prosecution. Whose fault? is the first question’ (Douglas, 1992, p. 15-16). In this context of blame both regulators and the media require precision in the identification of who is responsible for adverse incidents, errors and professional misconduct. As O’Neill says the ‘new accountability culture aims at ever more perfect administrative control of institutional and professional life’ (2002, p. 46). Such conditions do not foster trust and collaboration between provider organisations and workers.

Two other but related problems have been identified in this project.

(iv) Risk management and the law governing professional malpractice and liability

The culture of blame, and the incentive to transfer risk, both arise from the legal, regulatory and administrative systems that manage both risk and accountability.

The law of negligence and professional malpractice always focuses responsibility on individuals and/or specific organisations. In a useful analysis of the regulatory and legal barriers to collaboration and inter-professional public practice in Canada, Lahey and Currie (2005) demonstrate how the law individualises accountability and creates uncertainty in the minds of professionals engaging in complex and integrated practice in the interests of their patients and clients. They conclude ‘there is a widespread consensus that structures for professional regulation, especially legislatively defined arenas of practice, are a barrier to a more integrated health care system in general and to interprofessional practice in particular’ (2005, p. 200). While this analysis is focused largely on the practice of medicine it is instructive for the way regulation and risk management constructs community care.

Effectively the legal enforcement of accountability through the law of negligence in health and welfare services is constructed on individual professional or agency responsibility. In situations of collaborative and multi-disciplinary service responses, Lahey and Currie found there is a probability that the courts will misallocate accountability among members of teams or partnerships based on ‘continuing reliance on traditional understandings of the allocation of work and responsibility among health care providers’ (2005, p. 198). Further, in professional malpractice matters, which involve highly specific processes for forensic examination of adverse incidents against accepted professional standards, collaborative work between providers may increase the liability of practitioners and reduce their capacity to protect themselves (2005, p. 212).

The impact of these common law approaches to negligence and professional malpractice is to create a high degree of apprehension among collaborating professionals and service providers about the processes of blame for adverse outcomes. This problem is compounded by the presence of agency specific risk management models, with different definitions, accountable requirements and procedures. Finally, longstanding habits of protecting practice domains further compound the problem in contexts where what is required is a sharing of responsibilities among providers and therefore the sharing of risk (Lahey and Currie, 2005, p. 201).

We return to this issue in the final chapter of this report.

(v) The problem of ‘acceptable’ risk

Finally, in community services and many other fields of public services, risk management has to work in the absence of agreed understandings of what are the limits of acceptable risk. While there is general agreement about duty of care and what constitutes negligence, there is great reluctance on the part of many parties to confront and agree on what levels of risk we can accept in community care. Acceptable risk, therefore, is usually defined by the media, public inquiries and the courts’ responses to high profile adverse incidents. In the meantime services walk what some called ‘a knife-edge’ in making judgments about acceptable risk.

The problem may be that it is not possible to define acceptable risk. There are just too many contexts and differences in events to be able to set some kind of standard. But as Parton (1998,
points out, by the late twentieth century, ‘our contemporary conceptualisations of risk have predominantly assumed that the world can be subject to prediction and control, and that rational systems of accountability should be constructed in case things go wrong’. Out of this framework highly rational and technical programs to deal with risk are constructed, adding to the expectation that all hazards can be controlled.

Corporate risk management strategies are generally based on a number of similar assumptions, including, for example, that uncertainty can be reduced or even eliminated with adequate knowledge; that dependency on human judgment can be mitigated, even replaced, by actuarial techniques and predictive instruments; and that rules and procedures can virtually eliminate the risks inherent in the decisions of workers (and clients) at operational levels (Lupton, 1999). These rational and technical constructions of risk are generally considered to be appropriate for many risky human endeavours, such as the production of chemicals, the mining of metals deep underground, the operation of sophisticated passenger aircraft and intricate surgery in operating theatres. In these contexts technical rationality prevails and there is little disagreement about community values and expectations, the competing rights of workers, service users and third parties, or the distribution of responsibility for the management and consequences of risks.

The problem is that risk management in many public services cannot be fully defined by technical rationality. Kemshall (2010) discusses this issue in the context of two very different risk rationalities. Business risk management models see the decision maker as being a rational actor ‘rooted in economic theory that sees risk choices as located in an economic rationality of cost and benefit’ (2010, p. 1248). The second rationality is that of the social actor, who is ‘seen as an adaptable actor, mediating social and personal constraints on their choices, and acting prudently within a situated rationality in which options to act otherwise can be severely limited by structural constraints and lack of power to act otherwise (2010, p. 1249). The community care professional bridges both these rationalities. Face to face with their client they must confront both the technical and economic rationality of formal risk management procedures and the situated reality of their client. In this territory there is often no agreement about what is acceptable risk. Some of the participants in this project articulate this dilemma in later chapters.

Reddy (1996, p. 236), argues that when the rational and technical approaches which work well in engineering or medicine are applied to social and ambiguous risk issues, they operate in a way which is ‘undemocratic’, in so far as they use scientific approaches for making decisions about issues that are essentially matters of judgment and values. In the absence of common understandings about the limits of community care for vulnerable people, and public policies about acceptable and unacceptable risks, public perceptions of risk in social care have generally been framed by high profile media coverage of worst-case examples of professional failure and systems failure.

Reddy claims that enormous costs arise from these rationalist approaches to complex social issues. He urges us ‘(t)o recover alternative and more humane conceptions of indeterminacy to substitute for the dominant scientific approach to uncertainty’ (Reddy, 1996, p. 230). In community care both organisations and professionals have to demonstrate rational and evidence based frameworks for making decisions, but at the same time the reality is that collaborative care for vulnerable and troubled people in unregulated community sites is radically uncertain, genuinely complex and contingent. In this context, therefore, the process of making decisions about contentious risk issues should be opened to a much broader discourse than one based on narrow technical, rationalist and corporate conceptions of risk.

In summary the conclusions of the internationally reputable researchers and theorists discussed in this brief historical review suggest that corporate approaches to risk can lead to a focus on avoiding blame, a failure to confront systemic risks, a reduction of trust between interdependent agencies, and the curtailment of innovation and/or partnerships as threats to corporate or professional reputation. Rothstein, Huber and Gaskell (2006) add the useful insight that primary and institutional risks ‘slide’ with each other, leading to considerable ambiguity as to which risk or risks are key to critical decisions. As providers see their institutional risk exposure increase, their capacity to respond to the risk taking preferences of their clients may decrease. Their practice
may become more risk averse and defensive, at the expense of the freedom and choice of their service users.

We return to these issues in the following Chapters 4, 5, 6, 7 and 8 as they emerge from our meetings with 166 participants from 30 different organisations.

CHAPTER 4

SERVICE PROVIDERS’ UNDERSTANDINGS OF ‘RISK’: THE INFLUENCE OF ROLES, RESPONSIBILITIES AND CONTEXTS

4.1 Introduction

We begin this chapter with a passage from an interview we conducted with David, a senior community nurse, who works on the frontline of a home-based nursing agency. Like other community nurses in our sample, David admitted going beyond the realm of his clearly defined nursing duties to help a client who was aged and frail, especially if there were no family members to provide support. In this passage, he explains how he weighs up the occupational health and safety risks involved in changing a light globe, a non-nursing duty that he is ‘not allowed to do’:

Going into a house and finding that the light globe has blown, the little old lady or gentleman… don’t have any family and they’re saying ‘but I can’t see what I’m doing in the evenings’, and so you sort of think - well it’s not rocket science to change a light globe. But if you look at the risk assessments there you don’t know what the wiring is like… whether you’re potentially going to electrocute yourself. So we are not allowed to do that… In the meantime they could get up at night time… and trip over something and break a hip and they’re in hospital, so for me personally - and I do not condone it in any way - I would change a light globe… So again, it’s a non-nursing duty, but it was something that I was able to help out with and was a five minute job, but again outside the realm of my role and responsibility. But you know if we can’t help a fellow human being and I see it as a low, extremely low risk, then I’m prepared to take that option.

David sees this ‘five minute job’ as an act of compassion – but he also sees it as risk-reducing in itself. The passage illustrates this worker’s resourcefulness and independence as a professional operating alone and exercising discretion. He calculates his options by undertaking his own ‘risk assessment’, leading to a decision to breach the policy based on both the probability of an adverse outcome and his own professional assessment of other issues involved.

One of the principal findings from our research was that perceptions of ‘risk’ varied according to participants’ roles and responsibilities and the particular contexts that shaped their day-to-day work and lives. This finding supports Peter Taylor-Gooby’s (2002, p. 110) conceptualisation of the ‘framing’ of risk in relation to the way in which it is experienced:

[T]he context in which the risk is perceived and understood exerts a major influence on the way people understand it and how they respond to it… the way people perceive things is crucially influenced by the context in which they are seen.

1 When quoting interview excerpts involving very personal views and understandings of an individual’s experiences and struggles related to ‘risk’, we have used pseudonyms as a storytelling device so as to invite the reader into the immediacy and intricacies of the participant’s private world. However, where the excerpts focus primarily on organisational policies, governance and risk cultures, and day-to-day work practices, we have not used pseudonyms. Hence, pseudonyms are used extensively in chapter 5, which analyses interviews with clients and family carers, and in chapter 6, which focuses on the way in which program managers and frontline workers negotiated ‘risk’ and risk management policies in their day-to-day work.
In the above example, David, a frontline worker, approaches ‘risk’ in terms of the wellbeing of a frail, aged client, focusing specifically on maintaining her safety and quality of life at home, and responds accordingly. He is highly conscious of having breached his organisation’s OH&S and risk management policies, noting later in the interview: ‘I’ve been told by my boss that I am not to do that [fix things for clients].’ David’s decision to change a light globe is seemingly influenced by several very particular contextual factors: his understanding of his professional ethics and responsibilities as a nurse, his identity as a senior nurse working independently, his relationship with his client, and also his gender (earlier in the interview, partly to explain his actions in changing the light globe, he describes himself as ‘very much a handyman’).

In contrast, David’s program manager is concerned primarily, though not solely, with risks to do with staff recruitment and retention – ‘the level of staffing required and the skill mix required in meeting the client need’ – and with maintaining the safety of staff:

> There are risks associated with constantly having an expectation of staff to work over and beyond the number of clients that might be seen as being safe, where they’re taking on additional clients because of the lack of staffing levels that we have... because the demand is so high, so to me that tends to put them at risk - the risk that they’re hurrying, when we’re already in an environment with driving a car etcetera.

This participant’s definition and analysis of ‘risk’ is specific to her role and responsibilities as a manager whose context is framed by staff shortages and ongoing difficulties in recruitment of nurses.

In this chapter and the following two chapters, we examine our participants’ responses from the point of view of their roles, responsibilities and contexts; i.e. how did they identify and interpret ‘risk’ in relation to their position in the organisational hierarchy? We consider the views of chief executive officers and senior managers, followed by those of program managers and frontline workers, clients and, finally, family carers. We also consider similarities and differences between the sectors of disability, aged care and mental health.

In a very general sense, chief executive officers and senior managers were most concerned with risks at the organisational level, especially those associated with financial management, funding, governance and quality systems, and the organisation’s reputation or public image. Program managers were most concerned about the risks involved in the actual running of their programs (e.g. recruiting and retaining staff, supporting workers in what was often described as ‘very demanding’ work, maintaining OH&S standards, operating within budgets), together with operational risks to clients and workers in the field. Frontline workers tended to focus on potential risks that could occur during home visits, and on a range of vulnerabilities and predicaments faced by clients. For the most part, clients interpreted risk in terms of their personal vulnerabilities and potential dangers that could arise in the context of their respective disabilities and illnesses. Consequently the risk management policies and procedures adopted by their services did not occupy a significant place in discussions of their experiences as service users. In contrast, family carers were frequently concerned that services’ strict adherence to risk management policies meant that the needs of their respective family member were not adequately met, whilst some others felt that services were not sufficiently protective or involved in the client’s care.

In the design of our interview schedules, we deliberately chose not to provide a definition of ‘risk’. Our aim was to give participants the freedom to define what ‘risk’ meant to them and to identify the range of risks they experienced in their day-to-day work or, from the perspective of clients and carers, in their interactions with service providers. These schedules are provided in Appendix 1.

### 4.2 Perceptions and experiences of risk among the Chief Executive Officers and senior managers

All Chief Executive Officers and senior managers reported an increased focus on risk and risk management over the past fifteen years, which required additional resources in terms of administration, time and funding. For most executives, the management of risk had become more formalised and central to their duties over this time. There were different degrees of risk
management formalisation amongst organisations, influenced in the main by an organisation’s size, access to resources and expertise, but also related to organisational culture, the Chief Executive Officer’s particular management style and philosophy, and sometimes the influence of risk, safety and audit committees or managers with these roles.

The impetus to formalising risk management strategies varied substantially. Often, the formalising of risk management had followed in the wake of an extensive review or audit of the organisation’s policies and procedures, its general operations and financial status. Most of the organisations had been involved in major reviews, generally taking place in the early 2000s. Some reviews were initiated by organisations themselves, whilst others were instigated by their primary funding agencies. In several cases, reviews were established to prepare for organisational re-structuring, or where a decision had been made to branch into new fields of endeavour such as diversifying their client base, adding new services or selling specialist education to other organisations.

Other factors influencing risk management formalisation included a need for greater accountability in financial management, governance, and occupational health and safety; the professionalisation of community services and increased competition for contracts, funding and staff. Over the past decade specific risk management arrangements have been built into legislative and regulatory requirements, reflecting the impact of tighter auditing processes and the increasing importance of accreditation, and a need to manage the organisation’s public profile in a climate of increased accountability and litigation. At the same time, the motivation to build an architecture for risk management also stemmed from a desire to avoid blame for adverse events from government, auditors, insurers, funders, regulators, the courts, the media, clients, advocacy groups and the general public.

**Institutional risks**

Whilst some chief executive officers and senior managers focused on discrete risks to clients, the overwhelming focus of their discussions was on organisational risks (governance risk, operational risk, financial risk and reputational risk), together with risks around managing the workforce – retaining staff and keeping them safe. In four of the 24 interviews, specific risks to clients were not mentioned, whereas in all interviews participants discussed a range of organisational risks and risks to worker safety. It must be pointed out that the chief executive officers and senior managers in our sample were not unconcerned with risks to their clients; rather, their concerns were interwoven into ‘higher-level’ issues about the organisation’s capacity to manage these organisational and governance risks.

These ‘higher-level’ concerns represent a relatively new and complex category of risks, described in the literature as ‘institutional’ or secondary risks - in contrast with ‘societal’ or primary risks (e.g. specific risks experienced by clients and frontline workers). Institutional risks also involve a range of dangers or threats that may be encountered by organisations through their management and regulation of societal risks (Rothstein, Huber and Gaskell, 2006, p. 92). All executives felt pressured to adopt a range of regulatory procedures, standards and quality frameworks as a means of protecting against the potential consequences of primary risks (see Munro, 2004; Power, 2004b, 2007).

In the context of the larger story of the rise of risk management, some form of monitoring and regulation became necessary as the state reduced its role in direct service provision and contracted providers from the voluntary and private sectors to deliver health and welfare services. Consequently, the state began to focus on ‘steering’ rather than ‘rowing’, to cite a much used slogan of the early 1990s (Osborne and Gaebler, 1992), and implemented a range of procedures to monitor and regulate both the quality of service delivered by these providers and their compliance with various public policy objectives. As Munro (2004, p. 1079) explains, over recent years the emphasis has shifted from direct auditing of organisations to a focus on their internal systems of checking:

[Contracted services] need to be regulated and policed and, increasingly, providers are expected to show evidence of self-regulation, through record keeping, protocols and
information processing systems. The public sector then audits these internal mechanisms of control, rather than studying the actual performance of the organization. In this way, it is argued, community-based services are taking more responsibility for the important regulatory roles traditionally carried by government. As noted earlier in this report, this form of regulation has been referred to as ‘responsive regulation’ (e.g. Braithwaite, 2000, p. 225), and aims to increase efficiency and accountability by relocating responsibility with the delegated services rather than the state.

In terms of institutional risks, Chief Executive Officers and senior managers focused largely on:

- Funding, itself increasingly volatile in the context of short term contracts and changes in government policy
- Financial management
- Governance and accountability systems
- Relationships with other agencies, including sub-contracting
- Reputation
- Recruitment and retention of staff

These institutional risks were also of great concern to many program managers, especially those directly responsible for managing budgets and recruiting staff. Therefore in discussing these risks we have included relevant data from the Stage 2 interviews with program managers. Only very occasionally did frontline workers provide examples of institutional risks when discussing the risks they experienced and dealt with on a day-to-day basis - and when they did it was in the context of risks to the public standing or reputation of their employing organisation.

Chief Executive Officers, senior managers and program managers from twelve organisations identified **funding as a risk**. It was of particular concern to participants from nine community service organisations (i.e. non-government organisations), the local government council, and two public health agencies, comprising an Area Mental Health Service and a specialist mental health service.

Since the greater proportion of the funding of community service organisations is derived from government grants, many participants felt extremely vulnerable in the face of changes in government policy and regulatory requirements, including changes of government itself. Some participants acknowledged that they may need to re-develop their services in different directions to ensure ongoing viability, such as broadening the range of services provided or selling specialist education and training packages to other organisations. The Chief Executive Officer of a small agency supporting clients with a range of disabilities from culturally and linguistically diverse (CALD) backgrounds, noted that the Howard government's shift away from 'multiculturalism', with its connotations of separateness, toward mainstreaming and associated notions of cohesion and unity, could threaten the future of CALD services. A senior manager from a metropolitan-based service providing support and home care to the aged expressed a similar sense of vulnerability concerning changes in government policy:

> Both our [two] major streams of funding are government funded, so a huge risk depending on the government of the day and the priority that aged care in-home support is given. At the moment it's putting people independently in their homes is a priority, however down the track things may change and it might swing around to the priority being residential facilities or whatever, and so yeah being reliant on the federal economy and all those sorts of things honestly is a huge risk to us.

Chief executive officers, senior managers and program managers from nine organisations identified **financial management, including the management of budgets**, as a major risk to their organisations. These organisations comprised five community service organisations, the local government council, and three public mental health services. The senior manager of an Area Mental Health Service commented that managing the budget was their 'number one risk'. He explained that poor financial management would generate other serious problems, including damage to the public perception of their service, which in turn could hinder their access to funding.
and their relationships with other agencies. Similarly, the manager of a home-based nursing agency cited ‘budget integrity’ as their major risk, heightened by increased demand for nursing services and increased acuity within their client group, which also meant that managing staff workloads was critical. As she explained:

The service demand has trebled... in the last year... so it’s the service demand and the type of demand, the acuity in the community is much heavier. We’re being asked now to look after people at home who even five years ago would have been placed in some form of care. So there are occasions where in fact we may send in two or three nurses to one client, so there’s high maintenance stuff going on with increased acuity demands.

To illustrate she gave the example of a son who had promised his mother she would never have to go into care; however, his mother’s health deteriorated to the point where three nurses were needed, partly to meet occupational health and safety requirements. To safeguard the budget, the manager negotiated with him and he agreed to fund the third nurse. The following excerpt reveals the pressures of interlocking financial, ethical and emotional considerations in the provision of community care:

In the end... we really worked very hard and very well with him to say, ‘I think the time has come - we want you to make that decision, but the time has come where I am not sure we can keep doing this.’ So there are issues around the family who have promised - ‘I won’t ever put you in care’. Sometimes we just have to call it a day – and it’s a struggle. We want those people to stay at home because they don’t want to go into care. They want to go into the right care if they go in and often there’s not a vacancy, so we sit it out and we wait and wait for the right vacancy to come up, but it’s a real struggle for us and the family and the son who’s promised... It’s an emotional tug of war sometimes.

What is striking about the analysis proffered by these two managers is the intersection of multiple issues that give rise to new organisational risks - changes in the severity of illness conditions, commonly referred to as ‘acuity’ by our participants, fluctuations in demand, the risks arising from working in partnership with other agencies and the importance of safeguarding reputation in these contexts.

Chief executive officers and senior managers from five community service organisations reported particular concerns about the nature of the governance and accountability systems they had in place to manage risks. These participants emphasised constraints in implementing reliable governance systems as a direct result of ‘infrastructure problems’, mainly due to limited finances or a lack of dedicated funding set aside for the emerging systems requirements necessary for effective governance. One chief executive officer of a support service for adults with physical disabilities noted that they were unable to audit as widely as desired because of ‘lack of funds’. The chief executive officer of a specialist disability service claimed that implementing risk management systems was costly, particularly in terms of administration, citing that 20 per cent of the budget was needed for administration whereas their funding department had suggested that 12 per cent was adequate. Participants from a large PDRS agency discussed problems associated with the organisation’s very limited infrastructure, particularly their lack of staffing in finance and information technology, including data protection. Recently they had felt the need to run a risk management workshop but found the consultants’ fees were too high and did not proceed.

These issues were not identified by participants from public agencies. Generally senior managers from public agencies for disability services and mental health reported that they had well-established infrastructure and systems in place for quality assurance, auditing and reviews, along with specific-purpose software to record, track and follow-up risks, access to lawyers for legal advice, and other resources. We have already discussed in Chapter 3 these uneven pressures on agencies and their differential capacities for risk management depending on size and government or non-government status, but stress this point again here as a major finding of our study.

The difficulties and challenges of working with other agencies, including subcontracting relationships, were frequently discussed. Problems could arise where multiple agencies were involved in a client’s care, notably because of the variation in standards, philosophy and
willingness to take on risks. Service delivery could easily become fragmented, a problem which worried a divisional manager from a large municipal council who recognised that a number of agencies could be involved without any of them gaining a ‘complete picture’ of the client and therefore not taking into account the overall situation.

Chief executive officers, senior managers and program managers from eight organisations - five community service organisations, the regional office of a government department and two public mental health agencies - were expressly concerned about risks that could arise from their relationships with other agencies. These concerns were generally twofold, relating to contracting practices and multi-agency care of an individual client. Some participants, particularly those from community service organisations, described the challenges and anxieties associated with their emerging roles as sub-contractors of services, in order to complement their own core services. In this context, they emphasised the unwieldiness of dealing with a range of funding sources from different levels of government which were usually uncoordinated.

The chief executive officer of a case management agency supporting aged clients, and adults and children with a range of disabilities, reported that her agency, which had funding from twenty-two sources or programs, was also involved in sub-contracting over two hundred provider organisations across the health, welfare, recreation, community transport, and home maintenance sectors. In addition, this organisation was itself subcontracted by at least twenty other providers purchasing their core service of case management. This chief executive officer described this system as ‘a nightmare for accounting and reporting’. Extensive resources were required to keep track of transactions and match invoices with services that had actually been delivered. Much of the complex contracting and sub-contracting, which occurs around home care and related specialised services, involves a web of interdependent relationships between numerous providers and case managers. Some of these providers are licensed or regulated, and some are only minimally regulated and have little capacity to manage their risks, which are now ‘shared’ with a wide range of partners.

The second area concerned tensions that could arise when multiple agencies were involved in the care of a client, especially when the agencies had conflicting or erroneous expectations of one another. A program manager from an Area Mental Health Service cited as a major challenge ‘working in with the PDRS services, getting them to provide the range of services that support us in helping people to make the transition through’. He also explained that their relationship with PDRS services was often complicated by reluctance on the part of both his staff and PDRS staff to share client information with one another because of concerns about breaking confidentiality:

    I’m of the view that we can share the information, that if we didn’t share information then that’s a bigger risk then if something goes wrong. And equally I’ve put it to those organisations that they should share information with us. They go and see someone and they’re presenting with an altered mental state… they should share information with us, but unfortunately the PDRSS - some of them have got a belief that client information is always privileged and that they are not in a position to share anything… because that would be betraying their relationship… you know this is a work in progress. I think we’ve got to shift that because we have to work together… to provide services to clients, and if people don’t share information about risk then they are doing a terrible disservice to each other.

Chief executive officers, senior managers and program managers from nineteen organisations highlighted the imperative to guard against negative publicity, making this the most consistently identified institutional risk across all the participating organisations.

The work of public agencies was seen as especially vulnerable to criticism or complaints in the media. The manager of a public disability service cited what he referred as the ‘Herald Sun test’ in terms of protecting his service’s public image:

    At the end of the day what’s this going to look like if it hits the front page of the Herald Sun and that is always in the back of your mind in terms of media interest and risk of exposure of negative publicity for the Department and the Minister… The driving focus or force that keeps us doing everything, the work that we do - that’s around getting good outcomes for
our clients and actually making a difference, but we have to be mindful that at the other end of that there's the sort of other political imperative around the services that we provide.

The aged care services manager of a large municipal council reported that many of its rate payers were under the impression that they were eligible for the council's home care services simply because they were rate payers. Therefore, he noted, it was critical for intake workers to explain very clearly the service's eligibility criteria in order to avoid conflict and reputational damage to the council:

If we're not managing the service well and providing customer service, certainly the customers and the clients will feel… disappointment with council. They feel very strongly, they're rate payers and they deserve a service and there's a risk of reputation… there's certainly an expectation of entitlement and that's where we have to be really clear about who is eligible and who we do prioritise and target the service to… And some of that's done at intake and referral, so we try and make sure the people taking the calls can screen appropriately and refer people on appropriately.

Similar sensitivities were reported by participants from most community service organisations. A senior program manager from a case management agency supporting aged clients, and adults and children with a range of disabilities, commented that 'it only takes one issue to blow up and an agency is ruined'. In another interview, the chief executive officer of a home-based nursing service highlighted the organisation's practice of countersigning all Guardianship applications made by staff in an attempt to prevent them from making statements to the court or tribunal that could be potentially damaging to the workers themselves and to the organisation. To cite a further example, the chief executive officer of a service providing support and home care to the aged described potentially damaging publicity that could flow from tensions between clients' wishes and the actual service that was provided, particularly in situations where clients and their carers did not fully understand the service's brief and limitations. These problems, coupled with significant grief and loss issues experienced by many of the relatives and carers of clients, who often transferred their emotions onto staff, had led this chief executive officer to consider setting up a counselling service for carers.

As noted above, several frontline workers highlighted the part they played in safeguarding the reputation of their organisations. The following excerpts illustrate the power of risk cultures (or 'risk thinking' as described by Rose, 1998, p. 177) in two workers' views of their roles and responsibilities, and illustrate how risk consciousness can be internalised by front line workers. These workers were acutely aware that their actions and the nature of their communication with other agencies could have serious ramifications for the reputational wellbeing of their employing organisations.

The first example comes from an interview with a senior case manager employed by a public disability service. This worker described herself as 'the mouthpiece for the department', acknowledging 'increased pressure' for frontline workers to 'keep up to date' in the contemporary environment of community care, to make sure they were 'providing the right sort of information' when discussing service provision with other agencies:

Especially if you know there's going to be a lot of difficult questions asked around service provision and resources… that you actually get the most up to date information, that you're representing the department on the right level because as a junior when you first come in, you think… ‘Oh yeah you'll be able to get outreach’, and then they come back and they go, ‘No – there's a wait-list and there's limited resources' and then you think, 'Oh heck'. So yeah, you live and learn, you try to be more informed and if you don't know answers, you outright say it, ‘Look I'm sorry, I don't know, I'll have to come back to you with that'. Because you don't want to give out incorrect information and put yourself at risk of representing the department in the wrong way too - answerable to management.

The second example comes from an interview with a senior case manager who was also a “team leader” in an Area Mental Health service. She described the range of responsibilities she had in protecting the reputation of the organisation:
When case managers are on leave for an extended period of time... auditing the case load, making sure that medication is adhered to, making sure that the client is being medically reviewed because in some instances, especially years ago, there were times where people would go on leave and the client wouldn’t really have any contact with anybody, and that’s a huge organisational risk, so maintaining contact and making sure that they’re getting their medication as a team leader... If you’re not monitoring [these things]... and if they become unwell, they hurt themselves, hurt somebody else, if there’s a suicide, a death, that reflects really badly on the organisation and that’s an organisational risk that we want to try and avoid... If we do need to face the coroner we can say... these are all the actions that we’ve made and we’ve made efforts in good faith in order to ensure that we’ve done the work to the best of our ability.

The majority of participants at all levels from both community service organisations and public agencies reported growth in the complexity of clients' needs, citing a range of related observations about these changes. The closure of institutions for adults with intellectual disabilities over the past fifteen years has increased the number of community clients with complex behavioural and communication needs. Homeless services have seen a reduction in the average age of their residents, along with higher levels of drug and alcohol misuse, behaviour disorders and other problems. Patients are ‘older, frailer and sicker’ when they arrive home from hospital as a consequence of shorter admission periods and early discharge planning. The manager of a large PDRS agency noted increased complexity of need amongst their younger clients, including ‘dangerous’ behaviours, new forms of drug use and involvement with the criminal justice system. The area manager of an Area Mental Health Service commented that drugs, particularly the increased use of ‘ice’, together with homelessness, had contributed to the increasing risks in their ‘changing client base’. On top of these issues, the ‘rationing’ of acute psychiatric beds means that higher levels of risk are now tolerated in the community, creating a heightened risk environment for services.

It is in this context that problems associated with recruiting suitably qualified and experienced frontline staff were seen as a critical risk by over half the participants with two participants from the mental health sector identifying this as their priority concern. Shortages of home care workers and nurses were frequently mentioned, as was the problem of inadequate training amongst direct care staff and varying standards across technical and further education courses. A senior manager from a public disability service, like several other managers, mentioned the problem of relatively poor award rates of pay compared with higher awards in other services or sectors. He also noted that the trend toward higher turnover of staff, with many qualified staff staying in jobs for only two years or so, created added difficulty in managing service demands because of the lead-time required to train workers:

The impact of staff turnover is underestimated because of the time it takes both in recruitment, training, this can be quite a complex role and it’s not something that new graduates are able just to walk in and do, there’s actually quite a bit of lead time and effort in terms of getting people trained up around the systems and processes and the nature of the requirements around just Departmental sort of stuff, that it actually takes a good solid couple of months before someone is able to confidently be managing a case load, so that time between someone leaving, recruitment, picking someone up can be six months and you’ve got a vacant case load with pressure.

Moreover, the increased complexity of clients creates difficulties in allocating ‘simple’ cases to new workers, as this senior manager observed: ‘there are no simple cases anymore... they’re all just complex cases’.

These powerful institutional risks were shared by executives across all three service sectors. However, some other risks were distinctive to particular sectors – but executives tended to define these as risks involved in actual frontline service delivery. Many such risks were often mentioned by chief executive officers, senior managers and program managers, as well as by frontline workers themselves. Generally, the further one moved down the organisational hierarchy the more differentiated the risks became across the sectors.
Distinctions in the nature of the risks encountered across the three sectors were closely tied to the ethical, philosophical, legal and professional frameworks underlying service provision in each sector. In mental health, risk assessment and risk management are informed by a clinical management framework. The medical paradigm is central to mental health care, and psychiatry is the dominant profession involved in care. Public policy focuses on early intervention and ‘treatment’, social inclusion (perhaps to a lesser extent than the emphasis in disability) and the reduction of stigma (see Victorian Department of Human Services, 2009). ‘Duty of care’ is framed predominantly in terms of clinical risks and clinical care, also with reference to the legal status of the client given that some clients are ‘involuntary’ under the Victorian Mental Health Act 1986. Clinical risks distinctive to mental health were usually described in terms of ‘risk to self or others’: that is, the risk of self-harm or suicide, and the risk of violence or aggression from clients as a consequence of mental disturbance. The threat of having to ‘front the Coroner’s Court’ was seen as the ultimate risk a worker would need to guard against, and there was much emphasis on having robust procedures in place to prevent future legal challenges (e.g. maintaining high standards of documentation in clients’ files).

In disability, normalisation theory has strongly influenced the concepts of ‘duty of care’, ‘dignity of risk’ and ‘person-centred’ service delivery (see Wolfensberger, 1972). Public policy focuses on social inclusion and social integration, specifically to enable people with disabilities to participate in the community with the same rights, responsibilities and opportunities as other citizens; and on the provision of individualised services to foster clients’ capacities to exercise choice and autonomy, thus leading to growth and change in their lives (see State Government of Victoria, 2002). In the disability field, tensions between ‘duty of care’ (to protect the client from potential dangers or harms) and ‘dignity of risk’ (to protect the client’s right to choice and independent decision-making) were frequently mentioned, particularly in the context of recent legislative requirements focused on individualised planning and service provision (see Victorian Disability Act 2006, ss. 5(3), 52 (2) (a)).

In aged care there is also a strong focus on duty of care and dignity of risk, and an emphasis on ‘ageing in place’. Since the mid-1980s Australian national and state governments of different political persuasions have adopted a common policy direction for aged care, focused on radically expanding community and home based services. This bipartisan approach has emerged from both the economic imperatives of population ageing, including the high costs of residential care, together with the increasing capacity of older people, including those with disabilities, to articulate their own needs and wishes. Consequently, over the last twenty years there has been a marked increase in levels of dependency, complexity and risk to be managed in the context of home and community care of the aged and people with disabilities (Draper, 2000; Duckett, 2007; Fine, 2005; Kemshall, 2002). It is in this context that OH&S regulations have become increasingly central in regulating the actual delivery of home-based care. The risks posed by frail clients and those with dementia, especially clients living alone at home, and the question of balancing the need for protection against the need for autonomy and independence, were issues of central concern.

4.3 Perceptions and experiences of risk among the program managers and frontline workers

As well as asking program managers and frontline workers what they identified as key risks, we also asked about the significant issues they faced in their day-to-day work; i.e. major concerns or challenges, matters that preoccupied or frustrated them (see Appendix 1). We wished to find out what was important to them in their jobs aside from the factors they deemed risks (i.e. potential harms or dangers). In this context an ‘issue’ was a matter of high priority, but not necessarily one involving explicit harm or danger; it could make service provision more difficult as in the case of recruitment and retention of staff. Some of the ‘issues’ raised were also identified as ‘risks’. The institutional risks identified by program managers and frontline workers (often seen by them as ‘issues’) were thematically similar to those identified by chief executive officers and senior managers, but focused more at the program level rather than the broader organisational level.
The major issues across the three sectors can be summarised as:

- recruitment and retention of staff
- lack of appropriate accommodation options for clients, including respite accommodation
- time pressures and increased workloads, especially increased administration
- concerns about government policy and funding
- managing budgets
- managing demand
- working with other agencies

The major risks across the three sectors can be summarised as:

- 'being on the road' - the unpredictability of other drivers and 'road rage'; the pressure to hurry to home visits because of delays with previous visits, including the stress of disrupting the day's schedule of visits; increased traffic on the road combined with increased workload; kangaroos on the road in rural areas; limited or absent mobile phone coverage in particular rural areas; fatigue from travelling long distances in rural areas
- unregulated nature of the home environment
- unpredictability in terms of what could eventuate during a home visit
- verbal and physical aggression from clients (and their families or associates)
- range of vulnerabilities experienced by clients
- increased complexity of clients, especially drug-induced presentations, behavioural problems and mental health problems

In the following discussion, we identify and explore the 'issues' and 'risks' encountered by program managers and frontline workers in each of the three service sectors.

**Mental health**

Participants from the mental health field worked as program managers and case managers in public agencies or in PDRS services. Most had university degrees, including three with post-graduate qualifications; the majority were social workers, along with several psychiatric nurses (Division-3) and clinical psychologists.

**Issues in mental health** - All but one program manager expressed concern over recruitment and retention of staff, particularly difficulties arising from an ever-diminishing labour supply of well-qualified and experienced workers. A program manager from a PDRS agency pointed out that a lower award rate of pay in the non-government sector created an additional disadvantage for their service.

Several program managers and frontline workers raised concerns about the shortage of appropriate services for clients. In rural areas reduced access to general practitioners (GPs) and recruitment of psychiatric registrars and consultant psychiatrists to country Victoria were major problems. Lack of appropriate housing and support options for clients were frequently mentioned.

Both program managers and frontline workers highlighted the need for good relationships with other agencies, particularly between ‘clinical’ (i.e. public) and PDRS services, and between ‘clinical’ services and GPs in rural areas. The GP was often the client’s first port of call in a rural area; living far from regional centres usually meant reduced contact with clinical psychiatric services and hence the GP was critical in managing risk and monitoring early signs of relapse.

Several participants from PDRS agencies were frustrated with what they saw as ‘inflexible’ service delivery by clinical services and government departments, explaining that they stuck too closely to bureaucratic rules and regulations and were too risk-focused and narrow in their approach to clients. At the same time these participants acknowledged that this was, at least in part, because of increased demand for clinical mental health services and that as a consequence these services had become focused on those individuals considered ‘most risky’.
Other issues included having to deal with crises occurring ‘out of the blue’ (which would then necessitate re-organising the day’s appointments and postponing contact with some clients); increased workloads, including requirements to complete additional paperwork; and engaging clients who might not want to attend services, especially those on Community Treatment Orders.

**Risks in mental health** - Clinical risks were deemed the most serious risks involved in mental health work, often described in terms of ‘risk to self or others’; i.e. the risk of self-harm or suicide and the risk of violence or aggression from clients as a result of mental disturbance. These risks were seen as inseparable from the work itself. As the program manager of a public mental health service commented:

> A mental health service is always going to have risky clients. It kind of goes with the turf really.

Most frontline workers and program managers highlighted the unpredictability of clients’ behaviours and several frontline workers provided examples of home visits where they had felt threatened and had exited the scene as soon as possible. Phoning prior to a visit would tell a worker only so much; the actual situation might be very different once the worker arrived. Risks were intensified for workers visiting alone; and all services had policies and procedures in place such as visiting with another worker or asking the client to attend the office as a means of managing identified risks; at times however service demand made it difficult for two workers to visit a client together, especially in rural areas. Risks were also intensified in the early stages of contact with a client when the worker was unfamiliar with his/her individual needs and relapse symptoms; this was more pronounced in rural settings where time between visits or appointments was likely to be longer than in metropolitan or regional settings.

In particular, participants mentioned the unpredictable and dangerous effects of substance misuse on a client’s mental state, which was even greater in the case of poly-substance use. Several also mentioned the powerful and disturbing effects of ‘ice’ (crystal methamphetamine), noting an increase in such presentations over recent years. The program manger of a PDRS outreach/support agency explained that the increased incidence of illicit drug use meant that services were now dealing with clients who were more complex:

> The clients that we’re getting referred… really have much more complex issues than I think was apparent when I first started in the field [some fifteen years ago]… There’s a lot more clients now that have a dual diagnosis so a mental illness and substance abuse issues. It’s highly prevalent now in our client group and really that dual diagnosis work is very much the work that we do.

The relationship between substance misuse and complexity was mentioned by many of the participants from mental health services.

Clients who were acutely psychotic might incorporate workers into their delusional systems and thus misinterpret the worker’s conversations and actions, culminating in potentially unsafe situations, so the worker had to be prepared for such possibilities. There was also a risk, particularly for case managers in public agencies, of breaching the trust that had developed between worker and client when it became necessary to organise an involuntary admission to hospital. As one case manager from an Area Mental Health Service explained:

> You may need to use an unwelcome use of force by way of police, not so much physical force but just the unpleasantness of having police come to the door and seeing, Well I’ve got no option - I’ve got to go and that case manager put me in. That can create some new risk when the person comes out of hospital because they may not forgive the case manager for making a professionally important decision for their health. So there’s a whole range of risks there.

In the context of running group programs, it was important to recognise that a client who was unwell or suicidal could have an unsettling effect on other clients, especially those whose mental states were fragile, thus causing them to ‘decompensate’. Several PDRS workers in these settings emphasised the need to be mindful of group dynamics and ‘boundaries’ between clients.
Beyond symptom-based clinical risks, several participants described a range of more insidious or pervasive risks faced by clients, largely because of their disadvantaged position in society, often referred to as ‘social exclusion’ in the literature. A program manager from an Area Mental Health Service explained that clients were vulnerable in terms of ‘exploitation from others’ and also as a consequence of living in areas ‘where the crime rate is higher and where they come into contact with people engaged in criminal activities… they’re at risk of being unemployed and falling into… dependency on government benefits, dependency on third parties to fill their life with meaningful occasions’. A case manager/psychiatric nurse from the same service explained that her rural clients were ‘socio-economically quite disadvantaged in terms of all services’, including acute health services and that this could lead to further risks:

Their physical health can sometimes deteriorate and that can lead to… deterioration in their mental health… A lot of people have moved to remote areas… because of cheap housing, because of their illness and the fact that they have some paranoid symptoms and would prefer to be more isolated… the risk is then that they withdraw further and further and… the multiple risks around that of becoming withdrawn, of not caring for themselves, of not being able to access services and just living a really diminished sort of life.

Risks emerging at the interface of the mental health service system and the housing sector were also seen as bringing a strong element of instability into clients’ already disadvantaged lives. A case manager/social worker from an Area Mental Health Service, who has over twenty years experience in public mental health, remarked on the lack of secure accommodation options for many of their clients and what she saw as increased tolerance of risky situations:

It’s not uncommon now for people to be discharged from an inpatient unit… into some form of emergency accommodation. That wouldn’t have happened twenty years ago… So we’ve got a focus on risk but at the same time people aren’t necessarily alarmed that their clients may be living in unsafe housing…[in] private rooming houses… there might be four or five different people who are strangers living there, many of whom have drug and alcohol issues… assaults occur, people’s belongings are stolen, their medication may be stolen and it’s really not conducive… to good mental health and yet people will be living there because there’s nowhere else for them to go… so that’s a significant problem but there’s a level of acceptance of it…

I had a client last year who was living in one of these emergency accommodation houses… She was physically assaulted when she was staying there and someone took her money and her mobile phone and her prescribed medications, one of the other residents of the house. She came here and she had noticeably been bashed, you could see a black eye and bruising; she was too scared to go back there, understandably. I rang X [non-government agency] on her behalf to find her alternative accommodation and all they could do was find her a room in another one of these houses in a slightly different location that may or may not have similar tenants. You’re not to know until you’re there, so that’s an unacceptable scenario that really had a very negative impact on her mental state and I spent about half a day trying to find alternative accommodation and that was the best we could come up with.

The risk of ‘burnout’ was mentioned frequently by frontline workers and program managers. A clinical psychologist from a specialist public mental health agency talked about the experience of ‘vicarious trauma… hearing terrible things’ on a regular basis, maintaining that it was ‘a risk to your own mental health and to your work’. Several very experienced workers identified the need to manage one’s anxiety because clients could easily detect fear and lack of confidence on the part of workers, which may in turn heighten the riskiness of certain situations. As a senior support worker from a PDRS agency explained:

I think it can almost become a self-fulfilling prophecy if you actually go into situations feeling really kind of tense [and] … looking for the worst case scenario in every single thing… To go into things with a slightly more ‘she’ll be right attitude’… can work in our favour…I think particularly, often because people with mental health issues are psychically quite sensitive. You know that thing where they say to draw parallels with animals… like if you are frightened around a frightened dog it might actually pick it up [and]… attack you… And I think
that sometimes...in these sort of situations where you’re collecting a lot of kind of unconscious material... it’s sort of like... if you’re really kind of anxious people know it.

Participants identified two specific risks that might arise as a result of the documentation of client information. First, a number of frontline workers were deeply concerned about the potentially damaging consequences of ‘high risk’ classifications in clients’ files. These classifications could prejudice workers’ attitudes long after they ceased to have any relevance, as an outreach worker from a PDRS agency noted:

> When it's in that file and following them around... a lot of Chinese whispers happen 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... it might cost people access to services that they might desperately need and depending on how you unpack it could be a risk to them.

Second, in a different vein, several participants discussed the importance of ensuring that case notes were up-to-date, comprehensive and accurate. Not only was this seen as critical to the overall quality of service provision, but necessary in protecting the worker’s professional integrity and the organisation’s reputation in the event of a future legal challenge:

> The use of the file is often held up as a very important tool because it’s going to be the only thing that really matters if it [the incident] goes to the Coroner’s Court... what action was taken, what did you do, why did you do it, can practice be justified, what plans were in place relating to this incident? ...So the use of professional note taking is highly important... if you look in someone’s file and they haven’t seen a doctor for eight months and they died and partly because of the side effect of the medication, you haven’t got a leg to stand on (case manager/social worker, Area Mental Health Service).

In summary, the diverse range of risks discussed by these participants, particularly clinical risks and risks associated with the increased incidence of dual diagnosis (as reported by the majority of participants), along with risks intensified by limited housing options, illustrates the challenges and pressures brought about as a result of deinstitutionalisation and the shift to models of community care.

**Aged care**

Participants from the aged care field were employed in agencies providing nursing care in the home, supported housing, in-home support (domestic assistance, personal care, respite care), and case management. Most program managers and frontline workers from case management agencies were qualified social workers and one was an occupational therapist. The other agencies employed Division-1 nurses and direct care workers, also referred to as ‘community care workers’. Several agencies had made TAFE qualifications mandatory for their direct care workers (e.g. ‘Certificate Three in Aged Care Work’; ‘Certificate Three in Home and Community Care’) whereas others relied primarily on in-house training.

**Issues in aged care** - All program managers, apart from one, were concerned about ongoing recruitment and retention of staff, especially in view of diminishing reserves of Division-1 nurses and direct care workers, together with an ageing workforce. In this context, some program managers were also concerned about the added strain that low staffing levels placed on workers having to cover extra shifts. Other concerns at the program level included managing service demand appropriately, the rising costs of service provision, operating within budget constraints, and maintaining occupational health and safety standards in order to protect workers’ safety.

Major concerns expressed by direct care workers centred on manual handling, the risk of accidents in clients’ homes and the very ‘emotional’ nature of the work, particularly stress caused by a client’s death. Several Division-1 nurses and program managers were concerned about the changing nature of their client base, characterised by a greater proportion of younger clients, many of whom had mental health problems (a consequence largely of the closure of psychiatric institutions), and an increase in drug-related psychoses and/or behavioural disorders. They emphasised a need for more psychiatric nurse consultants within their system and closer working relationships with mental health service providers. In addition, these workers mentioned the
challenges involved in caring for a population of older frail clients with greater ‘high care’ needs, who would have been placed in residential care in the past.

Both program managers and frontline workers were troubled by limited resources; e.g. inadequate funding for aids and equipment, and a shortage of respite options for families caring for a person with dementia. Again, as in other fields of work, time pressures and high workloads, including additional paperwork, were reported by frontline workers.

**Risks in aged care** - Risks associated with manual handling, along with the physical and repetitive nature of home care work, were noted by most participants, particularly direct care workers. Such specific risks included back strain from lifting equipment and shifting heavy furniture in the home, washing floors, kneeling and squatting actions required to put on a client’s shoes, and shoulder injuries to nurses as a result of the repeated opening and closing of car doors during a shift requiring many home visits.

Environmental risks associated with clients’ homes were mentioned by most participants, especially community nurses and direct care workers. These included mats that presented a slipping risk, frayed cords, malfunctioning equipment (e.g. irons), clients or others smoking in the home, pets in the home, and houses not clearly numbered which could compromise workers’ safety during evening shifts. The poor condition of many clients’ homes was frequently mentioned, including old bathrooms in a bad state of repair, cramped bathrooms with little space to safely assist the client in the shower, old hot water services that were hard to adjust to the required temperature, rotting verandas and slippery paths.

Program managers and frontline workers from home-based nursing agencies identified ‘no go’ zones - areas considered too dangerous for sole workers. For the most part these were public housing estates, and two agencies had contracts with security firms to escort sole workers into these properties late at night or whilst ‘on call’ over night.

Several nurses discussed the risks involved when young or inexperienced nurses did not have the skills to deal with clients who were aggressive:

> It’s about being able to defuse situations as opposed to escalating them and a lot of the young staff, I think the fear factor can prevent any normal sense of trying to deal with a situation or the fear factor is they’ll actually inadvertently worsen the situation by the type of response and things like that (program manager, home-based nursing agency).

> There are a lot of younger nurses who don’t necessarily have a lot of experience behind them and who may perceive anybody who acts a little bit strangely as being threatening where they may be quite safe but they don’t know that, so they may be scared of going to particular houses and it’s not often the client, it may be the spouse or children, or parents, somebody else in the house (community nurse, home-based nursing agency).

All frontline workers and most program managers identified unpredictable behaviours of clients and others in the home as a major, though infrequently experienced, risk. Several female workers had been confronted by inappropriate sexual remarks and touching by male clients; in each case these episodes were resolved by the respective agency. Clients with dementia could be ‘volatile’ and verbally aggressive, particularly when frustrated by their communication deficits. One direct care worker from a service providing support and home care to the aged had experienced a situation where a client tried to get out of the car whilst she was driving; and others reported verbal aggression from clients with mental health problems. The first meeting with a client could be especially unpredictable as this community nurse from a home-based nursing agency explained:

> Even though you’ve had that communication on the telephone, quite often you’ve got no idea what you’re going to be coming up against. It could be a relative that they have not mentioned who has schizophrenia, who is unstable… you can go and do a risk assessment on a house and things can change either whilst you’re there or twenty-four hours later. You can go back the next day and you can be confronted with something that was never picked up at your first visit [and] has been brought in either by a relative who’s come to stay and they’ve bought their over-hungry Newfoundland or whatever.
Workers were concerned about the vulnerability of particular clients living alone at home, especially those who were very frail or cognitively impaired and had little support outside the service system. They might accidentally over-use medication, neglect their nutritional needs, smoke in the house, leave the gas on, or leave the home unlocked. They might also be at risk of falling or tripping or at risk of financial exploitation from their families or unscrupulous others.

Finally, within the broader context of an ageing population, the range of risks discussed by these participants reflects the growing emphasis on providing aged care in the home and facilitating individual choice and autonomy for clients who, in the past, would have been ‘admitted’ to some form of residential care.

Disability
Participants from the disability field worked in a range of generalist and specialist services covering physical disability, intellectual disability, acquired brain injury and criminal justice. The qualifications of disability workers were more diverse than those in aged care and mental health. All case managers and most program managers had tertiary qualifications, including social work, welfare and nursing, and several had completed generalist degrees (e.g. BA, BSc) before entering the field. Some of the direct care workers had TAFE qualifications. All agencies offered in-house training and short courses or seminars conducted by accredited training organisations.

Issues in disability - As in the mental health and aged care sectors, program managers in disability identified recruitment and retention of staff as a major issue.

Several case managers mentioned that they often felt pressured by the very high expectations placed on them by clients and their families. This was heightened by insufficient resources, including availability of funding packages and appropriate housing for clients, especially for those with offending backgrounds. Situations could also arise where workers and clients' families had different perceptions of what was needed; in some cases the family might want something different from the client. In the context of risk management, there were occasions when family carers did not perceive the environmental risks identified by workers as worthy of attention. Such issues were usually resolved by the worker explaining why a particular aspect of the home environment might be risky; as noted by a team leader:

> If it's bad flooring, it needs to be worded in a way that they understand that everybody is going to be put at a risk... Quite often the biggest hurdle for us is actually trying to get the people that we support or their families to see where we're coming from with risk.

Changes to work practices as a consequence of new legislation, namely the new Victorian Disability Act 2006, and new client information systems were also identified as particular challenges. Again, as in mental health and aged care, frontline workers reported time pressures and heavy workloads. In that context, several participants highlighted the effect of increased paperwork and administration. One case manager from a service supporting aged clients, and adults and children with a range of disabilities, felt that the demands of paperwork took her away from direct client work:

> You can’t fit it all in... sometimes I feel like we’re doing more admin than anything… so you try to balance wherever you can, but sometimes it's like – well, do you want me to see this person or do you want me to do that a bit of paperwork?

Reiterating that the 'administrative requirements' of case management created ‘a volume of paperwork’, a program manager from the same agency commented:

> People go into case management because they want to help people have a good life... And what they find is they have this much time [gesturing] actually interfacing with the participant... and 80 percent of their day is negotiating stuff [with other agencies, funding bodies etc].

Risks in disability - At the organisational level, several program managers and frontline workers identified their agency’s public image and the management of contracts with other providers (including the need to ensure that invoices were correct and all providers had undergone police checks) as major risks, along with risks associated with the growth of an organisation. Under
conditions of rapid growth, as noted by a program manager from a case management service that supports aged clients, and children and adults with a range of disabilities, it was important to ensure that supervision and management structures were in place and that policies and procedures were developed and revised as appropriate.

As in mental health and aged care, most disability workers mentioned the unregulated nature of the client’s home environment; the unpredictability of clients’ behaviours, including verbal and physical aggression; and increased risks occasioned by visiting a client and his/her family for the first time:

Some of the people that you deal with, especially criminal justice issues and stuff like that, they might come into the meeting fairly happy but then they might change and decide that they’re not happy with something else and it might not even be related to you or what you’re doing, and then escalate into sort of aggressive behaviours (case manager/psychiatric nurse, government disability service).

Because a lot of my clients do have anger management issues and drug and alcohol issues, I’m always running the risk of if I go and do a home visit with them, I’m at risk because I am on my own (case manager, government disability service).

So the unavoidable risks are that we have to meet with people whom we don’t really know… and I don’t necessarily just mean the client, it could be anyone around the client… you are stepping into a new world each time you are stepping into a new case and you never quite know what you’re stepping into (program manager/psychiatric nurse, government disability service).

Clients with an acquired brain injury were identified as particularly unpredictable and challenging because of their low frustration tolerance, potentially volatile behaviours, and their impaired understanding and retention of information provided by workers:

When somebody gets an acquired brain injury we find it challenging to know that we’re actually providing them with what they want because with an ABI, people can often confabulate a lot, they can change the goal posts a lot on what they want and change their mind from week by week… a lot of the people we support are still users as well… they can be as high as a kite or they can be affected by alcohol… it is really difficult to provide services and to ensure that people are given an informed sort of choice with what’s going on (program manager/psychiatric nurse, government disability service).

A number of workers also mentioned the risks involved in transporting clients whilst they were substance-affected and thus unpredictable.

In contrast with mental health and aged care services, disability services had a more explicit focus on clients’ ‘dignity of risk’ and the positive role of risk in the delivery of ‘person-centred services’. We are not suggesting that other services were not client-centred; rather, disability workers used this terminology frequently when discussing their roles and interactions with clients. Several program managers and case managers talked about the need to balance ‘dignity of risk’ (the client’s right to choice and independent decision-making) with the worker’s ‘duty of care’ (to protect the client from potential dangers or harms). Often situations were not clear-cut and there was a ‘fine line’ in negotiating the two.

As a consequence of the recent State government adoption of the approach known as ‘person-centred planning’, as outlined in the *State Plan for Disability Services 2002-2012* and the new *Victorian Disability Act 2006*, agencies were in the midst of developing and implementing person-centred plans. The program manager of a day program for adults with physical disabilities described the introduction of the person-centred approach as a ‘paradigm shift’:

It’s a move not only from groups to individuals but from, if you like, providing care for people who are dependent to trying to support people to be citizens in the same way you and I are citizens - so a huge shift.

The risks that might arise from this philosophical shift were not always obvious given its recent *formal* introduction. A program manager/psychiatric nurse from a government disability service
talked about the risks involved for clients making the transition from supported accommodation to independent living:

A lot of times that transition to independence increases vulnerability to exploitation, a less than standard lifestyle, poor choices of friendship groups... and I guess that individual may or may not have norms to compare things to, so that’s a fairly significant risk.

In terms of specific risks experienced by direct care workers, manual handling and lifting were mentioned – lifting wheelchairs in and out of cars, helping clients into cars and ‘transferring’ clients according to occupational health and safety regulations. One direct care worker from a support service for adults and children with disabilities highlighted the risks brought about by ‘walking into blind shifts’; i.e. covering sick leave without receiving an adequate ‘handover’ of the clients in the facility. A program manager of a day program for adults with physical disabilities discussed the ageing of direct care workers and the wear and tear on the bodies of those who had worked in the field for many years.

As in mental health and aged care, most disability workers acknowledged the risk of burnout and the ‘stressful’ nature of their work. The frustration of not being able to affect positive outcomes was mentioned by several workers, related in the main to the client’s social situation, history and personal capacities, and limited social resources.

Participants reported a number of risks faced by their clients. Clients who used wheelchairs could experience problems manoeuvring them in certain situations (e.g. over guttering where the ‘lip’ was too high); and unless well maintained, a wheelchair could malfunction. In the context of person-centred planning, a direct care worker from a day program for adults with physical disabilities noted that when facilitating an outing of the client’s choosing, it was imperative to check first that the venue was wheelchair-accessible so as to prevent disappointment or a sense of ‘failure’.

Again, as reported by mental health and aged care workers, some clients faced risks from smoking and from poor hygiene. Clients could also be vulnerable to exploitation, as pointed out by a case manager from a service that supports aged clients and children and adults with a range of disabilities; e.g. being ‘signed up’ for credit cards and mobile phone contracts by door-knocking salespeople when unable to afford the cost. At the same time failing to recognise the context of a client’s behaviours could generate heightened and unnecessary degrees of protection and risk aversion, resulting in restrictions on the person’s quality of life and access to the community:

It’s then part of their profile, which then perhaps negatively, significantly, over a longer period of time... carries a lot of weight and follows them for a long, long time and often is only added to, rather than taken away (case manager, government disability service).

Finally, the diverse range of risks discussed by these participants reflect the impact not only of the recent historical shift from institutional to community-based care, but also the emphasis on person-centred service delivery and social inclusion within the disability sector.
5.1 Introduction

One of the major aims of this research project was to explore how workers actually dealt with the risk management policies and procedures of their respective services; specifically:

- To investigate the processes by which the practices and technologies of risk management have been taken up and translated into the practices of community service organizations.
- To examine the ways community services, professionals and clients adopted and adapted risk management to service goals and ideals.

How did the frontline workers and program managers we interviewed experience ‘risk management’ when providing services to clients? Did they feel that risk management policies and procedures facilitated their day-to-day work, or did they feel constrained by them? Did they feel that these policies and procedures had any effect on clients’ needs, desires and aspirations, and on service outcomes? We developed the concept of ‘risk rationality’ in order to think about the ways in which these participants interpreted and negotiated risk management policies and procedures in their everyday practices and how they felt about them. The term ‘rationality’ was used to encapsulate the complex, active and sophisticated reasoning processes that workers engaged in when analysing and identifying risks and making judgements about clients’ situations.

Several interview questions were particularly useful in determining workers’ risk rationalities. These included questions that focused on the major risks encountered in one’s work, perceptions as to whether risk management requirements had affected service delivery to clients, and whether the worker had experienced conflict between the organisation’s risk management requirements and the needs and desires of clients.

Three different risk rationalities - modes of adaptation to the employing organisation’s risk management requirements - emerged from the analysis of our interviews with frontline workers and program managers: a positive’ rationality, a ‘critical’ rationality and a ‘compliant’ rationality. We categorised participants as follows:

- **Positive rationality**: 19 professionals and 7 non-professionals
- **Critical rationality**: 13 professionals
- **Compliant rationality**: 4 non-professionals

The positive rationality was expressed by both professionals and non-professionals (the latter included four managers, a team leader and two direct care workers). In contrast, the critical rationality was expressed exclusively by professional staff, and the compliant rationality was expressed exclusively by untrained or non-professional workers, namely ‘direct care’ workers or ‘community care’ workers.

It must be emphasised that these rationalities did not reflect discrete categories of experience, but rather broad tendencies in the way ‘risk’ and risk management policies and procedures of the work place were thought about and negotiated. A further ten participants expressed a ‘mixed’ rationality, which incorporated elements of both the positive and critical rationality. These participants highlighted the positive aspects of risk management policies and procedures, but also acknowledged certain constraints that such requirements imposed on their practice.

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2 We defined professional workers as those with discipline-specific qualifications such as social work or psychology, or generalist qualifications (e.g. several case managers had B.A. or teaching degrees), whereas non-professionals were those with TAFE qualifications (e.g. ‘certificate’-level courses) and those without any formal qualifications or training (including several managers who had extensive experience and had worked their way into relatively senior positions in the non-government sector without the need for formal post-secondary education).
Nevertheless we identified several key characteristics that differentiated the three rationalities. Not all characteristics relating to the respective rationality were present in every interview and some participants emphasised particular characteristics over others.

Participants with a positive rationality saw risk management policies and procedures as ensuring safety for both workers and clients, and as fulfilling quality and accountability requirements for the respective organisation. In the main they were not troubled by the need to comply with risk management policies and procedures and did not resist them. Some participants argued that these policies and procedures actually strengthened their practice, made them more reflective and creative, and more responsible and accountable to their clients. Generally participants tended to see the obligation to carry out these policies and procedures as congruent with their professional values and ethics. From this perspective risk management activities were integrated into their professional practice and professional identities.

On the other hand, participants with a critical rationality tended to view risk management policies and procedures as constraining their practice, particularly in terms of disrupting the worker’s capacity to develop trust and rapport with the client. These participants often expressed antagonism towards specific risk management requirements, which they saw as adverse to clients’ needs and as creating a range of new risks associated with reduced quality of service. Several admitted to breaching risk management policies in order to provide clients with a more therapeutic and needs-based intervention than that permitted within the confines of agency policy. Generally these participants saw these policies and procedures as antithetical to their professional values and ethics. From this perspective risk management activities were experienced as external to professional practice and professional identities. However, it did not follow that participants with a critical rationality eschewed risk management as such. They had their own very individual and carefully considered perceptions of what risk meant and how best to manage it within a given situation. They were still actively involved with risk, often conformed to formal requirements, but their sense of professionalism and commitment to clients was strengthened by their critical and more independent approach to risk.

As noted above, the compliant rationality was expressed exclusively by non-professional workers, usually designated as ‘direct care’ workers or ‘community care’ workers. These participants conveyed a largely unreflective, rule-bound stance towards risk management policies and procedures which, in the context of their day-to-day work, primarily involved occupational health and safety rules and regulations. They expressed a strong habit of obedience to their employing organisation. Through their interviews they argued that risk management rules and regulations ensured high standards of safety for workers and also for the clients and carers for whom they provided home-based support. Some workers specifically mentioned that OH&S policies and procedures were crucially important in safeguarding workers against back injuries, noting that many workers had developed longstanding ‘bad backs’ in the past without this protection.

5.2 Expressions of the ‘positive risk rationality’

This section is organised around three aspects of risk management in frontline practice that offered the most exemplary expressions of the positive risk rationality:

- formal requirements to complete risk assessment screens
- negotiating risk management procedures with clients and family carers
- supporting positive risk-taking by clients in the provision of individualised care

Formal methods of risk assessment were seen as strengthening professional practice - Documenting the degree of risk posed by service users has become standard practice over the past fifteen years, particularly in mental health services (Rose, 1998, pp. 180, 184). Allan, a case manager/social worker with five years experience in public mental health, explained that his workplace policy required all case managers to complete a ‘risk sticker’ each time they had face-to-face contact with a client. (This form comprises a tick-box format to rate the level of risk - absent, low, medium, high - and space to elaborate on the particular risk, if applicable.) Allan
embraced this technology enthusiastically, explaining that it forced him to think more consciously about the subtleties involved in different manifestations of risk:

The very fact that I have to fill out a risk sticker - it forces me to bring into my thinking elements of risk because if you get to know a client and you get to know them well and you feel very comfortable, then sometimes you can miss the cues because you’re used to the conversation. Like I’ve got a fellow who says, ‘oh I just want to die, I feel like jumping off a bridge’ - but he says that every single time and he has for the last eighteen months and then in the next breath he’ll say, ‘oh yeah and what are we doing next week, are we going out for coffee?’… But another person might say, ‘oh I just feel really lousy’ - and for them to say that when they haven’t said it for six months means that they are really at risk, and having this framework that’s in the back of your mind it does I think sort of raise a level of consciousness towards risk issues… I do need to take into account risk probably more than I would if I didn’t have that as a constant reminder. Now because I come back to the office and I’ve got to read those questions, I’ve got to tick those boxes - and hang on a minute you know just because so and so said this every home visit for the last six months, should I just ignore it - I still need to think through and so I do think that the requirement to manage risk does shape the way I practise. And my experience in the organisation is that it’s been largely positive and not constrictive. It’s been a learning approach (Allan, case manager/social worker, Area Mental Health Service).

Allan also observed that he was a more reflective practitioner as a result of using the risk assessment tool: ‘Anything that makes a clinician think about their work and how they practice is ultimately a good thing… and it gives a better chance for good outcomes’. In effect, he has taken what could be experienced as a routine administrative procedure and adapted it to enhance his own reflective practice as a professional.

In a similar vein, Sonia, a psychiatric nurse employed as a case manager in a government disability service, felt that risk management policies and procedures made workers more reflective and thoughtful: ‘it just gives you more awareness and makes you more alert to what you’re doing and how you do it’. She also explained how these policies and procedures had heightened workers’ awareness of the potential risks involved in making home visits, suggesting that practice and safety standards, along with team cohesion and camaraderie had improved as a consequence:

We’re a lot more aware now of assessing our environments and our clients… eight years ago we used to just drive off, go and visit people out in their homes and not even think twice about it. Not even think what could be the risk - even from an aggressive dog to a gun behind the door to being out in the middle of nowhere with no way of contacting people or even thinking, you know someone’s got a late visit and no one’s going to be waiting for you at home, so who checks to see that they got home? Whereas now, it’s more we as a peer group, and if we know that somebody’s going on a home visit… we check with them and say, ‘are you right, are you going to get home at the time you think you’re going to get home, do you need anyone to call you?’ And we do all that double-checking now. We openly talk… in discussion with our supervisors, ‘should we make a home visit or should we call them into the office… what’s the feeling about that?’ Yeah, there’s a lot more discussion, there’s a lot more thought put into what you’re doing.

Helen, a case manager/social worker from an agency that supports aged clients, and adults and children with a range of disabilities, explained how OH&S policies had made workers ‘a lot more accountable’ to their clients and ‘more conscious’ of potential risks in clients’ homes. She related a situation in which she had intervened to create a safer environment for a client and his elderly parents:

I think just being conscious again of the environment, conscious that it’s someone’s home but it’s also someone else’s workplace… so that where we work is okay and going into someone’s home… making sure that we eliminate as many risks or as many OH&S risks as we can and you know again, making them conscious to the person… I was visiting someone and their son was in a wheelchair. Now their son only came home once [per week], Friday night he came because he lived in a nursing home and he went back Sunday
night and what they had was a step… but they had two planks of wood and that was it for the wheelchair to go up… and it wasn’t secured - and Mum and Dad were quite elderly and frail so it was quite scary and plus when he got out of the wheelchair to even sort of help - because the Dad could no longer push him - he was sort of holding on the wall because there were no handles, no nothing. I thought, ‘Oh this is so dangerous for him to walk because if he fell, they would definitely need an ambulance to help pick him up plus potentially broken bones etc’ - so as simple as getting an OT out there, we got them a portable ramp, a proper secured ramp, got someone in to bolt it down… And then we got a handle to go from basically where the ramp started to inside to the front door, so if he chose to walk at least he’d have something to hang on to rather than the wall and because the ramp was quite secure, Dad then found it a lot of easier rather than two pieces of wood to wheel him up. So I suppose always being conscious [of the client’s home environment].

The excerpts from these three interviews show the reasoning processes that these workers engaged in when analysing and negotiating particular risk management policies and procedures in their day-to-day work. These three participants argued that such formal ‘risk’ requirements heightened their consciousness of risk issues and thus made conditions safer for both workers and clients and ensured greater accountability to their clients, leading to enhanced standards of practice.

Negotiating ‘risk management’ with clients and family carers was seen as strengthening relationships between worker and client - Some workers argued that relationships of mutual trust and respect between workers and clients often helped to create a shared experience of problem-solving around identified risks. At the same time, the need to consider risk in one’s day-to-day practice also provided an opportunity or pathway into developing relationships of trust with clients and their family carers.

Several community nurses highlighted the importance of educating clients about risks for both themselves and the workers visiting them at home. Andrea, a community nurse in a home-based nursing agency, explained how she might approach a situation where a client was reluctant to have a smoke detector installed:

You would speak to your line manager who would then have to use a bit more influence with the family members to explain the risks to that person… and you would hope that sense would prevail. And if there’s no family member you’d speak directly with the client. Alternatively if there’s a case manager, then that case manager would be contacted and they would be doing that liaising with the client and the family member mostly. I mean generally people are fairly good when a safety issue like that is brought to their attention. They’ve often just not even thought about it.

Jenny, a team leader from a support service for adults and children with disabilities explained that the imperative to manage risk actually strengthened the relationship between worker and client because it forced her to think very carefully about how to raise particular risk issues sensitively and ethically with clients and their families. She felt that this rendered her more reflective and self-conscious about her practice, and thus enhanced her interpersonal skills and communication:

The risk management stuff [is]… part of everyday conversation that you have with families… ‘Is everything okay, do you feel that everything is going okay, do you feel that everything is safe?’ …So it’s always been part of the conversation [since she started with this agency four years ago]... I think it’s only when an issue comes up that’s probably going to be irresolvable without money being thrown at it [that tensions may arise], but we’ve only had one instance of that and we worked together and came up with another alternative… I think it actually, if anything probably strengthens the relationship because you need to communicate really well, but hopefully you’ve got that set up well in the first place anyway, or you build that up.

These two examples, along with those in the preceding section, demonstrate how these workers have integrated the tasks of risk management into their day-to-day practice, and how these tasks and the consciousness of managing risk have become part of their professional ethos.
Risk management was seen as supporting individualised service provision and the upholding of clients’ human rights. Leading on from the previous excerpts, the capacity to integrate risk management into day-to-day practice with clients also appeared to be critical in the delivery of individualised or ‘person-centred’ services. This is amply demonstrated in the following excerpt from an interview with Anne, a program manager from an agency supporting aged clients, and adults and children with a range of disabilities.

She related a situation of a woman with muscular dystrophy, ‘whose body is failing her miserably’. This ‘participant’, as the agency referred to its service users, wished emphatically to remain living alone at home:

> She says, ‘Look at the end of the day, my choice is to live at home - if I have to lie on the floor for two hours in the middle of the night if I’ve fallen out of bed… that’s the risk I want to take, because I do not want to go to a nursing home at fifty.’ So look, we’ll do all the checks that we can, but she put it very nicely: ‘That’s my choice, if I have an accident in bed… if I have to wait till the carer comes at seven in the morning, I’ll wait… that’s the choice I make - not to live in a place where there’s a nurse down the hall.’ So it’s about agreeing on risk and getting permission to put certain things in place to manage the risk.

In this example, ‘risk’ is integrated into practice, and constructed as both positive and negative. On the positive side, the participant is seen as having the right to risk-taking, independence and choice; she makes a decision to lie on the floor and wait for assistance should she get into difficulty over-night, rather than enter residential care ‘where there’s a nurse down the hall’. On the negative or protective side, workers will ensure that ‘certain things’ are organised to reduce potential risks, thus upholding their duty of care in terms of their professional ethics and organisational policy. The participant is conceptualised as a partner in the care she receives - demonstrated through active negotiations over the management of risks and through the use of the term ‘participant’. Her opinions are sought and discussed openly – ‘it’s about agreeing on risk’ and ‘getting permission’ to manage it in specific ways. Both worker and client acknowledge the risks inherent in community-based care and accept that not all risks are eliminatory.

Daniel, a direct care worker from a support service for adults and children with disabilities, also recounted a situation in which he had supported a client in positive risk-taking. This worker argued that ‘duty of care’, itself a form of risk management, and the principles of ‘dignity of risk’ had strengthened his practice and provided a framework for ensuring a person-centred approach to his client. A conflict arose when Daniel’s client, who was in the early stages of dementia, expressed a wish to pay his own bills. This particular service has a very strong ethos of person-centred care; Daniel explained how he negotiated with his client’s family to reach a decision that seemed to meet the needs of his client, his client’s family and his own understanding of ethical practice in the context of the service’s aims and ideals:

> Everybody out there has got the right to take a risk and if we lock that away, they wouldn’t learn anything, but there is a point where you’ve got to actually draw the line but it has to be a combined decision - like I can’t just go, ‘No you can’t do that’ because… the person might be quite capable of doing it in a round-about fashion… you’ve got a fine line and that’s where the organisation comes into it because then you’ve got to have a meeting and run through it, because yeah it’s not my decision to say yes or no, unless I feel that it’s coming into the area of duty of care… I had gentleman with dementia and the family said ‘No’ when he wanted to… pay his own bills… He felt like a lump of meat sitting in the corner that was useless for everything and he was getting really down. And I spoke to his daughter and I said, ‘Look I’ll be there, why can’t he go there and try and pay his own bills’? …he wants to pay these specific ones with Bank Card’. I finally convinced her… what she did was she told him the pin number and that it was a credit and not a savings card… We went out and he made one mistake; he thought it was a savings card and not a credit card. He didn’t forget the pin number, he didn’t forget the bills, he did them all with the assistance of the shopkeepers and I only made one comment and that was, ‘It is a credit card’ the first time and that was the one mistake he made. That’s all I did. I sat back and he was empowered. He just [said], ‘I can do it. I can do it’…

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It was just this smothering effect. ‘You make mistakes, I can’t trust you with this’ - and that’s not my job. My job is to get out there and make these guys do what they can. I don’t care what it takes, as long as I can talk with the family like that. Like I talk direct to most of my families, mainly because they’re there and I’m there [on site]. If something is going on, I can say, ‘Yes, at the moment’ or – ‘Hang on a minute, I’ll talk to Jenny [team leader]… and then work it out’.

Both excerpts demonstrate the significance of relationship-building in the context of positive risk-taking (balanced with safety) which, in turn, appears to be a central factor in the provision of individualised or ‘person-centred’ care (see Titterton, 2005).

5.3 - Expressions of the ‘critical risk rationality’

This section is organised around six aspects of risk management in frontline practice that offered the most exemplary expressions of the critical risk rationality:

- formal requirements to complete risk assessment screens
- labelling effects of ‘high risk’ ratings
- occupational health and safety regulations
- relationship-building with clients
- managing clients’ medication
- an emphasis on ‘duty of care’ may limit the provision of individualised care

Formal methods of risk assessment were seen as hindering impeding professional practice - Anna, a psychiatric nurse with almost thirty years experience, who works as a case manager alongside Allan (introduced above), had a very different view of the ‘risk sticker’. She felt that it was overly bureaucratic and constrained her capacity to exercise professional judgement and creativity, noting that ‘before we had the stickers… my risk assessments were far more comprehensive in terms of the detail and the strategies’. She deemed the stickers ‘probably a bad thing’ on the basis that some workers tended to rate level of risk without providing a description of the actual risk and the strategies in place to manage it:

If you tick ‘high’ for risk of substance abuse, but don’t stipulate that it’s poly-substance or that it’s heroin, IV drug use …[and] don’t actually document that you’ve referred them to drug and alcohol and they’ve got an appointment pending or they’ve refused to attend, then you’re not providing a comprehensive risk assessment. And so what I see the stickers’ potential downfall is that you tick the boxes and you don’t provide the depth of information and the actions that are required to manage that risk.

Anna was also concerned that the auditing of client files, in which she had been involved, simply involved checking whether the risk sticker had been filled out rather than evaluating how clearly and comprehensively it had been completed (see Munro, 2004, p. 1086; Power, 2004b, p. 26).

Risk management was seen as labelling and disadvantaging some clients - Assigning levels of risk to clients has become standard practice in risk management, but participants with a critical rationality tended to emphasise how this labels clients. A number of participants reflected on the potentially 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.

Stacey, a program manager of a specialist disability service was concerned that case managers often developed negative perceptions of clients, including fearfulness, long before they had face-to-face experience of interacting with them. Such attitudes could restrict a client’s opportunities:

Because there’s already those preconceived ideas from this person that’s already put into some kind of form or into that person’s file, which puts on alerts… so you don’t want to limit
people’s opportunities because people are scared of working with them because of what they’ve heard about that person… whoever makes that initial assessment and puts that down on paper on someone’s file - that really does tend to set up what that person gets in the future. It’s something that personally bothers me because I think these things need to be assessed by lots of other people as well to give people [clients] an opportunity. You know we have partnerships with Supported Housing and we have a lot of people through case management who are placed into housing with them and because of the perceptions of certain case managers who have worked with people that’s been passed onto them, and that means that that person isn’t given that opportunity to move into a house because that person already has that reputation.

Alice, a case manager/welfare worker from a government disability service, was concerned about the way in which ‘high risk’ behaviours from a client’s past could come to dominate the way he/she was perceived by health and welfare agencies, regardless of any positive changes that might have occurred in the person’s life since then:

A lot of workers… make their assessment on what they read, so what’s written once by a person - they can be tagged with that for life. It doesn’t mean to say that lots of changes have happened in that person’s life and now they’ve actually either done something, done some education to learn about a certain thing or they’ve grown and our clients do. They get opportunities in life, so they grow with that - and so I think that we should be very much aware of where the client’s at in the present day and not so much judge them on past experience… I’ve got a client [who] was a justice client - he lit a fire and so now it’s everywhere and he got a police record for that, and he’s become so insular now and so isolated for fear of everyone knowing what he’s done, and sure that happens - but that will stay on our system and people… they immediately look to see what he’s done, not what he’s done since. It was just a one off thing - and so yeah I just think we can label our clients quite quickly.

Jane, a senior support worker from a PDRS agency, elucidated the nuances involved in identifying risk from the perspective of organisational accountability as against the client’s subjective experiences as follows:

Once a client’s been 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… and that the extent to which we perpetuate that inability to move… I feel like that’s always the really kind of delicate balance. And because you know places like [forensic service X] for example - because to cover their arses they 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 continuing and actually might be in quite a different place than they were five years ago… And 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.

These workers were concerned about the persistent disadvantaging effects that ‘high risk’ labels could have on clients’ life chances, and each expressed great sensitivity about the feelings of disempowerment that such labelling could potentially engender in a client’s consciousness and sense of future possibilities.

Occupational health and safety regulations were seen as constraining professional practice and creating further risks - Experienced professional workers have developed their own risk management strategies over the years, which may not be compatible with current more stringently applied occupational health and safety requirements. Several workers claimed that these regulations often seemed oriented to protecting workers and the organization rather than clients and could, in some instances, restrict the range of interventions available to use with clients. Michael, a social worker from a PDRS outreach/support agency, admitted that he had breached the ‘no smoking’ policy in order to work therapeutically and safely with clients. He argued that taking this risk would reduce other risks:
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…I readily admit I use a cigarette with 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.

This worker also reported how he had breached his organisation’s policy, which prohibited working with clients whilst they were ‘drug and alcohol-affected’. Denying service on those grounds, he argued, could potentially heighten a client’s vulnerability and also endanger the community. He felt that intervening was safer than following the organisation’s policy, which he saw as risk-creating:

I breached it because… I’ve worked with that client… I’ve had to work with them until I felt that they were safe. Until I felt that the community was safe… In the eyes of the organisation I work for… if something happened to me that would be my fault… You cannot let these [vulnerable] people in the community, the CAT Team won’t respond, the police quite often won’t respond in time, so you constantly put yourself in a situation where there is potential risk… to ensure that the community and that individual is safe.

Occupational health and safety regulations, as exemplified through these two excerpts and the excerpt that opens Chapter Four (David, the community nurse, who explained why he would change a light globe for a frail aged client) present problems for experienced professionals accustomed to working independently and making their own ‘risk assessments’. The regulations create competing goods – between the official, objective ‘good’ and the ‘good’ embedded in the subjective world of actual practice with individuals. In each situation, however, these workers weighed up the likelihood of an adverse outcome and acted accordingly in the interests of the client.

Risk management policies and procedures were seen as constraining relationship-building with clients - Several participants felt troubled that the emphasis on risk reduced opportunities for broader therapeutic interventions. Julia, a case manager/social worker from an Area Mental Health Service, argued that ‘it skews your mindset to focus on risk… at times it’s almost an over-focus on risk’. This worker, who has over twenty years experience in ‘the system’, recognised the importance of assessing and managing risk but felt that there was also a price to pay for the almost obsessive preoccupation with it: Younger less experienced staff who join our service… can feel that they have to pay attention to it because it seems to be such a huge part of our role… at times [risk] may prevent them from exploring other issues with clients because they feel in order to be doing their job as a case manager they need to be ticking all those boxes and making sure that they’ve done the risk assessment - and they would be very cautious… I think the less experienced people feel the need to routinely ask the client questions rather than making some judgments based on the way the person is presenting. For the client, they can often feel like you know they’re being asked, ‘Are you having suicidal thoughts?’ and if the person says, ‘Sometimes’ - and some people have chronic suicidal thoughts - that’s what gets explored and discussed at each appointment, rather than a whole range of other issues that might sit under that and might be contributing to them having a suicidal thought…

In fact, the less experienced staff, they often feel they can’t ignore this stuff once a person maybe talked about having thoughts of deliberate self-harm or thoughts of suicide, they then feel obliged to explore that with the person and maybe even at a level of depth that’s not helpful because it might be a chronic sort of risk and it might have been there for years. And it can take them a long time to feel confident enough and say, ‘Okay, well we don’t have to discuss this every fortnight.’

Later in the interview, Julia observed that the role of case manager had narrowed as a consequence of the rise of risk management. Her observation supports Elaine Munro’s (2004, p.
argument that the work of social workers and human service professionals in general is now monitored in terms of the 'paperwork attached to the work' rather than 'their actual practice with people'. Julia elaborates this issue as follows:

[So, risk] can exclude or minimize… the work we’re able to do with clients because we’re so focused on risk management… so some case managers… feel that their job has been almost reduced to monitoring someone’s mental state, monitoring the compliance with medication and managing any potential risk… and it doesn’t leave a lot of room for them to do more therapeutic work… and they feel that they would ignore those three issues… at their peril or that if… something went wrong, then they’d be in deep water, so they feel a lot of pressure to pay attention to those issues and all the paperwork associated with that and therefore at times that means the exclusion of other things.

By alluding to the spectre of blame that envelops these monitoring activities, Julia considers risk management policies and procedures as external to her understanding of ethical professional practice. This example, along with the preceding excerpts, demonstrates that these very experienced workers saw formal risk management procedures as antithetical to good professional practice.

Risk management policies concerning supervision of medication were seen as disadvantaging clients and their families and creating further risks - Risks associated with medication management were a fraught matter amongst some participants, especially program managers working in aged care. These participants were concerned that undue responsibility had been placed on clients and their families, thus engendering further risks.

Margaret, the nursing services manager of a home-based nursing agency, explained that nurses had previously filled clients’ ‘dosette’ boxes and administered medication to them during home visits. Now, for the most part, clients’ medication is dispensed in ‘blister packs’ to enable them to self-medicate. ‘What we’ve actually done there’, Margaret surmised, ‘is we have transferred the risk from nurses to the client and the family.’ She cited a recent survey by a health service, which reported that 20 per cent of clients’ medication problems were due to mismanagement of medication resulting from the introduction of blister packs. In some instances, clients had received somebody else’s blister pack and, in others, prescriptions were incorrect. Margaret reported that some pharmacists were employing untrained people to fill the blister packs, which carried its own risks. The shift to blister packs, she noted, has ‘created a huge problem for the client, but we don’t have the risk anymore as nurses because they’re self-medicating. We go in and say, Mary have you taken your tablets? But we take no responsibility for what’s in those blister packs and it is a big, big risk… the risk got transferred because we said, No – we’re not doing it – it’s too risky. We said - Let the patients do it.’

In this context, the emphasis of risk management seemed directed to protecting the organisation, but in so doing clients and their families were newly vulnerable. Importantly, this approach to risk management is potentially at odds with the objectives of individualised service provision, especially in cases where the client could benefit from assistance with taking medication.

Risk management policies that emphasise ‘duty of care’ may hinder individualised approaches to the client - A number of participants decried the dominating influence of ‘duty of care’ obligations which often meant a largely inflexible blanket approach to managing risk that severely limited client choices and autonomy, and also their capacity for growth and change. Risk management regimes tend to construct ‘duty of care’ in a negative, defensive light. Risk is to be avoided at all costs. Taking a ‘safety-first’ approach (Titterton, 2005: 76) means assessing for the risk of harmful consequences by focusing on a person’s deficits and history rather than his/her strengths and needs.

Margaret, the nursing services manager introduced above, was concerned that the management of risk from the organisational perspective may mean that ‘we are actually going to eliminate the client sometimes to the point of them not having any say, having no control over their life’. The following two examples illustrate this claim.
Alice, a case manager from a government disability service, introduced above, expressed concern that some agencies’ risk management procedures were overly protective and as a consequence could hinder clients’ opportunities for growth and development and, ultimately, social inclusion. In this context, she related an episode involving a young male client who had recently moved into supported accommodation:

I helped to relocate him... it was a brand new building and a whole new program and they were extremely protective of trying to do everything by the rules and regulations. And he wanted to show me in his bedroom and I thought that was fantastic. I wasn’t allowed to do it unless I had someone go in there and I said, ‘Why? That’s not on... I’m not happy about that at all’. So I just said to the client, ‘I’m happy to come back another time’ - because it was obvious that everyone was being so cautious about trying to live by the rules... this same client, then later got a girlfriend and it was similar... ‘He’s got a girlfriend’ and I said, ‘Well he’s nineteen, it’s a normal pattern, it’s wonderful for this young man, his life is really blossoming, he’s doing normal things’ - and it was about, ‘Oh, but what if they have sex?’ and I’m going, ‘That’s normal. She’s over the age of consent, she’s nineteen as well’... They were very much focused on duty of care and Departmental policy and my thing was, let’s get back to the client who just wants to be normal, he is normal, let him just live, it’s normal to be nineteen and want to have a girlfriend.

In this context, Alice approaches the client as ‘a unique centre of subjective experience’ (Yeatman, 2009, p. 16), whereas these facility-based workers begin from the perspective of the rules and regulations - a risk-averse stance that potentially reinforces the client’s experience of social exclusion and difference, discounts his individuality, and generates a further range of risks. In a similar vein, Kate, a program manager/social worker of a PDRS outreach-support agency, felt troubled that risk-averse policies could deny some clients ‘a full opportunity at times to do what they need to do’ in order to deal with traumatic experiences. She discussed having taken a very carefully calculated risk with a suicidal client. This caused alarm amongst other agencies, but she felt that it was important to work with the client to respect his individual needs and allow his expression of grief, rather than simply admitting him involuntarily to hospital without considering his particular circumstances. This client had a recent history of self-harm and frequently talked about harming himself:

His dog died and he was a very isolated individual and his dog was very important. [T]he vet recommended putting the dog down and he asked if he could have time alone with the dog, and I thought this is one of those times where it’s a judgment call and I felt confident enough to say ‘I’m going to take the risk’. Because he had been talking about... if the dog had to die that he was going to die with the dog and I made the judgment call, but I could see that was really important for him and I drove him home to have time with the dog. I picked the dog up from the vet with him and gave him a period of time... and he brings up regularly that we did that together and he knew not many staff would have trusted him and would have given him the opportunity.

This excerpt points to the underlying tension between risk management policies that focus exclusively on ensuring safety, and client autonomy and choice. Particularly in mental health there is often ‘evidence’ that informs duty of care situations and the need for restrictions on client choice. However, professional workers may be confronted with a situation where a client’s capacity to exercise some control and decision-making may be more important than the risks arising from denying this control. The professional who knows the client well will recognise the significance of the exercise of autonomy and decision-making and will discern the particularities and subtleties of the client’s vulnerabilities. Conflict between formalised constructs of duty of care and the idiosyncratic significance of decision-making at particular points in a client’s life represents one of the most problematic aspects of reconciling professional agency, judgment and risk responsibility.
5.4 Expressions of the ‘compliant risk rationality’

Only a small number of participants, four in all, expressed a ‘compliant risk rationality’. We focus on the experiences of two of these workers in drawing out the main characteristics of this rationality - Vera and Mary. Vera has over fifteen years experience as a ‘direct care worker’ in a large agency providing support and home care to the aged, and Mary has worked for several years as a ‘community care worker’ in a home-based nursing agency.

Vera reflected on the way in which her work had become increasingly regulated over the past fifteen years by a range of ‘risk management’ requirements:

> We don’t have our feet leave the floor so we don’t stand on anything, we don’t get up to change light globes or things like that. I mean we’ve got a handy man that will go out and do that if they need that type of thing done. We just do not do anything that would put ourselves at risk in any way...

> I don’t like cats and one of my ladies has a cat, but it’s locked in a different room while I’m there because I just really don’t like them and she knows that. And clients are not supposed to have animals in the house while we’re there… they’re not to smoke in the house while we’re there, but if they can’t go outside to smoke we can go outside while they do smoke… Things like that, so there are all different types of things you can do to get around it...

> Years and years ago we would be climbing up step ladders, doing all these jobs - now we’re just not allowed to do things like that, so just little things have changed and it’s changed gradually sort of over the years, but I do know that we were doing a lot more risky things, you might say, years ago to what we do now.

Like most direct care workers in our sample, Vera expressed strong loyalty and obedience to her employing organisation. Recourse to the OH&S rules provided protection in situations where clients asked workers to do things outside their prescribed roles, as the following example demonstrates:

> I had a lady who was adamant I take my shoes off to go into her house and I said to her, ‘But I can’t do that’, ‘Well, why not? I don’t like shoes being worn in my house’. I said, ‘It’s against occupational health and safety’, I said, ‘if I drop something on my foot and I didn’t have proper shoes on’, I said, ‘I’m not covered you know’, so she was getting quite agro. And I said, ‘Well you call the office and you ask them’, you know so I put it back on them.

Mary also expressed strong consciousness of the rules and regulations that circumscribed her role, often focusing on what she was ‘not allowed’ to do:

> That goes back to another thing that is a risk, animals… I always went to this house always, you know, twice a week. And I went to go in the gate and these two big golden retrievers rushed around the gate… and I mean I’d never seen them before. But I’ve got golden retrievers so… I know that they were probably alright. But I thought, ‘No, you can’t risk that… because you don’t know.’ So I went back to the car and I rang up and they said, ‘Oh you can come, they’ll be fine.’ And I said, ‘No, I am not allowed to.’ And they were fine; they put them into the backyard… because, you know, the daughter said, ‘Alright’, but then when I went in she said, ‘They wouldn’t have hurt you, they’re calm.’ But I just explained our policy about dogs… And I mean if that had been another breed of dog… I mean even that I wouldn’t go in because I know we’re not allowed to.

In another example, Mary explained how she dealt with a carer’s request that contravened the organisation’s ‘no lift’ policy:

> A carer got cranky with me – [his] mother had slipped out of her chair and he wanted me to lift her into the chair and I said ‘Well I can’t, I’ll have to ring up and someone will have to come out with a lifting machine.’ And he was really cross and he did it himself in the end; he wouldn’t let me ring. But he expected me to - and I get that because I get from carers… ‘Oh I am glad you came and not so and so’, and I will say ‘Why?’ and they will say ‘Oh because she is only a skinny little thing.’ And I will say ‘Well, what has that got to do with
it?’ ‘Because if Mum fell you would be able to lift her’, and I said ‘No I can’t - I am not allowed to.’ And they get a bit cross about that, they think we should be able to just lift or whatever. And it doesn’t matter whether you are big or little, you are not allowed to lift and that is all there is to it.

For the most part, those workers with a compliant rationality did not feel that OH&S requirements had a constraining or disadvantageous effect on the service they delivered to their clients. In some cases, it might mean a delay in providing a particular service, such as changing a light globe, especially if a handyman had to be called in for the task – or if a lifting machine had to be brought to the client’s home. Nevertheless these workers considered they could uphold the rules and still provide a very good service that ensured safety for all parties, as Vera argued:

If you do things sensibly and how you’re supposed to do them, you can deliver this service quite well, you know if you’re not silly about things and just stick to what you’re allowed to do… it’s common sense if going to get a cobweb down you’ve got something with a long handle, you don’t get up and try and get it down with something, you know it’s all common sense really. And you can get a person’s house extremely clean without ever having to have your feet leave the ground.

Both Vera and Mary had very positive views about risk management policies and procedures and both were highly conscious of their position in the organisation. Mary, in particular, was explicit about her relative lack of power in the organisational structure. She described herself as being at ‘the bottom of the chart’ which explains, at least in part, her focus on what was ‘allowed’ and ‘not allowed’. When asked how her organisation responded to adverse incidents, Mary commented as follows:

I think they respond really well… But you see if I came in and reported something that was not really good - they would then take over it more or less… you know like the supervisors, and that they would manage it and then I would be told what would happen because you know I’m the bottom of the chart anyway.

Although Mary was a representative on the OH&S Committee she was nevertheless keenly aware of her position in the organisation and the greater responsibilities assumed by registered nurses, compared with community care workers, including their greater participation in decision-making and access to organisational knowledge and processes:

We have a staff newsletter and they can say… look the policy is such and such and this is what we are doing or you know stuff like that… I mean, sometimes things slip through and… the lower ones don’t know. Because I guess they think well we don’t need to know I guess… There is always a lot happening that we don’t need to know about, whereas the Div 1s have to know.

In a similar vein, Vera noted that when receiving their weekly rosters the direct care workers also received ‘any communication [about policies and procedures] that they want us to know about’, thus showing how the dissemination of information is differentially related to the worker’s position in the organisation.

Amongst those direct care workers who expressed a compliant rationality the act of complying with OH&S regulations was central to a strong work ethic and to the demonstration of loyalty to the worker’s employing organisation. Both Mary and Vera cited a number of situations where they had enforced the organisation’s rules directly with clients and carers. In the provision of home care, these rules and regulations are unambiguous and the overriding focus is on the worker fulfilling her duty of care (to the client, to herself as worker and to the organisation) in meeting prescribed levels of safety. Workers with a compliant rationality did not engage with such service ideals as ‘dignity of risk’ and ‘person-centred planning’ as did other (non-professional) support workers engaged in different roles (e.g. assisting clients with physical disabilities to engage in mainstream recreational activities).
5.5 Conclusion

All of these workers – professional and non-professional - experience increasingly complex risk management procedures and reporting requirements as they engage in their everyday therapeutic, supportive, caring and protective relationships with their clients. The evidence from this study supports the view that community care providers have to adapt to the increasing significance of risk in meeting their duties and obligations. Community care has been built on structural and governance arrangements defined by the technologies of ‘new public management’. These arrangements may be detailed, defensive and prescriptive, but community care workers are still required to confront unpredictable and uncertain situations and make many difficult decisions and judgements alone.

For professional workers, risk and risk taking becomes increasingly important in the definition of their professional identities, their sense of agency, and their capacity to meet professional obligations. These demands help explain why professional workers adopt the positive and critical risk rationalities discussed in this chapter. The new professional obligations arising from community care are experienced not only in formal, legal and organisational terms, but as part of the subjective process which shapes professional identity. Godin (2004) identified similar patterns in a study of community mental health nurses in the United Kingdom. He argued that while some nurses were positive and others very critical about new technologies for assessing risk, all interviewees made use of professional intuition in making judgements about risk (see Alaszewski and Alaszewski, 1998; Harrison et al., 1998; p. 85).

Similarly, our interviewees drew upon their professional ethos, broader experience and understanding of client needs and risk to find their own ways of working within new structural, managerial and accountability frameworks. They were actors negotiating new structural conditions, rather than individuals acted on and transformed by new structures, as commonly suggested by researchers such as Rose (1998), Webb (2006), and McDonald et al. (2008). Our evidence suggests the need to recognize and understand the way subjectivity, including professional subjectivity, shapes and responds to new conditions, including those created by new public management. Moreover, we found that both the positive and critical risk rationalities we identified involved a close and intense focus on therapeutic relationships. We found no evidence that their therapeutic approach had been displaced by a managerial, risk-averse agenda as reported by McDonald et al. (2008) and Webb (2006). These general findings suggest that human service professionals continue to maintain a strong sense of agency, a professional ethos and a focus on clients’ needs.

There were no factors (including gender, age, disciplinary background, and agency function) that unequivocally differentiated participants who experienced risk management policies as positive from those who were critical of them. Given the small sample size and the exploratory nature of this study, it is not possible to discern particular connections between these factors and participants’ risk rationalities. Nevertheless, the findings presented here generate important questions and directions for future research. It is possible that other factors not considered in the research design of this project (e.g. nature and length of a professional’s work experience) or, indeed, a combination of factors, are important in shaping a worker’s response to risk management regimes.

One factor, however - length of experience in the mental health field - seemed to gesture towards explanation, though further research with a larger sample would be required to ascertain its veracity. Those participants with at least fifteen years in the field tended to be critical of risk management policies, whereas amongst the more recent recruits the picture was mixed (some were positive about risk management and others were critical of it). In this context, one might speculate on the significance of differential socialisation processes. It appears that professionals socialised into the mental health system prior to the implementation of new public management, and at a time when it was organised more clearly along disciplinary lines, are critical of the erosion of professional autonomy, the growing dominance of paperwork and procedures, and the ‘over focus’ on risk and monitoring, as one participant described it. Conversely, mental health professionals entering the workforce from around the late 1990s have largely been socialised into ‘risk thinking’ (Rose, 1998, p. 181) and have not experienced - or perhaps resisted - the same
transformation in their work contexts and professional obligations as those entering the field much earlier. What is especially interesting about these findings is that some, though not all, participants who entered the field in recent years appear to have internalised various technologies of risk management into their professional identities, and did not feel at odds with organisational goals that involved monitoring activities. Such practices were perceived as a given or 'natural' part of their professional duties.

Notwithstanding these differences in risk rationalities, we are confident that, the evidence of this research demonstrates that the demands of community care and managing risk have not demoralised human service professionals, nor undermined their sense of agency and individual professional commitments. The professionals in our sample are managing risk in much less structured settings than their predecessors in the modern disciplinary era, often practising alone and making judgments and decisions in isolated and unregulated situations. While their professional identities are different, they are strong professional identities nevertheless, with therapeutic rather than managerial skills and values at their core.

While professional workers often develop their own critiques and frameworks in terms of interpreting and responding to risk management policies and protocols, non-professional 'community care' and 'direct care' workers are less likely to do so. As discussed above, it was within this sample of interview participants that a 'compliant' rationality was sometimes evident. It seems that this comparative lack of flexibility and security in testing a set of rules on the part of untrained workers (expressing a compliant rationality) is related to their relatively low level of autonomy and power in the organisation and the relatively clear-cut nature of both their work tasks and their occupational health and safety practices.

CHAPTER 6
PERCEPTIONS AND EXPERIENCES OF ‘RISK’ AMONG CLIENTS AND FAMILY CARERS

6.1 Introduction
We now move from the level of service providers to discuss and analyse the perceptions and experiences of risk and risk management among clients and family carers. As noted in Chapter 1 one of our major objectives was ‘To test the contention that there are dysfunctional interactions between the values, objectives and practices of community services and values, objectives and practices of risk management.’ As part of this, we wanted to investigate whether there was any conflict between the needs and wishes of clients and the practices of risk management. In this context we had not initially included family carers as interview participants, but came to review this decision on the basis of our early analysis of interviews with clients, frontline workers and program managers. We were finding that while some clients were active in defining and negotiating their risks and the management of risk, it appeared that families and carers undertook this role for a significant proportion of the clients of these services. Thus, we incorporated in our sample family carers and chief executive officers/senior managers from six advocacy/support organisations, and report in this chapter on their thoughts and experiences as well as those of clients.

6.2 Perceptions and experiences of the clients
The overwhelming majority of clients were very positive about the services they received. Ten of the 34 clients were disappointed or frustrated with certain aspects of service provision and felt that improvements could be made in some areas, whilst also commenting on other aspects they found helpful and supportive. Most of the problems they identified were systemic in nature, such as a shortage of psychiatric inpatient beds, frequent turnover of frontline staff, difficulties in
obtaining adequate funding to cover the time needed for desired activities and support, and low levels of staffing in some services.

More specifically four clients reported having had services ‘pull out’ after a period of involvement - a middle-aged male who was to be discharged from an Area Mental Health Service but wished to remain engaged with the service; a young woman with a history of homelessness and substance misuse had been refused various services in the past because she was deemed ‘out of control’; the mother of a disabled son reported that he had been refused service seemingly because of his threatening behaviours, though this was never made explicit; and a male client, who had a history of self-harm, reported that the local Crisis Assessment and Treatment Team had refused to get involved with him on a number of occasions because the Team viewed his self-harming behaviours as ‘attention-seeking’. Only one client reported having been restricted in any way; in that that she had requested a particular type of walking frame, which was deemed unsafe by the physiotherapist who had conducted an assessment of her needs.

The major themes in clients’ experiences of risk management as service users across the three sectors can be summarised as follows:

- Details and concerns about agencies’ risk management policies did not occupy a significant place in discussions of their experiences as service users
- For the majority of clients ‘risk’ was interpreted in terms of personal vulnerabilities and potential dangers arising in the context of dealing with their disabilities and illnesses
- For most their relationships with respective case managers and direct care workers were central to their experiences as service users

An overview of the meaning of risk for clients

The concept of ‘risk management’ in terms of agency policies and practices did not figure significantly in our interviews with clients. There was little consciousness or identification of agencies’ risk management policies and practices, except in discussions we had with two clients who had been in the workforce and had had their own experiences of managing work place risks. Several other clients, also with histories of workforce participation, seemed to take for granted the idea that a direct care worker was required to operate within a particular framework or set of rules – although they did not focus specifically on risk management policies and practices. As demonstrated in the following discussion, most participants’ conceptualisations of risk were rooted in personal experiences of the potential dangers, mishaps and vulnerabilities they could encounter as a result of their particular disabilities.

Moreover, the nature of their relationships with case managers and direct care workers seemed of principal importance. Could the client relate to the worker? Was the worker supportive and personable? Did the worker understand the clients’ needs? How could the worker actually assist? Trust and respect were seen as crucial in a client’s relationship with his/her direct care worker, particularly considering the very intimate and personal nature of the work (e.g. assistance with showering). Because many human service workers, especially younger workers, tend to change jobs frequently, most clients experienced new workers on a regular basis. These disruptions were often difficult, given the time it takes to build trust and confidence in a new worker; and was more acute for clients with histories of loss, grief and social isolation. The centrality of supportive and therapeutic relationships with workers was palpable from these interviews.

The following discussion is organised in terms of the three service sectors represented in this study: mental health, aged care and disability. For each, we discuss participants’ major concerns, any refusals or restrictions imposed by service providers, and how they felt about the services they received.

**Mental health**

Most clients had developed mental health problems in their late teens or early adulthood, apart from one female client whose difficulties seemed to manifest in middle age. At the time of interview, three participants had longstanding mental health problems of at least ten years. Most had experienced several episodes of psychosis and two males had significant histories of
substance misuse. All but one client were currently prescribed anti-psychotic medication; several were also taking anti-depressant medication. Two were divorced, two were married and four were single. Six had very strong family support.

**Major concerns** - In a very general sense, clients were concerned about the wellbeing of family members; financial stresses; ‘side-effects’ from medication, and the struggle to control anxiety symptoms. One participant was fearful of falling back into her former ‘lifestyle’ and returning to prison for gambling-related offences; several were apprehensive about being discharged from their respective programs, which would mean getting by with significantly less support and monitoring, and in this regard two clients were especially concerned about finding suitable accommodation. Three middle-aged clients were troubled by poor physical health; in each instance they suffered from chronic, painful arthritis, which limited their mobility and activities. Zoe, a young woman who had recently experienced her first episode of psychosis, was worried that younger family members might also develop psychosis given the increased risk in first-degree relatives. She was also very concerned about her experience of memory loss and poor concentration following electro-convulsive shock therapy (ECT), and her loss of energy in the aftermath of her psychotic episode:

I’m just finding it really hard to take in… what I’m reading. That was a major problem for me when I was psychotic, like… I kept trying to read over and over things. I’d always been quite a big reader, I’d been a studier so I’ve done a lot of reading up until now, and it’s very frustrating for me not being able to take in what I’m reading.

I’m finding that… I’ll sleep for probably twelve hours a day, I just get really exhausted quite easily, whereas I never used to be like that, I used to sleep for eight hours a night… and I used to be quite an active runner… whereas now I just don’t have the energy for that anymore… I can go for a walk and feel absolutely exhausted, so I guess my fitness is another sort of side of things that’s been disrupted as well.

Most poignantly, however, the majority of clients focused their concerns on what might happen if they were to ‘get sick’ again. How to ‘stay safe’ was their most abiding concern. Harry, a middle-aged man with a history of paranoid schizophrenia, multiple admissions and suicide attempts, described his main concern as:

Personally is when I get sick. My main concern is that I might hurt somebody or do something stupid. General - my main concern is there is not really enough help out there… once again it all comes down to the funding and I also think that where some of the funding goes, it shouldn’t.

For Harry, these concerns were intensified in the context of having been ‘left in the community’ when acutely unwell in the past:

For me as a paranoid schizophrenic, I then start feeling unsafe about my surroundings and I feel like people are after me… it just snowballs so the risk then starts to get real high for me. I have actually gone up to people and yelled and screamed at them… and felt like attacking them because I feel like they’re going to attack me and when I’m at that risk I should be in hospital but because there is not enough beds I can’t get into hospital.

Frank, another middle-aged man, also with the same diagnosis, was very concerned about the possibility of a future relapse:

I have some weeks where I get really down and I struggle just to keep up with the housework… And my fear is that I’ll slip back to what I was like a few years ago, where I was just hopeless; it was really bad and I don’t want to put my wife through what she’s already gone through now, so I have a fear that I’m going to slip back but I keep going on… I’ve had my mental illness thirteen, fourteen years now and the first five to six years, I was just blown away on medication. I didn’t do anything. I was sleeping twenty hours a day. It was just terrible… I tried to commit suicide and different things like that and she stood by me through it all. But I just don’t want to go back and put her through that again, so I have a very strong determination not to do that. But some weeks it feels like I’m headed that way.
Merryn, a young woman with an anxiety condition, who had become involved with services only within the last twelve months, cited her major concern as ‘staying safe’, explaining that she constantly monitored her mood and anxiety level and often sought help:

I get worried that things will tip me off and I’ll go back to the way I was [suicidal]. That’s probably my biggest concern that something will set me off, so I’m really conscientious about things… I just have to keep working at it myself.

Several clients mentioned their desire for part-time employment. Harry was concerned that he would not be able to manage a job, especially if he were to get sick again:

There aren’t many places that would be able to hold a job open if you’re sick for three months… it’s not just having the episode; it’s the weeks and months after the episode. The recovery process? Yeah, and that is also a risk factor in the recovery because that’s also the time where you’re likely to have another episode… so you could be off work for six months or twelve months.

Tim, a young man with a history of psychosis and substance misuse commented that he would like to have a ‘relationship’ and children like others his age, but without stable accommodation and employment these hopes seemed far away.

**Restrictions and refusals by service providers** - Only one participant - Harry - reported having been refused service by an agency. He was to be discharged from the public agency he had been attending for several years because he had been coping relatively well over recent months. He found ‘scary’ the prospect of managing without the security of a case manager in the background.

Ruth, a middle-aged female client felt unhappy about her Community Treatment Order and the restrictions entailed therein. She preferred not to attend the mental health service, but understood that she was legally compelled to do so:

There’s support there [with the Continuing Care Team] if I have a bad time or something you know. Just some back-up there… I haven’t been that happy about it because of the circumstances that I’ve got involved with them, but they’ve been supportive… I can’t say they haven’t been supportive.

The process of involuntary detention makes public mental health services distinctive from other services. Most clients who had experienced involuntary admissions accepted that the services involved were protecting them from the potentially destructive consequences of their psychotic symptoms e.g. suicidal intent, tendency to act on delusions. In this context, Zoe commented ‘but that was for my own good’.

**Feelings about services** - All clients made some positive comments about the services they received. An empathic, trusting and supportive relationship with the primary caseworker was deemed most important by a majority of clients.

Abby, a young female client from a PDRS agency claimed that the program had ‘given me my life back’. She highlighted that workers were especially helpful with supportive counselling, facilitating her return to study, and encouraging her to get involved in community groups, and also through developing her knowledge of social norms and how to structure her time – ‘just how to live like the rest of society’ -- as she put it. In contrast, Tim, a client from the same PDRS agency, felt that workers relied too much on file information, rather than talking to clients directly - but he also acknowledged that his own worker was very helpful and supportive.

Frank, who attended a PDRS outreach/support agency, looked forward to his caseworker’s visits and found him ‘very encouraging’ in discussing various strategies to deal with ‘the voices’. However, like several other clients, he found the frequent turnover of staff quite difficult:

I only wish that they didn’t have such a turnover in people… I’ve got very close to workers that worked with me and it’s very hard to see them go and then have someone else come along and it takes awhile before you get to know them… Other than that, they’ve been fantastic.
Frank contrasted the collaborative approach taken by his PDRS agency with that of the Area Mental Health Service he was involved with some years earlier, which he saw as unsympathetic and controlling:

They weren’t very sympathetic… the answer to your problem is this - that’s what they’d treat you like… They were very legalistic, I suppose you might say. You know, you couldn’t talk to them about how you were feeling because they would keep correcting you and saying, ‘You don’t feel like that, this is the reason’. Sort of like trying to find a quick fix for every situation, instead of listening to what I was saying. The other thing is as soon as you’d start saying you’re not coping, they’d go and change your medication or they’d increase your medication, so after a while you said nothing… you’d go and sit down with them and you’d be scared to talk about what’s happening because of the quick fix sort of mentality that they had. But X [PDRS outreach/support agency] is not like that. X sits down and listens to you and… can sympathize with you and suggest things, and try them out and see if they work for you and if not we’ll try something else. That’s X’s philosophy, I think.

Harry, who received both public and PDRS services, highlighted what he saw as major shortcomings in the service system. Like other clients he emphasised the significance of a close, supportive relationship with one’s primary worker and identified the stresses involved in changing workers:

I think that is one part of the system that breaks down… because you might get used to one worker whether it’s from another support group or from the mental health side of it. And if they’ve got so many clients because there is not enough funding to get the workers in, they can’t spend as much time as they would like with the client, so they don’t get to know the client very well. They don’t get to know their illnesses that well and that would also frustrate the client… It’s just not that, it’s also trying to get a hospital bed when you’re sick… Eighteen months ago it took six weeks for me to get in.

Harry was particularly concerned about not having access to appropriate services in a timely manner, noting that such a situation was likely to increase the risks encountered by clients as they attempted to deal with their mental health problems. Specifically, he felt that the current arrangement whereby his case manager saw him every six weeks or so was too infrequent. He explained that greater frequency of contact enabled a case manager to be more responsive in discerning when his/her client was becoming unwell, hence facilitating increased support and monitoring at an earlier stage:

It’s very infrequent and that doesn’t help because my old case manager knew when I was getting sick… He was seeing me more frequently and he knew when I was depressed, so he could then try and get me a bed where this way… the thing that scares me is okay, I’m okay at the moment but because it’s so infrequent they don’t see me every week. I do have days where I’m a bit down you know and the thing that scares me and why I feel at risk is not having that support… sometimes I feel I’ve been let down because I don’t get the same kind of treatment I did two years ago.

Harry was also alarmed at the pending prospect of his discharge from the public mental health system:

It just feels like part of your left arm and your left leg have been cut off… okay I know I’m doing okay but I still think I should have a case manager, even if it’s every three months… instead of just being like put on a life boat and said goodbye. Oh you’re doing so well, here’s your lifeboat - off you go on your own. And that’s very scary.

Zoe who had recently experienced her first episode of psychosis had ‘mixed feelings’ about the public agency with which she had been involved, partly because she felt that her family had missed out on much needed support during her admission to hospital:

I think it’s a really good service… the group programs that they run are really excellent… that sort of thing I really like about it. I don’t really feel as though my family has gotten enough out of the service, like enough support and that could partly be because they haven’t sought it out actively themselves, but I think that there could be more that could be
done for them… there was a delay in me getting a case manager for some reason, so what happened was the time when my family was most in need, so when I was really at crisis point and in the hospital… when they needed the support they couldn’t get it. So I think that was a bit of a problem.

In summary, most mental health service users were troubled primarily by the prospect of becoming unwell again but generally they felt supported by the service(s) they were receiving and valued workers who were sensitive to the intricacies of their personal needs. Their concerns focused on the particularities of their individual life circumstances and on maintaining stability in their lives, including stability in the services and stability of the workers who supported them. From their perspective the risk management policies and practices of the agencies they used were not dominant factors or concerns, even if they indirectly impacted on service provision.

**Aged care**

Most of the aged clients interviewed for this project had developed various illnesses or injuries associated with ageing; two had suffered strokes, one had an inoperable brain tumour, another had osteoporosis, and two had sustained injuries from falls. As a consequence, their mobility and dexterity were impaired to various degrees. They received a range of services to help them remain at home, most often assistance with housework, hygiene and bathing, dressing, and wound care. For most, using services was a very unfamiliar experience and had become necessary only as a consequence of the process of ageing. Within this group, the duration of service provision varied from several months to six years. Most clients reported having several physical problems or illness conditions, including three cases of diabetes. Four received high levels of care and support, which enabled them to stay at home rather than go into residential care; e.g. one received personal care seven days per week, another six days per week, and two received personal care three days per week.

Although some clients received intensive levels of care, all received ongoing support from at least one family member or friend; e.g. the close friend of one female client visited each night to cook her meal and stayed for an hour or so to chat or watch television with her. A client in her eighties, who had suffered a stroke, lived with her adult son who drove her to and from appointments and cooked their meals; her daughter who lived close by came every evening to help her mother prepare for bed; and the wife of a male client helped him shower each morning. In each case, community care was provided by both formal services and the informal care and support of family and close friends (see Fine, 2007, p. 276). All clients lived in their own homes, and all had been married and had children and grandchildren. Four women lived alone, including two who were widowed and had remained in the marital home.

**Major concerns --** Clients expressed a range of concerns or worries; several worried over what might happen to them if something untoward happened to their adult children; Charlie worried that his wife was not fully prepared to take over their finances if something happened to him; several expressed concern for their grandchildren in terms of wanting the best for them; and Beryl, a client in her eighties, mentioned ‘hanging on’ for as long as possible by staying in her own home. Winnie, who has an inoperable brain tumour, was concerned about her tendency to fall and the very real risk of future injuries.

Most clients expressed anxieties about their poor mobility and the accompanying vulnerabilities and risks – and many felt very keenly the loss of their independence and autonomy, often acknowledging a range of regrets and desires for more active lives. Maria, who had suffered a stroke, wanted to go on holiday to Europe; and Isabel, who was wheelchair-bound, said that her ‘biggest wish’ was to get out of her wheelchair ‘and start running down the street’. Charlie, who had suffered a back injury, was unable to drive, noting that ‘I’m sitting in the passenger seat, which is different’; he wished to be ‘an action part of the household, rather than sitting here and receiving’. Two other clients were also very regreful that they could no longer drive. Winnie explained that before she was diagnosed with a brain tumour she had enjoyed wandering around the shops:
I used to do things like that all the time when I had my car, but I haven’t got my car now. So I don’t do any of that now. I miss all that… just get out and about a bit now. You get sick of the house.

For Beryl who lived with the daily pain and constrictions of osteoporosis: ‘the hardest thing I’ve ever done was to hand in my driving licence’; she also wished that she had become ‘computer literate’ and felt that in her mid-eighties it was too late ‘to go on the net like the young ones’, noting that she should have done so five years ago.

**Restrictions and refusals by service providers** – None of the clients had been refused service by an agency. Maria was the only client who described a restriction imposed by the service with which she was involved. She had suffered a stroke some years ago and received personal care seven days per week. She was prevented from having a walking frame with wheels because, following an assessment, the physiotherapist deemed that she would not be safe with it, and recommended that a walking frame without wheels would be more suitable. This issue was raised in the interview, in which the Maria’s daughter also participated:

[Daughter] The physios assessed mum and felt that she wouldn’t have been safe so that was something that you used to fret about a lot, wasn’t it? [Maria] Yes, that’s right.
[Interviewer] And how do you manage with this one without wheels? [Maria] Well it’s all right, but it would be better if I had the other one. [Interviewer] So do the wheels just help you manœuvre more because you don’t have to lift it up all the time? [Daughter] Yes, that’s right - this one you’ve got to actually lift up and place down before you step and sort of walk up to it and then lift it and walk and lift and walk, whereas the wheels you’re continuously moving, but the problem is with the wheels is that they can sort of get away from you and if you don’t have the sort of coordination to put the breaks on and things like that and a certain amount of balance, so that if it does start to go a bit fast or something it’s not going to throw you off balance. But that was one thing that mum felt she really was stopped from doing, but there was a reason behind it.

Clients were often surprised by questions about restrictions and service refusal, suggesting that these issues for the most part were outside their realm of experience and not issues they had previously thought about or pondered. Clients did not express a strong consciousness of the risk management policies and practices of the agencies with which they were involved; that is, it was not part of the way they generally framed their relationship with those services. They were much more concerned about coping day-to-day with the effects of their illnesses and various physical conditions in terms of the actual care they received. This reality is of course undeniable, but later we discuss the value of bringing risk issues ‘to the surface’ as they are so critical to the planning and delivery of community care.

Several clients were restricted in terms of not being ‘allowed’ to drive as a result of their illness; however, this was generally a medical decision, rather than a decision made by the particular community-based service.

**Feelings about services** – Clients were overwhelmingly positive about the services they used and several recognised that having personal care and assistance with housework had enabled them to stay at home rather than go into residential care, and on this basis the care was very highly valued. Four commented on the warm relationships they had with their personal carers. Winnie described the direct care worker who helped her in the shower as ‘lovely’; the same carer also did the housework for her:

I’ve only just started the showering lately. I was all right until just recently and I had a fall in the shower… The doctor said, ‘I think it’s time you had someone’. And do you usually get the same person? Yeah, Anna [pseudonym], she’s lovely. Oh, that’s good. And it’s a different person who does the housework? No, no she does the housework… I had a different one for the house and then I asked if I could have Anna because I’m familiar with Anna’s ways… and she’s familiar with me, you know, so I have her now for both which is good.
In summary, the aged clients especially valued the quality of the relationships they had with their personal carers; this was understandable given the context of the very intimate tasks for which they provided assistance, namely showering and attending to other personal needs. For these participants, it seemed that their relationship with workers, along with the desire to remain at home, took precedence over most other issues. For many the most present risk was the possibility of having to go into some form of residential care, or ‘losing’ a trusted carer.

**Disability**

Unlike the aged care clients, the majority of clients from the disability services had been coping and struggling with their particular disabilities and accompanying difficulties and challenges for most, if not all, of their lives. In several instances, clients were dealing with multiple difficulties, including licit and illicit substance misuse; criminal justice issues; self-harm; as well as impaired physical mobility necessitating the use of wheelchairs and hoists to transfer in and out of bed.

All clients except two had used services since adolescence or early adulthood (including one since early childhood). The exceptions were two female clients. One had a physical disability and entered the service system following the death of her mother, who had cared for her since birth (apparently without the use of formal services). The other, in her early twenties, with an intellectual disability, had recently been discharged from services after making significant gains in social functioning, including her own involvement in advocacy work.

As a consequence most clients were generally well acquainted with using services and some used multiple services (e.g. public health, criminal justice and public mental health services). Three clients with physical disabilities lived in supported accommodation with other clients (i.e. with a carer on-site over-night) - a very different situation from the community aged care clients. Two clients lived with their families in the ‘family home’ – one with his mother and sister, and the other with her parents. One female client lived with her husband; and three male clients lived alone in rented flats. None owned their own homes, and more than three-quarters of these participants lived in public or subsidised housing. Two clients had been institutionalised in the past; a male client had lived in an intellectual disability facility (‘training centre’) for sixteen years until the institution closed in the late 1980s, and a female client had spent several periods in residential juvenile justice centres during her adolescence. All received Disability Support Pensions. The State Trustees managed the finances of several clients who had encountered significant difficulties in the past (e.g. serious over-spending).

Only one client was married; one had been married in the past; and none had children. These clients were more socially disadvantaged than the aged-care clients, their social location having been shaped by their disabilities and the fact that they had not been able to participate in the primary labour force. Several had been employed but only in very short-term, low paid casual jobs; e.g. delivering brochures (‘junk mail’). One, possibly two, clients had experienced brushes with the law, which also set this group apart from the aged-care clients.

**Major concerns** - Some clients claimed to have no worries or concerns. Four expressed ongoing concerns about their physical, emotional and behavioural wellbeing. Robert, a middle-aged client, worried about not being able to control his propensity to self-harm:

> The thing that really worries me and it’s to do with this self-harm stuff... is that the CAT Team seem to think that this is all attention-seeking behaviour, but... there’s more to it than they really think... I’m worried that I’m going to go too far one day, and I know they’re going to be the blame for it because they’re not really seeing what’s really going on.

Robert also worried that his behaviour could ‘affect’ his mother ‘emotionally’, especially if she found him dead one day. Samantha, a young woman who struggled with substance misuse, was concerned about taking too many pills – whatever I can get my hands on’ – and her potential for overdosing. John was concerned about persistent migraine headaches, and Bradley was troubled about controlling his anger and stress in an effort to curb his tendency to ‘have a go’ at people who annoyed him.

Freda, who had recently become involved in advocacy work, expressed concern that many people did not fully understand the nature of her disability:
Because you can’t see it, it makes it a lot harder because people don’t know you’ve got a disability and like if they don’t understand me or if I don’t understand what they’ve told me, they don’t understand why I haven’t understood them, like they don’t understand why I haven’t understood what they’ve told me, so yeah. So that makes it a little bit difficult at times, but most of the time I’m pretty good, depends how tired I am how much I understand what they’re saying.

Lorraine needed to use a wheelchair and worried from time to time about negotiating streets and rail crossings, especially if street works were underway:

If they’re doing work like on the footpath like construction work, then there are parts where it’s unsteady, I try and find another way to get to the shops because I don’t feel safe and also I’ve had to have my front tyres changed because I was getting stuck on the railway tracks.

Gilda, who was wheelchair-dependent and required the use of a hoist to transfer in and out of bed, was apprehensive about the prospect of ‘independent living’. This meant that a carer would no longer ‘sleep over’ each night and instead residents would have access to an on-call system. She was especially concerned about getting through the evenings without support given her need to be hoisted in and out of bed. Nevertheless, she was determined to become more independent.

Most clients mentioned a desire to work for the normality and esteem of having an occupation and improved financial prospects. However, in reality this was problematic, particularly for individuals with significant cognitive impairment and accompanying poor concentration, and often a range of other health problems. Freda highlighted what she saw as insufficient funded hours for care and support, commenting that she preferred a focus on socialising rather than living skills development. For example she wished to go on holiday with a carer but this required ‘too many’ hours. John stated that he would like to be more tolerant of others and not react so quickly, generally to learn to deal better with interpersonal stress. Several others stated that they would like to learn to drive a car.

Restrictions and refusals by service providers - Two participants reported that services had refused involvement with them in the past. Robert, who has a history of self-harm, had been refused service by the CAT Team because the Team deemed his self-harming behaviours ‘attention-seeking’, rather than the manifestation of a treatable mental illness. Samantha, who has a history of drug misuse, over-doses, and petty crime, reported that some services had refused to work with her in the past because she was considered too difficult or ‘out of control’.

Feelings about services - Most clients were very positive about the services they used, often stating that they were supportive. For example, Freda claimed that the service had helped her to do the things she wanted to do – ‘to be more independent and grow up a lot’. Another felt the service she was involved with had encouraged her to do things she had never thought of doing or had not been able to do in the past.

There were very few negative comments about services. Freda, who had been involved in advocacy work, reported that DHS carers often did not turn up at their appointed times and were frequently unsuccessful with their interventions compared with the non-government service she had used. She also described the emotional loss she had experienced when a trusted caseworker left:

It’s kind of heart-breaking… like I got to know my case manager really, really well and then she left and then… she said I wasn’t allowed to talk to her anymore. I wasn’t even ringing her that often, I just rang her to see how she was one day, and she’s like ‘I can’t talk to you’… which I think is a bit sad because I know a lot of people that’s happened to. Like people will leave, like your file will be closed, they don’t do that job or whatever anymore, and it’s heartbreaking because you get to know the person so well and then they just go – ‘no that’s it’, and it’s just like well what do I do now? Like they don’t give you… the stability of someone else to keep on with that role or you know to get to know someone else. They just cut you out completely.
Again, this excerpt attests to the significance of supportive and therapeutic relationships with workers, and the loss of those relationships as constituting very significant risks to clients.

In summary, clients from disability services, like those from mental health and aged care, were concerned about the quality of care and support they received from case managers and direct care workers, particularly in facilitating their independence and their access to community resources. Like other clients participating in this study, they did not express strong consciousness of risk management policies and practices and were primarily focused on the details of their day-to-day coping and wellbeing.

6.3 – Perceptions and experiences of the family carers

Because the interviews with family carers and advocacy/support organisations were conducted late in the life of the study, we were still in the preliminary stages of analysing these interviews at the time of writing this report. Hence this section is limited to a discussion of some emerging themes from our interviews with family carers. (Further analysis is to be undertaken in the near future; and our findings will be published in a paper focused on carers’ experiences of agencies’ risk management policies and procedures.)

While clients and patients did not identify risk management as a problem or issue for them, carers generally did see ‘risk’ and risk management as problematic either for them and/or for their family members. As in our interviews with other participants we did not provide a readymade definition of ‘risk’; rather we encouraged family carers to define what risk meant to them in their day-to-day interactions and negotiations with service providers. Family carers tended to interpret risk quite broadly, as the following excerpts show - as harms, dangers and disadvantages, either for themselves or for their family member as the designated service user. Four general themes or clusters of problems were identified by carers

(1) First, the most significant theme involved carers’ concerns about what they saw as the very circumscribed roles of support workers, particularly in respite settings, accommodation facilities, and sometimes in the home. Sometimes the circumscribed nature of workers’ roles related to the organisation’s compliance with OH&S rules and regulations, including measures to reduce perceived risks to workers. This often meant that family carers felt that the needs of their respective family member were not attended to adequately, and/or that the quality and comprehensiveness of care warranted much improvement.

Judith, the mother of a 30-year old woman with a history of intellectual disability and psychosis, was concerned about the nature and quality of the care her daughter received whilst in respite care:

If they don’t check her batteries in her hearing aid or if the hearing aid gets clogged up with wax - because I clean her hearing aids every night and check the batteries every night - she’ll start hearing the voices again and go off into the other world… She’ll hear all sorts of angry voices and I’m worried that - I’m going to have to speak to them about it next week, whether they can check her hearing aids but they don’t think they should have to do that. That’s not their job; this is what you’re up against all the time, that’s not their job. It’s like… I have to cut her toe nails and finger nails. They would say, ‘Well you’ll have to pay for a podiatrist to come in and cut her toe nails’ - and this sort of thing. She couldn’t do it herself because… the Epilim [medication] now has given her hands a shake…

She likes exercise, swimming, and we have a pool, she swims very well and she finds that very relaxing and walking the dog. She enjoys a walk. Exercise seems to improve her whereas these facilities, they seem to be always inside, they don’t seem to take them out to be exercising and doing things. They should be out running around just like normal people really as much as possible… maybe there’s not enough helpers you know… some of the other clients are not good walkers, they may have something wrong with their feet, this sort of thing… it may be difficult to manage outside.

Judith was concerned about the restrictions imposed on her daughter’s physical activity and personal hygiene (i.e. regular cleaning of her hearing aid and cutting of her nails) because of the
standard routines and procedures of the service. The level of care to which her daughter is accustomed at home is not provided in the respite facility which, from Judith’s perspective and experience, may inadvertently create other risks in the longer term. If her daughter starts ‘hearing voices’ again this may trigger a relapse of her psychotic illness, along with the added stress of a prolonged recovery period. In addition, reduced physical exercise may also increase her daughter’s level of irritability – since Judith observed that she ‘seems to improve’ with exercise.

Rachel, the mother of a 25-year old man with a range of very high needs, reported similar concerns. Her son, who has a severe intellectual disability, cerebral palsy, cortical visual impairment and ‘is not mobile’, had recently moved from the family home into ‘shared supported accommodation’. Rachel explained how aspects of his physical care were neglected compared with that which he had received whilst living at home. Two main issues stood out for this carer - her son’s physical mobility and his dental hygiene. In both instances, workers were concerned about safety and with upholding OH&S regulations and, on that basis, argued that they could not deliver the kind of care that Rachel and her husband had provided at home. As the following excerpts illustrate, tensions can arise between services and family carers over their different expectations and understandings of the nature of ‘care’.

Over the years, as Rachel explained, she and her husband had helped their son ‘to walk’:

We always have walked Stephen. We stand behind him and walk him along even though his feet have deteriorated over time. That’s what he wants to do. He wants to be walked just like anybody else, so it’s pretty much only my husband able to do that now or the boys [other two sons] when they’re around. He’s bigger than me so I have a lot of trouble but I do my best if I have to. At the house [supported accommodation facility] and anywhere else where Stephen goes, no one is allowed to walk him because they say that staff might have an accident or fall... it’s unsafe for the workers so even with two people they’re saying no - he might fling himself back, he might suddenly bend at the knees, his gait isn’t good enough you know, there’s too much lifting involved, our staff aren’t tall enough. I could probably write a book on the number of reasons that people have given for not walking him any more. And really sadly you know when he moved in there they put in ceiling hoist tracks and they got a walking harness for him and it never gets used because they say that they don’t think the walking harness is safe for him and safe for the staff, so it just sits there... it never gets used either at his day program or at the house because once again OH&S issues and that was recommended by an OT, so it’s not like it wasn’t recommended. So the idea was that he would keep his walking skills up because the longer he can weight bear all the better on the service system it is. So at the moment we’re the only people who are keeping those legs going and you know it’s really sad because as soon as we stop he’s going to end up I guess you know more physically disabled.

Like other carers, Rachel and her husband had developed what often appeared to be very idiosyncratic techniques of care in order to complete routine tasks of daily hygiene or to deal with particularly challenging behaviours. For the most part, it seemed that services were unwilling to adopt or integrate such peculiar or non-standard techniques into their practices, even though these techniques would be likely to ensure success with the respective task. To illustrate, Rachel described one of the idiosyncratic ‘patterns’ they used to settle Stephen in order to clean his teeth. For several reasons, including safety, workers at the accommodation facility felt unable to adopt this technique. Thus Rachel was concerned that lack of an effective technique was likely to have negative consequences for Stephen’s future dental health:

We stand him up to clean his teeth, we stand him up against the sink and we cut his nails, so we’ve got all these little patterns that we use. The staff don’t cut his nails at the house because they had too much trouble... He’s a Wally with water, he wastes a lot of water and while I’m holding Stephen up against the sink my husband cleans his teeth or cuts his nails or does things like that... I guess the dentist feedback on Friday was well you know staff need to be cleaning his teeth better, you know he’s got plaque, they can see that we do it properly but that’s not enough of the week [he stays with his parents two nights per week] and you speak to the staff and they say, ‘Yes but we can’t get him to open his mouth, he just bites the brush’. And we say, ‘Well he doesn’t do that if his hands are under water and
you know he’s distracted in that way’. Then their answer is, ‘Well we’re not allowed to stand him up against the sink... we can’t get the wheelchair up to the sink so he can get his hands in, so we can’t do it’. Yeah, so it’s tricky. (Our emphasis)

(2) A second theme emerging from our interviews with carers was the considerable emotional stress they experienced in their roles as carers (which created its own range of risks, including poor physical health), along with difficulties in negotiating very complex service systems. In the following excerpt, Cathy, the mother of a teenage girl who had experienced intensely disturbing psychotic symptoms from the age of eleven or twelve, describes the bewilderment and confusion she felt at the time, not knowing exactly what was happening or to whom she might turn:

In the initial phase when you need the most help and assistance and support... they [public mental health service] didn’t respond, they had their own agenda and they didn’t listen to us at all, they didn’t explain, they didn’t help Emma, they didn’t listen to her, all they did was try and discipline her and tell her that what she was feeling and seeing actually wasn’t happening so they were denying the reality that she was living in, they were telling her that there weren’t spiders on her skin... because she had tactile hallucinations, she had visual hallucinations and it was very hard as her mother to hear them saying on one hand, ‘No it’s not happening’ and her saying on the other side, being absolutely distraught at what was obviously happening for her, and being stuck in the middle and having nobody that could explain that - what I subsequently got later down the track.

Carers see themselves as having to bridge two different realities—that of their disabled or frail relative and that of the professional and service world. Reconciling these realities can itself be stressful, as Cathy explains:

The realities that Emma was living and the nightmare that she was living, it was very hard initially because you believe these people, they’re professionals, they must know. But you’ve got this distraught young person and I can remember saying, ‘But why would she make it up? Nobody can dream up the nightmare that she is living you know; where does that kind of imagination come from? You can’t make that up’. But they just said, ‘No, she’s a badly behaved child.’ It was more damaging because I was absolutely torn - these professionals are saying this, my daughter is saying this, who do I believe you know, so what I chose to do was educate myself and get help... so I read books and I talked to people. I remember one day I made fifty-four phone calls, STD phone calls, because we were living at P; I made fifty-four phone calls to try and get somebody to listen, to get help and I only started out on that track only because I’m a pre-school teacher and in one of the newsletters that came through from X [non-government agency] to my centre, I found the name of somebody and I thought that might help me and I rang them and they said, ‘Ring somebody else’, and ‘Ring somebody else’. I spent two and a half days on the phone trying to get help for the family and for Emma.

(3) Another theme, which relates closely to the previous one, involves carers’ experiences of not ‘being heard’ - feeling that they were not respected for the intimate and expert knowledge they possessed about their family member, nor utilised as a resource in situations where they felt their input could make a difference. In the following excerpt, Estelle reflects on the experience of accompanying her father, who had dementia, to an Emergency Department of a general hospital:

An acute hospital isn’t geared to cope with relatives. And you know they don’t see that the relatives could give helpful suggestions and advice and be of assistance to them - they just see you as being in the road and want you out of the way. And then you feel frustrated because you know that if you were listened to you can make the situation so much easier both for the person with dementia and for the hospital staff that are caring for them... In my experience it was at its worst in an acute hospital situation when they’re hospitalized for a medical condition that’s got nothing to do with their dementia and the hospital doesn’t seem to be able to care for the two conditions together. They will treat them as a heart patient
whatever, but the fact that they’ve got dementia is irrelevant or we’ve had students, residents, whatever doing a mini-memory test and turning around and say, ‘Oh he’s scored fine - he hasn’t got dementia’. You think, ‘Well yeah you haven’t lived with him’.

(4) Finally, some carers were concerned that a strong emphasis on duty of care, the need to protect against risks, was at odds with public policy objectives to deliver individualised or person-centred care. They reported that duty of care had actually limited opportunities for their relatives to get involved in a range of community-based activities. In the following example, Susan, whose 30-year old brother resides in a CRU, had recently engaged the services of a non-government support agency (‘day service’) to take her brother on outings and to involve him in various activities. She explained that the CRU was very risk-focused in their practices and had not provided him with individualised activities in line with state policy:

I’m relying on them [CRU] to provide care to my brother and they come and say we can’t do this because there’s a risk of this, this and this and as an example, sometimes the terminology they use sort of criminalizes the behaviours - they say he’s ‘assaulting people’ and ‘attacking people’ and that sort of stuff…

We report in detail a story Susan told which demonstrates how significant the context of a risk incident and the roles of the actors are to the way they frame and understand risks.

…..I’ll just give you an example of the differences between the CRU and the other guy [new non-government service]... The day service, and the X [CRU] person… took him out… to the city and Southern Cross Station and so then Richard wandered off because he can’t sit still, so he wandered off and he looked like he was going for somebody else’s food… like at a table nearby so they redirected him and they took him for a walk along the Yarra. And then as he was getting redirected, the new service person - Richard grabbed his hand as if to go back to the food and it was firm but it was playful like it wasn’t to be aggressive, but he did grab his hand, not briskly but he did grab it and he did everything appropriate - he changed it into high fives and said you can have food and this and that… and that’s what happens and the X [CRU] person and the new service person… they were both there and it was fine, the day was fine so they came home and the house supervisor said, ‘How was the day?’ and he [from the new service] said, ‘It was great. Oh he did wander off for a bit and you know grabbed my hand to go back’, and it was – ‘Oh you’ve got to write an incident report’. He goes, ‘I don’t really think that’, and he goes – ‘Well you have to’. And this guy is new, he’s only been there for three weeks and he says, ‘I wouldn’t have thought I had to, but okay I will’.

So he wrote an incident report and the X [CRU] person... was an agency person, so he did that with the assistance of the house supervisor, so they wrote it independently and after he got back to the office he faxed it through. So the day service person wrote one exactly what I described - he wandered off this and that... [whereas] the house supervisor said, ‘Richard attacked and assaulted two staff and he’s absconded’ so those words conjure up a criminal sort of, and it’s so dangerous because that sets him up for restriction and punishment and first of all it wasn’t, he was playful the whole time and fortunately the day service person was at the care meeting and said, ‘Hang on, that’s not what happened at all’ and the house supervisor said, ‘Well those are the terms that we use and if he’s assaulted staff maybe he shouldn’t have gone out’, and from my perspective I think that’s extremely dangerous to term it in that way because if a person hadn’t been there to correct it then there’s two different pictures of who my brother is and he’s not an assaultive attacking person.

In this excerpt, Susan highlights the potentially punitive consequences of risk-averse discourse and standard terminology that can sometimes ‘label’ a service user as a high risk without considering the person’s behaviour within a context, including his/her personal needs and any shifts in behaviour that may have occurred.

Our preliminary analysis of the interviews we conducted with family carers demonstrated a number of themes, but we have focused on those most common and the most significant to the participants. In summary some carers expressed concern about the way risks could circumscribe
the roles of support workers in particular; some carers described experiencing considerable emotional stress in their roles particularly around difficulties in negotiating very complex service systems; many carers felt that they were not ‘heard’ by services, that they were not respected for the intimate and expert knowledge they possessed about their family member; and finally some carers were concerned that a strong emphasis on duty of care was at odds with public policy objectives to deliver person-centred services.

CHAPTER 7

SHARING RISK: HOW IS ‘RISK’ MANAGED WHEN MULTIPLE AGENCIES ARE INVOLVED IN THE CARE OF THE SAME CLIENT?

7.1 Introduction

The increasing complexity of community care over the last few decades is well documented in the international and Australian literature. This complexity, including the fragmentation of services, means that risk is often shared across agencies. As part of this project we set out to investigate how agencies and individual workers perceived and managed the sharing of risks. In our interviews we found that ‘risk sharing’ between partners or collaborating organisations was an unfamiliar way of thinking to most participants, and clearly not part of their conceptual world. Risks were generally framed within each individual’s organisational context, although several program managers in particular highlighted the need to develop strong collaborative relationships with partner organisations in order to achieve more effective and safer levels of care.

Specifically, we asked program managers and frontline workers:

*When you have a client involved with other agencies at the same time as yours, who carries the risk or is it divided amongst the agencies? How does this work? [Draw out specific examples.]*

Seven themes emerged from participants’ responses and reactions to this question:

(1) There was a high degree of difference, confusion or lack of clarity concerning the notion of sharing risk with other agencies involved in providing care to the same client; and some participants admitted not knowing how to answer this question, thus suggesting that it was outside their frame of reference (or the discursive materials used in their day-to-day work).

(2) Around half of the participants believed that risk was ‘shared’ or ‘divided’ amongst agencies involved in the care of the same client. They generally understood that the degree of an agency’s risk responsibility was related to its particular role or function in the delivery of services and to the individual agency’s risk management policies and procedures.

(3) Case managers were seen as having a focal role in managing risks when several agencies were involved in a client’s care, especially in relation to their planning, coordinating and facilitating roles.

(4) Discussions of risk sharing by community mental health workers stood out from other workers’ discussions because of their focus on defined clinical risks. Participants were unequivocal in their view that serious clinical risks were to be transferred to the relevant public mental health agency.

(5) Several participants identified specific tensions and inherent difficulties in the nature of sharing risk and risk information with other agencies; particularly around the need to uphold client confidentiality, negotiate around different expectations about what was acceptable risk, and resolve competing interests in the management of those risks.

(6) Four agencies reported what we described as ‘risk dumping’ - when a referring agency withholds certain details about a client’s riskiness in order to have the referral accepted.
(7) Amongst all the interviews with program managers and frontline workers, there was only one discussion of a formal risk sharing arrangement at the organisational level.

In the following analysis we illustrate these seven themes with a selection of responses evoked by our main question about ‘risk sharing.’ We will return to this major issue in more detail in Part Three of this report.

7.2 Key themes

(1) For most participants, the risk sharing question was not straightforward; on occasions it caused genuine puzzlement and some participants were surprised and challenged by the question. A case manager from a large agency that supports aged clients, and adults and children with a range of disabilities, found this a ‘very interesting’ question. The following excerpt shows how she thought through the complex issues and ambiguities that were raised by this question:

I’ll try and think of an example – so a lot of our clients would be involved with us, X [home nursing service], the council and perhaps a private agency. If it’s a private agency and we’re paying for it I guess we’re carrying the risk, that’s how I see it anyway. They are to an extent – no, but we’re paying for them and so the agency has to have done police checks and they have to train the carer but we have to ensure that’s happened in a sense - if they’re on our books then we have to have made sure that they and, so I feel if something was to happen - I suppose you share it with the agency but I think it ends up with us. With say X [home nursing service] that’s an interesting one. We probably are sharing it; it feels like at the end of the day though it will always come back to us because as the case manager… sort of the buck stops [here]. Less so here [in this agency] because I’ve always worked in DHS and things which it definitely does there. But here, if you haven’t been engaged properly with the other service providers then you can leave yourself wide open I think - that’s what I always keep saying about working jointly with them. I don’t know - council would do the same and flick it straight back to us, that’s what would happen, ‘talk to the case manager’. But in reality I think it should be shared but I don’t think it always is.

In the following example, although this program manager/social worker from a PDRS outreach-support agency expresses uncertainty over the allocation of risk responsibilities across multiple agencies, she is very clear about her own agency’s responsibilities and the hierarchies involved in the transfer of risk between agencies:

That’s a good question… often the GP is involved… I don’t know if this is true or not, but my perception is that we carry more of the risk. If clinical services are involved and we believe there’s risk and we let them know, my opinion is that they would carry the risk. And if we assess a client needs to have increased services, it might be that their mental state has decompensated or, for example, they might be under the influence of substances for an ongoing period and they’re becoming more and more erratic and unpredictable. We would be letting other services know that, and I have gone to the extent of when we’ve done phone calls and verbally let clinical services know and haven’t been happy with the response, then the next step is to write down that we’ve noticed a change, we’re concerned, this is what our concerns are and if it’s after five, I’ll fax it through to Triage, noting that I’ve also phoned them. And then during business hours we actually hand deliver it to clinical services as well for their files.

Eight participants voiced marked uncertainties about the question of risk sharing; several felt they could not give an answer and others found it ‘tricky’ or ‘confusing’. Most highlighted the ‘lack of clarity’ around issues of risk sharing, often noting that situations tended to be dealt with on a case by case basis. A program manager/social worker from a large agency that supports aged clients, and adults and children with a range of disabilities, reflected on the ‘tricky’ nature of inter-agency relationships and risk responsibilities as follows:

That’s a very tricky one… I couldn’t safely say, or couldn’t clearly identify who carries the risk; we all carry bits of it… Sometimes it’s more clearly identifiable, but in a lot of cases when you have a lot of agencies involved… it does get tricky, especially if you’re reliant on
good information from one area to deliver a service in another area. So if that information can be misconstrued, misinterpreted, or just errant, then do you say that the person who gave the information is the one that takes the risk, because they have been negligent in their job, or is it the person… who’s actually gone in there to do the work?

A case manager/social worker from an Area Mental Health agency provided a very compelling analysis of the confusion that can arise when multiple agencies are involved in a client’s care. Using a specific case which involved mental health, intellectual disability and other services, he illustrated how such confusion was heightened in cases of high complexity and risk and conflicting perspectives amongst service providers – and significantly because there were no clearly prescribed or accepted procedures to ‘make sense of what’s happening’. In fact, this participant felt that the situation provided a learning opportunity. In his case example, an intellectual disability service was designated as ‘lead agency’ on account of the client’s diagnosis:

So therefore that means that we’ve got to… fit in with their plan and learn about it you know and I guess respect their role as lead agent. But once you have established a lead agency then it does make it a lot easier because you don’t have these two equal forces going bang, you’ve got one that has pre-eminence if you like…

I mean I’m currently involved in a difficult situation where there’s multiple organisations involved in the care of a young lady - I’m a case manager for her and the whole question of risk is, well it’s probably one of the biggest aspects and contentions between these seven or eight organisations including police, ambulance, ED department, disability services, psych services, everybody has got a different attitude. The family themselves - there’s a highly volatile situation there - and that is an example where it’s almost too hard to talk about because, not from an emotional point of view, but trying to make sense of what’s happening… it’s just an endless, trying to arrive at a consistent equally understood and agreed upon plan where all parties feel as though they’re meeting the requirements of their own respective organizations - it’s a very, very difficult situation. And certainly that’s one where the family’s understanding of risk and how it should be managed is really poles apart from our own, and also I might say many of the other organisations.

A specialist case worker from a government disability service felt that risk sharing with other agencies was poorly defined, but focused his discussion on the related issue of different risk-taking thresholds across funded agencies and argued that this was driven, at least in part, by competition to win government contracts:

The agencies… take risks, in my view, take too greater risks because they are seeking work from the Department and for them to say that they’re not going to do something because the risk is too great, that opens them up to the possibilities of the Department moving somewhere else and finding another agency to do that… some agencies are prepared to take greater risks than say maybe the Department would if it was doing the same piece of work… some agencies take risks in order to get the work.

(2) Those participants who felt that risks were ‘shared’ or ‘divided’ amongst community-based agencies had specific ideas about how the risk responsibilities of respective agencies were defined and distributed, and qualified their responses accordingly. Factors identified as significant in determining the extent of an agency’s responsibility included: the agency’s functions or roles, the agency’s specific risk management policies and procedures, the nature of the risks involved in a given client’s situation, the degree to which the client was engaged with the agency, and ‘who’ was on the scene when the risks actually manifested. Some of these perceptions are illustrated in the following excerpts, which also show that these participants saw risk sharing as agency-specific (i.e. agencies were individually accountable for managing very particular risks):

Between the agencies - depends on what role that agency is actually taking. I guess we case manage a lot of people and then we might have attendant care that goes out to another agency like DASSI or Wesley or somewhere like that. And really we would approach them… with the package of money and say, ‘Look this is the person, this is what we need’ and then they would make an assessment of whether it was within their
capabilities to do it and if they weren't, then that would be their call. And look vice versa, if we were asked to do attendant care for somebody and we saw it as being too risky, then we also have the right to say no to that and probably wouldn't take it on, so it's very much you negotiate that with the other organisations (program manager, specialist disability service; our emphasis).

I'm thinking of a client [who]... has extreme suicidality... extreme self-harming... I have linked her into a number of other agencies, so that she gets the support that she needs - so that's a mental health agency, occupational therapist, and I've talked to her doctor, her psychologist and I've linked her in with home help... As far as risk is concerned, I personally will carry the risk, I'll carry the can... if she's not linked into relevant agencies that she needs to be linked into. I'll take responsibility for that, that's my job to link her in. But say, for instance, she commits suicide, now as her case manager I've already made a plan with her, I've covered myself... Now it's not my responsibility if she commits suicide. I've linked her into a mental health outreach team and it's really not theirs' either... if I found out that she was for some reason being treated really badly as a client, say for example she had a really bad worker for some reason, then it's my job to advocate on her behalf with the management in that team. So, I will take those positions of advocate and case manager - linkage. I don’t know if you call that responsibility or taking responsibility. That's my responsibility, that's my role, but if things go pear-shaped, I don’t think that's necessarily my responsibility. It would be my responsibility if I neglected this person and didn't link her in, in the first place (case manager/social worker, church-based provider of a wide range of services to adults and children, including housing, welfare and disability support, our emphasis).

I think the risks sit with whoever is working with that person at the time. So we may support someone from say 2 o’clock to 4 o’clock on a Monday, but somebody might support them from 9 o’clock till 12:30 for example, so... for us it’s done as an individual agency so even though... we do work with other agencies for the better of the person, but that’s around their program [client’s personal program]. I think how we see it is that whoever the support worker, whatever agency they’re working for, you know risk to that person that’s working there - that’s how the system works, it comes under whichever agency they’re working for (team leader/direct care worker, support service for adults and children with disabilities, our emphasis).

It’s divided amongst the agencies, so the risk attributed to your agency for the care that you’re providing is yours to own and nobody else’s and each agency would assume that sort of risk. If the service is brokered out to us from another agency, so they’re the fund holder, but we’re the service provider then all the risk around service provisions, so Occupational Health and Safety and you know work cover and all those sorts of things, are ours and we wear that. Things like I guess public liability, that's actually the client’s risk, so when you’re in their home, that's theirs. The financial risks and so forth are the fund holders’, so it's sort of portioned up depending on what you’re doing and what you’ve assumed responsibility for (program manager/nurse, service providing support and home care to the aged, our emphasis).

(3) Case managers were seen as having a focal role in managing risks where several agencies were involved in a client’s care, largely because of their ‘linking role’ (as exemplified by the second excerpt in the above theme analysis). The particular role of case managers in ‘sharing’ risk was mentioned frequently, mostly by case managers themselves and also by program managers from case management agencies. Several participants noted that case managers were responsible for coordinating and communicating all relevant risk information to the other agencies involved in a client’s care, and therefore carried greater responsibility than individual workers from these other agencies. The following two excerpts from interviews with case managers show very clearly that they saw the sharing of risk information as central to their responsibilities:
We as an agency are responsible for communication about managing risk - that's probably the most effective tool you have in pre-empting or preventing known risks. So the line of communication is very important, that’s a crucial thing in case management from my point of view... As to who gets to know what, when, for what reason - often we will have situations where clients and external providers collude as to the outcomes and what we know from the point of view of monitoring and supporting things that if there’s a change... it just needs to be put on the page and if it’s not been put on the page it can have all sorts of practical implications, so it’s got to be that open communication and trust in sharing information. And if it’s not occurring, nine times out of ten the client’s going to miss out as a result (case manager/social worker, case management agency providing assessment and home care to the aged).

That’s interesting because our job is a linking job, and when the clients come to us they might not be involved with any other agencies, so as... the linker and the leader in a lot of ways we would be responsible for the risks, although there would be more specific things like if we linked them in with an OT or physiotherapist or speech therapist, things that are more related to those specific areas, the risk would then be more shared. Okay, could you give me an example of shared risk? Well, I guess if I linked a client... in with an OT because there’s a lot of clutter in his house and he’s been homeless on and off for a lot of years, so he’s really a floor person - like he likes to do things on the floor - and we need to support him to live how he wants to, but to make it safe for other people coming in and for his own health, to make his kitchen a bit cleaner, so that he doesn’t get sick all the time - and so the OT is more responsible for those kind of things like looking at what sorts of things he can manage in his daily life... so that would be one example... I guess if we referred someone to other specific medical agencies like a GP or optometrist or dental, then all those parts are shared. But we’d still be the umbrella I think, yeah (case manager/social worker, specialist disability service).

(4) Program managers and frontline workers from the participating mental health agencies had very specific ideas about the sharing of clinical risk, particularly risk of self-harm and harm to others, primarily because of the more extreme nature of these 'risks' – which were often perceived as a matter of life or death. Participants from both PDRS and public mental health agencies were unequivocal over who would take responsibility in situations of serious clinical risk. Public mental health services were seen as the risk specialists, given their ‘clinical’ or medical expertise and their statutory obligations. In contrast, PDRS services were responsible for ‘rehab’. So, when a PDRS agency and a ‘clinical’/public service had a client in common, clinical services would take the lead in terms of conducting a risk assessment and advising on how the particular risks were to be managed.

Nevertheless, several frontline workers from PDRS agencies explained that the greater burden of risk was actually carried by PDRS services - though ultimately they might not be responsible for it - through dealing with risk issues on a day-to-day basis. As a result of the nature of their work, PDRS workers often spent significantly more time with their clients than did case managers from clinical services, and thus bore the brunt of managing risk in a very practical, hands-on sense. A clinical psychologist from an Area Mental Health Service explained that, in her role as case manager, she was responsible for arranging meetings with other agencies, following which she would formulate a management plan and inform the other agencies about it – but as the mental health specialist and as part of the ‘clinical’ treating team, she made the final decision regarding the management of any risks. The following excerpts provide an insight into how mental health participants in our sample regarded risk sharing with other agencies:

I feel that we carry most of the risk here, especially because we have the most contact... we know day-to-day what’s happening with the clients, where someone like clinical services might get a snapshot every two weeks... so I feel that yeah I’m holding the risk and I’m kind of ringing up clinical services and saying, I feel the client’s at risk of whatever... so yeah we definitely do... we get to know the clients really well, they’re here for three years. Case managers turn over a lot (support worker/ social worker, PDRS agency).
It depends on the type of risk. So, I consider that I’m clinically responsible around young people’s deterioration in mental health, self-harm, suicide, those things. Risk around vulnerability or homelessness… I think if there’s other services involved like an accommodation service or Child Protection, risk within the family environment, I think I have a responsibility to feed that back to the organization, but I don’t see it as my active role that I can intervene in it except to advocate that the service assess and consider what needs to happen and I think other services, the way I set up crisis plans is if you know they’re concerned around self harm, suicide risk that they need to notify the treating team and that we are responsible for assessing that and then coming up with an intervention for that. So, I think it’s shared responsibility but then some organisations need to take the primary role as well, but we all have a responsibility with communicating around them (case manager/psychologist, specialist public mental health service).

I think definitely it’s being divided and… I see clinical services as taking a greater burden of the risk at the extreme end of the scale in terms of risk of say assessing if someone’s going to be violent or if they’re making threats about violence - is that because they’re unwell or they’re just being horrid? And suicide risk, as well… I see our role as alerting clinical services, okay it looks like there’s this sign here. It’s one of the risk signs and then I would say we’re handing it over to them to investigate and have a look at and make a clinical judgment about that (program manager, PDRS agency).

My sense is that it is divided amongst the agencies and I do think sometimes there is some kind of mutual anxiety around that… sometimes you know [program manager] might say, yeah okay well we can do that but get the clinic to say it. Do you know what I mean? …Make sure that it’s documented… If someone’s skipped their meds for a couple of days there is nothing that the clinic can necessarily do about that, but we ring them and let them know… Just so that if anything goes wrong, we’ve got documentation to say the clinic knew about that, right. So I think we do kind of really try and spread the responsibility (senior support worker, PDRS agency).

(5) Several participants identified very specific tensions and difficulties involved in sharing risk information with other agencies. Most frequently mentioned were tensions between the need to protect client confidentiality and duty of care to other agencies or person(s) involved in the client’s care. The following two excerpts highlight this tension. In the first example, a case manager from a government disability service talks about the ‘internal conflict’ she experienced over the prospect of revealing to another agency that her client was a sex offender:

I didn’t think it was fair to him, to know that he was a registered sex offender, so I had an internal conflict happening for me. Anyhow, I sought supervision and I said, ‘well… this is a bit tricky’ - but the service that was going to provide the support had a right to know as well, so it gets really difficult and the outcome of that was, well he’s done the crime, he’s done the time, but there’s a duty of care also to his support workers and so then I’m just hoping that they dealt with that in a respectful manner, but it was out of my hands and that to me was a difficult time as well.

In the second example, a case manager/psychiatric nurse from an Area Mental Health Service, questioned the extent to which a mental health agency should take ‘the lead’ in situations where multiple agencies were involved, simply by dint of dealing with mental health matters. She also discussed a situation where she had felt uncertain over how much information to hand over to a female volunteer about a male client’s mental illness without jeopardising his privacy, but at the same time providing adequate information to enable the volunteer (who was to provide him with a much needed food parcel) to responsibly protect herself:

I don’t think… just because somebody has a mental health issue and they have drug and alcohol and financial and you know rehab or physical health issues that we should be the lead agency or the lead clinician, that’s absurd. That’s virtually saying that that’s the most important part of them or the most critical issue in their life, whereas it may be that the relationship with their partner and the counselling that they’re having is the primary concern for them. So in terms of risk we shouldn’t translate that to mean that the primary
responsibility lies with us. I don’t think it does. I think it should be multi-faceted you know. And it should be something that’s coordinated and known and I guess the difficulties around working with other agencies is how far do you go in terms of passing on information about risk to other agencies and that’s always been a bit of a dilemma, particularly with me working with GPs and sometimes counsellors. For example there was a guy in C [remote area] who needed some food parcels and I had no idea who the guys were that could provide any sort of assistance in that regard and managed to get hold of a lady who ran the local opportunity shop who also did food parcels and you know basically what I had to say to her was this guy is on a CTO and he has a health issue, you need to be mindful of not doing a home visit alone or at all and if you’re going to meet this gentleman, may I suggest that you have somebody else in attendance when you’re meeting with him in the shop or somewhere in a mutual situation without giving too much information or frightening the poor woman half to death.

The program manager of a government disability service observed that it was difficult to share risk effectively with the Department’s funded services because these services had their own separate risk management structures:

If something goes horribly wrong, they’re liable for that because they’re managing the service. But the other side of that is when things go wrong in funded services, clients come back… it’s difficult when you’re the funder rather than the manager of that service because it limits how much influence you can have on the way the service is managed. At the end of the day if the service says, ‘No we’re not going to do that because we don’t think that’s how we want to manage it’, all you can do really is - you have a choice of saying, ‘Alright, well we’ll find another service’ of which there were none.

Finally, an occupational therapist based in an aged care assessment team felt that the idea of risk sharing with other services was inherently problematic, in view of the very different tasks and philosophies of each agency:

Because they’re doing different tasks, so local government - the person is going to be throwing a mop around the floor and some people have… holes in their floor covered up with bits of wood… that kind of thing. So you know you want to keep the direct care worker, the home care worker - if they’ve got one set of risks and the RDNS nurse calling around at 8 pm to give the person their medications - they’ve got another set of risks. I mean, it would be lovely if one set of questions could be asked and everyone could benefit.

(6) Workers from four agencies discussed episodes of ‘risk shifting’ (our term), where the referring agency withheld certain details of a client’s riskiness in order to have the referral accepted. As the following excerpts suggest, such episodes could generate a range of difficulties. A program manager from a home-based nursing agency argued that duty of care to other organisations ought to override confidentiality considerations:

I’ve been in the situation where we’ve perhaps had a referral from somewhere where a risk hasn’t been shared with us, so a risk situation. We had one just the other day where one service provider wasn’t prepared to go in and they pulled out, so they referred to us and… to me there should be a duty of care from one organisation to another to actually protect one another and to share that information.

A support worker/social worker from a PDRS agency expressed concern about the potentially damaging consequences of risk dumping for clients:

They’re [some agencies] a bit reluctant somewhat at times because they think if they put too much information in the referral we are likely to not take them on… One client we just exited from the program, we only just found out after we exited the client that he had a lot more extensive criminal history than we thought, including assaults, which kind of wasn’t disclosed to us, which is really disempowering, because we’d rather know that kind of stuff… So we could deal with it and it’s kind of worked against the client because, if we had of known that beforehand we could have put in place interventions… to keep him in the
program... But then all this kind of weird behaviour came out and we didn't know. It was unexpected... threatening 'to do me' kind of thing.

There were a number of discussions of risk sharing with other agencies in terms of case conferences but these were generally ad hoc arrangements that were made as the need arose, according to the circumstances of individual clients, rather than formal structures and processes for inter-agency collaboration and problem-solving.

(7) Amongst all the interviews with program managers and frontline workers, there was only one instance of a formal risk sharing arrangement at the organisational (management) level. This particular arrangement was discussed by the program manager of a home-based nursing agency. She felt that risk sharing was 'problematic' without formal risk agreements between organisations:

I shouldn’t mention X Council but we have a really good working relationship with them. We actually have set up a Shared Care Committee, so... we’re going to work through those issues, so that we believe we’ve managed our risks to the point where we can’t do any better. What we are asking the Council to do is to share that with us and we already use the same risk forms... We are going to do similar training, so that when we all go in we’re saying the same things, so somebody who’s going in to do home care is not saying, ‘Oh it’s okay - I'm not afraid of you’, but we’re going in saying, ‘Hang on, we’re not coming in because you’ve got a Rottweiler’ or something, so we’re trying to get shared agreement on processes.

7.3 Conclusion
The interview excerpts discussed here demonstrate the diversity of understandings through which workers framed their ideas of responsibly managing risks when working in partnership with other community-based agencies. These findings seem to suggest the absence of clearly defined protocols or guidelines for negotiating and sharing risks with other agencies, and a general reliance on ad hoc measures implemented on a case by case basis. We will discuss further the implications of this finding in Chapter 9, where we will also offer some suggestions for possible solutions.
CHAPTER 8
RISK CULTURES: HOW DO DIFFERENT ORGANISATIONS UNDERSTAND AND FRAME ‘RISK’ AND WHAT ARE THE POSSIBLE CONSEQUENCES?

8.1 Introduction
We conclude this reporting of our main findings from the interview phase of the project with a brief discussion of ‘risk cultures’. We had not set out specifically to study the risk cultures of our participating organisations. Over the different stages of the project observations about the way in which issues of risk and risk management were framed at the organisational level emerged as significant to our research questions. However, the present study was exploratory and sampled small numbers of people from thirty different participating organisations. To examine organisational culture more systematically would require depth, rather than breadth, by interviewing a larger number of managers and professionals from fewer organisations. It would also be important to consider the degree to which a coherent ethos or risk culture was articulated within an agency. In many cases, because of the research design of this project and its exploratory nature, it was not possible to make definitive statements about the character of each participating organisation’s risk culture and there was great variation across the interviews in terms of the extent to which participants described their organisational risk cultures.

In this chapter, we only report on some emerging findings which require further study and also suggest fruitful areas for future research. Though this chapter is relatively brief and in part impressionistic, we felt that what emerged from the interviews was significant and distinct enough to warrant a separate discussion.

8.2 Risk Culture
The way in which service policies and organisational cultures around ‘risk’ shape the practices and experiences of human service professionals is an important question – especially in the context of the current public policy emphasis on the provision of individualised care and concerns expressed by academics and professionals over the loss of professional agency in the human service professions.

We found that the extent to which organisations successfully balanced their service goals and clients’ needs alongside responsibly managing risk depended not so much on the procedures and systems adopted but on the organisation’s risk culture and the degree to which the organisation and its workers were able to approach the management of risk as part of, and integrated with, their service goals. Organisations with a positive risk culture were characterised by an open dialogue about risk and service values and goals, and this dialogue appeared more likely to occur in non-government and smaller organisations.

Drawing on the literature, Kirsten Stalker (2003, p. 227) notes that ‘different styles of risk management are located along a continuum ranging from control at one end to empowerment at the other’. Organisations may be controlling in some areas of risk management and empowering in others. In some agencies workers are encouraged to report any concerns with the aim of improving practice, whereas other agencies may evince a blaming attitude that discourages the reporting of risks, fosters risk aversion and heightens workers’ anxieties (Stalker, 2003, p. 227). Some adopt a ‘broad participatory approach’, involving clients in risk management decisions as much as possible, whereas others rely solely on professionals’ views (Stalker, 2003, p. 219). In some cases, as we found in our research, frontline workers feel disenfranchised in situations where administrative and bureaucratic risk management procedures are given precedence over professional expertise and decision-making. Anna Yeatman (2009, p. 19) argues that such disempowering effects occur in contexts where the policy environment of the service ‘bureaucratizes’ the relationship between worker and client by ‘subjecting it to externally prescribed rules, procedures, and form-filling that deprive the service worker of initiative,'
creativity, and, above all, a sense of being trusted to respond professionally and appropriately to the needs of the individual client’ (Yeatman, 2009, p. 19).

8.3 Key themes
The following excerpts and commentary provide a spread of program managers’ and frontline workers’ experiences and insights into their employing agency’s risk management culture. Several themes emerged from these excerpts: participants’ identification of different organisational approaches to risk management, the need to integrate risk management practices into the practices of case management and clinical care, the degree to which workers could ‘openly’ discuss issues of risk, and tensions that could arise in the context of organisational policies that seemed to ‘bureaucratize’ the relationship between worker and client.

Framing different organisational approaches to risk management
Some participants identified differences between their respective organisation’s approach to risk management and that of other service providers with whom they had a working relationship as partners, collaborators or members of an interdependent service team. A senior program manager from a case management agency that supports aged clients, and adults and children with a range of disabilities, highlighted the difference between her organisation’s approach to risk management and that of a local municipal council. She felt that the difference concerned ‘the spirit’ of the approach rather than any disparities in ‘written rules’:

Councils seem to be extremely bureaucratic… supporting people by adherence to rigid rules… Other agencies approach it… they think - this woman needs to do xyz. How can we keep her safe, keep our staff safe, but get her needs met? You know the ‘can do’ attitude, as opposed to… looking at the obstacles - and all the negatives… It’s a breath of fresh air when someone says – ‘Oh look, I think we can do such and such’ and you know ‘we’ll try this and see what happens’ and you go – ‘Oh thank god, there’s somebody who’s just creatively thinking about a problem’ because we all want to support this person, you know… So agencies do have cultures - some I can think of, I won’t name agencies, but you know I can think of one that just goes out of their way to try and think creatively and others don’t.

This program manager observed that the need to comply with OH&S requirements sometimes meant that services ‘sunk to the lowest common denominator’, whereas she felt that her service worked hard to maintain a strong philosophy and practice of person-centred care while at the same time ensuring that any new legislative requirements were integrated ‘into the mix, rather than becoming a lesser service’. Again, she understood these differences in terms of the way risk management was framed by the respective organisations. She argued that her organisation started with the client who was viewed in terms of his/her individuality and particular needs, whereas the local council seemed to start from the perspective of OH&S rules and regulations; hence the client was seen as potentially problematic from the outset:

And you know they’re not doing it because they’re nasty people, but they have said there’s legislation up there, everything is about that, whereas we’ve said there’s the participant up there, how can we mediate this, mediate that?…And some of the legislative stuff is very good and very appropriate… But it’s just when that stops service and creativity which is what everybody’s supposed to be about now.

Integrating risk management into the practices of case management and clinical care
Several program managers and frontline workers highlighted the need to integrate risk management procedures into their everyday interactions with clients. This was seen as critical to both the achievement of ethical professional practice and the fulfilment of service goals and values, including individualised or person-centred care. A program manager from an Area Mental Health Service explained the importance of integrating the risk screening into the process of ‘relationship building’ with clients:

It depends on how it’s [risk screening] done. New clinicians who go through the ‘risk assessment’ in that fairly automated way - there is a risk that they will negatively impact on
their relationship building. It’s the same as mental status assessment...The more experienced clinicians will cover all of those points and will make that assessment but do it in a way that’s not as obvious, so it’s to do with the individual’s skill and their experience and their personality as to how that’s conducted. And so it can be done in a way that it’s imperceptible to the client and... conveys empathy and caring, not just about form filling like you’re being interviewed by the police. So I think that being overly cautious, overly sensitive to risk can... reduce the responsiveness of the service to the client’s needs. If you’re very rigid and hide behind it in the way that you conduct your risk assessments or act on risk, so if you get a very rigid clinician who says... you know there’s a risk and the risk can easily be attenuated and they want to respond by having two clinicians attend... or you can only go there with the police - well that’s going to negatively impact on the way you deliver your service. So it requires balance and judgment and a degree of empathy, but in a way that protects the clinician without sliding over into ignoring the risk and just throwing all the controls out the window.

The senior program manager from a case management agency, introduced above, gave a very convincing account of how her agency had attempted to integrate risk management requirements into the actual practice of case management, including an emphasis on involving clients in their own risk management processes where possible:

So I say to case managers, you need to externalize the OH&S issues... put them on the table... we are obliged to take them into account, let’s think how we can respond in a way that meets the requirements, the legislative requirements but gets your needs met as well... So I’m always encouraging staff... to actually explain that process and you can do it in a professional way that doesn’t bag the government [or local council], you know... just say look every organization has OH&S requirements and sometimes unfortunately they don’t take into account individual blah, blah [situations], so... we need to get around them and some... of the ways that you get around them quite legitimately.

She then proceeded to illustrate with an example, showing how a highly risky bathroom in a client’s home did not necessitate excluding that client from service; instead, a ‘creative’ solution was found that fulfilled both the legislative requirements of risk management and the client’s personal needs and desires (including her wish not to have a sponge bath in bed as the safest option):

I know somebody who had a bathroom floor that was absolutely rotting... the part that was rotting was by the shower... because the shower was leaking. Now this was a clear OH&S safety thing. If you were a large person walking on that floor you know you’d be at risk. But the reality is - two old people living in this house, we’re in the process of getting funding; what did we do? The bathroom was quite large, we basically said - Don’t go near that shower [to the direct care worker]. And we got a bath hoist and a mobile hoist to get the person sitting on a shower chair in the bath... and with a hand-held thing... and all documented while we are getting quotes [to repair the shower]... so long as you can see a process and that was a creative response to that.

In this context, she discussed another example which involved a more explicit illustration of externalising and sharing risk management decisions with a client. This situation involved a woman in her early fifties with muscular dystrophy and has been discussed in Chapter 5 as an expression of the positive risk rationality. In this example, the program manager recounted the open dialogue that the service had established with this client; the client, wishing to remain living alone at home, argued that she was willing to take the risk falling overnight and having to lie on the floor until a carer arrived the next morning rather than going into residential care; the service respected her right to take these risks but also ensured that appropriate supports were in place should she require some assistance. The example provides a clear illustration of positive risk-taking and the integration of ‘risk management’ into practice.

Creating an open dialogue about risk and risk management

Not surprisingly, frontline professionals felt empowered and secure in organisational contexts where an open dialogue about risk management was encouraged. In the following excerpt, a
community nurse from a home-based nursing agency described his employing organisation’s approach to incident reporting, explaining that the ‘incident report’ not only fulfilled reporting and compliance requirements but also functioned as a basis for informing frontline workers about risk issues, and encouraging discussion amongst frontline workers themselves and between frontline staff and management. This community nurse conveyed a strong sense of confidence in the organisation to resolve identified risks in collaboration with workers and a sense that staff concerns would be ‘heard’ and taken seriously:

There have been some instances where we’ve had aggression in the community [during home visits]. Nurses have gone into an area where there have been some aggressive clients they feel uncomfortable with, which then it’s up to them to… fill in an incident report, pass that on so everyone knows that there’s something going on there, so the next person doesn’t go in unprepared, which we’ve had in the past, we’ve had the odd client where someone has felt uncomfortable, maybe a female has felt uncomfortable with a male client. And it might have been… sexual advances and that sort of thing, and sometimes that has been countered [in the past] by – ‘Okay let’s send men instead of women’, instead of really approaching the situation and saying to the client, ‘Look this is not on’, contacting the doctor, contacting the family whatever. And since I’ve been with this organization, I’ve realised that things do happen quickly and they get sorted out, you know if there’s any issue then we speak about it as a group. There’ll be a special meeting called and we’ll say this is what’s happening here and we need to be a bit more aware of what’s happening and these are the processes that have taken place, this is what we’ve done, which is very good from an organizational perspective. It covers everybody because you really don’t want to walk into an area that’s a danger to yourself.

In a similar vein, a senior program manager from a PDRS outreach/support agency described how she had been working to establish ‘cultural norms’ of transparency and trust within the workplace. She argued that managing risk was not simply about the policies and procedures an organisation had implemented, but about ‘openness’ and workplace culture:

So, I suppose it’s trying to set up cultural norms because policies and procedures do so much, but [for] the staff and clients to be open - there needs to transparency across all of the organization… if I know someone’s not travelling well, I won’t necessarily go to the team leader to ask them to follow up. I’ll be following it up with staff… If a staff member feels like they need to talk, they know they can come directly to me - and also if a staff member is not feeling safe or comfortable to talk to the team leader about something they can also come to me. And that’s something we’ve tried to put in place right across [the organisation]… And so once again it comes back to an openness… I really don’t mind which [OH&S] rep they go to talk to or if they do it through the management stream - like push it up through the hierarchy of managers, supervisors, whatever, so long as the issues come out and are talked about and there will be some sort of response to that.

And I think it’s the same with clients. If a client wants to talk about something and they approach me before their key worker or before the team leader, I’ll talk to them. I’m really happy to do that. I have no problem taking complaints. Often within a complaint that’s where issues can be identified and it might not necessarily have to go through a dispute resolution process, even though that is available but there’s other ways to look at it. So there’s policies and procedures, but I think there’s something about work place culture, I think it goes further than what’s written on paper. It’s how it’s implemented that’s really important.

Some organisational risk management policies seemed to ‘bureaucratise’ the relationship between worker and client

Several frontline workers discussed situations where they felt that bureaucratic-managerial imperatives to improve accountability and risk management actually encroached on clinical-professional expertise and could, inadvertently, create further risks by reducing the responsiveness of services to clients. In the following example, a clinical psychologist from a
specialist mental health service expressed concern about the potential effects that an upcoming audit might have on workloads and on the framing of interactions between clinicians and clients:

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… that will be quite a bit of documentation and not necessarily driven by clinical significance… 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 doing longer term work and the message that you give a client around that. 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.

Organisational demands for professionals to monitor their clients by completing relevant paperwork at designated points overrides the meaningful distinctions made by professionals involved in the actual work with people, as exemplified by the clinical significance of ‘chronic’ versus acute risks. From a professional viewpoint, this worker considers the potentially harmful effects of repeatedly assessing for risk, noting that these largely administrative processes could hinder ‘therapeutic’ work, especially with clients who have chronic risks (persistent, longstanding suicidal ideation).

It might also be argued that this top-down approach to risk management makes it difficult (at least in some circumstances) for workers to integrate risk management into their clinical practices – and can give rise to feelings of disempowerment and decreased professional autonomy; additional paperwork may be viewed as simply burdensome and as external to actual clinical practice. A further example of the way in which bureaucratic demands to complete paperwork may deprive clinicians from exercising creativity and initiative in their therapeutic work is provided in Chapter 5 as an illustration of the critical risk rationality.

8.4 Conclusion

In conclusion, these findings concerning risk management cultures demonstrate the significance given by a number of participants to of openness and trust amongst frontline workers themselves and between frontline workers and managers across different levels of the organisational hierarchy. This limited range of excerpts also suggests the importance of providing opportunities in the workplace for reflection on organisational processes of managing risk – how these processes might be achieved most effectively and the impacts that particular processes might have on clients and also on workers.
PART THREE
IMPLICATIONS

CHAPTER 9
IMPLICATIONS OF THESE FINDINGS FOR COMMUNITY SERVICES, PROVIDER ORGANISATIONS AND THE RELEVANT PROFESSIONS

9.1 Introduction
This project and the international literature demonstrate that risk relationships in public human services like community care are complex. The nature of service user risks, worker risks and third party risks vary over time as the needs and capacities of the service user changes, as the environment changes, and as shifts in public policy and social attitudes occur. This sets conditions for very subtle risk relationships, which also have to accommodate the different roles of different services, the expectations of various participants, and the risk management policies of each of the service providers.

Business models of risk management, designed to protect particular businesses from dangers and hazards, are not generally well attuned to the new and complex interdependent world of community care. Not surprisingly corporate models of risk management are weighted toward organisationally specific issues and interests. As a result, the complexity of service arrangements is compounded by fragmented approaches to the management of risk. Different definitions, assessment tools, levels of risk appetite, risk management procedures, all add to this complexity. Possibly of greater importance is the argument of Hood, Rothstein and Baldwin (2004, p. 178) that the business risk management approaches adopted by private firms, and increasingly by public agencies, take ‘no account of the so-called systemic risks which affect whole industries rather than those affecting single industries’.

This context adds to the imperative to seek integrating and interdisciplinary approaches to solve problems which cross the boundaries between professional and organisational domains (Klein, 2000). However, in the absence of sector wide strategies for dealing with risk, providers have to develop their own strategies to manage this complexity, while ensuring their compliance with regulations as well as protecting their reputations and competitiveness. This task is made even more difficult when they work to implement different programs, different compliance requirements and different expectations about risks.

These are, in the most general terms, the problems we felt needed to be addressed in this chapter of the report.

9.2 Four possible responses for consideration
This project did not set out to develop specific recommendations. It was an exploratory study which has ranged over many issues and problems. However, in so far as we can report with confidence about some problems, based on our findings and overseas research, we have identified four possible strategies which relevant departments and services may consider worth exploring.
They are as follows:

1. A common framework for care planning and supported decision making in community services
2. Strategies for risk management across coordinated and integrated services in community care.
3. Risk management as an integral part of human service professional education and training
4. Developing positive risk cultures in community service organisations.

9.2.1 A COMMON FRAMEWORK FOR CARE PLANNING AND SUPPORTED DECISION MAKING IN COMMUNITY SERVICES

The Issue

This project has demonstrated a lack of common approaches to managing risks in community care, not only between sectors but between services within the same sector. These differences are most noticeable with respect to risk assessment and risk decision making as they inform care planning and service delivery, particularly in the context of collaborative and interdependent community care.

These findings are significant in the context of the following assumptions about the future of community care:

- Community care will continue to be the preferred service direction for the service sectors participating in this project, as public policy favours community options over high-cost hospital and residential alternatives.
- In addition, public policy, advocacy, and consumer groups, and the professions will continue to support more individualised service models for community care, together with the rights of service consumers to participate in the planning of their services, including their capacity to make decisions about risks.
- The increasing complexity of community care will demand more integrated and interdependent care arrangements between formal services in a range of sectors; between formal services and their clients and patients; and between formal services and informal carers, family members and friends.

Notwithstanding these trends and the readiness of service providers to collaborate, and engage in interdependent care arrangements, most organisations have adopted risk policies and procedures which are based on different assumptions, namely those about the primacy of protecting their organisation, clients and staff.

The findings of this project would support consideration of a common framework for service providers in their approach to care planning and decision making with clients and their representatives. This project has found that while there are tendencies to risk averse and risk shifting practices, overall services work hard to balance risk and the interests of their clients, staff, and third parties. However, most organisations and significantly many of their frontline workers have to resolve these issues in isolation, and often in the absence of common understandings of the legal, social, clinical and community issues.

Only in occupational health and safety regulations are there common languages, definitions and specification of acceptable levels of risk. Of course, occupational health and safety risks are more readily defined and measured, while many care planning decisions relate to risks which are not even the subject of common definitions, let alone measurable in terms of either probability or impact. However, despite and/or because of these differences, it may be useful to consider the
elements and feasibility of a common framework. Based on recent work done by the UK Department of Health, we propose consideration of such an approach to care planning and supported decision making.

The relationship between individualised services, risk management and human rights—the evidence of this project and the literature

The first time the objectives of individualised services, independence and choice were brought together in a major policy strategy for community care in Australia was the Victorian Government’s State Disability Plan released in 2001. It declared that ‘by 2011 Victoria will be a stronger and more inclusive community—a place where diversity is embraced and celebrated, and where everyone has the same opportunities to fulfil their aspirations and to participate in the life of the community’ (Victorian Department of Human Services, 2001, p. ix). The plan drew its legitimacy from a human rights framework. On that basis community inclusion, access and individualised services were defined as pathways to rights and social justice. Eventually this policy led to a concrete determination to enhance choice through personalised services and new measures for individual budgeting (Victorian Department of Human Services, 2009). At no point in these developments was the issue of risk identified as a relevant factor in meeting these policy objectives, although some advocacy organisations stressed the significance of the ‘dignity of risk’ in considering reforms.

In the United Kingdom these issues had already been hotly debated over almost two decades. The White Paper Caring for People (UK Department of Health, 1989) required professionals to involve vulnerable people in assessment processes, as a means of assisting them to increase their control over their own lives. Health policy espoused the view that ‘personalised health care can be used to empower patients to take control of their own health, particularly in relation to chronic illneses’ (Redfern, McKeveit and Wolfe, 2006, p. 124). In a paper entitled Choosing Health: making healthier choices easier (UK Department of Health, 2004) patient choice ‘moved to the centre of UK government’s programme of health system reform’ (Calnan and Rowe, 2005, p. 10). And the case for personalised health care now goes far beyond informed consent, to the need to empower patients to take control of their own lives and their own health (Redfern et al, 2006).

These developments in health care were followed by a related Green Paper on social care, Independence, well-being and choice (UK Department of Health, 2005), which argued for similar approaches to the delivery and organisation of services in order to foster independence and individualisation, considered to be key foundations for improved social inclusion and social participation. The principal policy objective of the Green Paper Independence, well-being and choice (UK Department of Health, 2005), was to put people in control of their services. This commitment was later confirmed by the subsequent White Paper on social care Our Health, Our Care, Our Say (UK Department of Health, 2006). Both papers confront head on the tension between protection of service users and their independence. The Green Paper states ‘(w)e want to move to a system where adults are able to take greater control of their lives. We want to encourage a debate about risk management and the right balance between protecting individuals and enabling them to manage their own risks’ (UK Department of Health, 2005, p. 28). While at this stage there was no indication as to how the tension between these imperatives would be resolved, both the Green Paper and the White Paper acknowledged that risk and individualised decision making and control in social care are closely linked.

We are of the view that these policy developments and discussions from the United Kingdom could usefully inform relevant Victorian agencies, which so far have not directly addressed the inter-relationships between policy commitments to individualised care, risk management and human rights.

Central to such policies in the United Kingdom and Australia is the conviction that services should ‘help maintain the independence of the individual by giving them greater choice and control over the way in which their needs are met’ (UK Department of Health, 2004, p. 204). For social care in the United Kingdom this means such strategies as direct payments, individual budgets, service user choice and appropriate risk management (UK Department of Health, 2006, pp. 79-85).
Advocacy organisations such as the UK Disability Rights Commission (2006) strongly support the cause of adults, particularly younger adults, who are seeking greater control over their own lives. Later these policies, based on participation, choice and personalised services, were also seen to enhance social inclusion and active citizenship, and became part of the rationale and language of social inclusion strategies in both the United Kingdom and Australia.

Importantly these movements for greater participation and control opened up the clear relationship between risk and rights. If governments take the view, which is consistent with human rights, that people have the right to live their lives to the full as long as that does not impinge on the freedom of others, it follows that services should not inhibit people’s freedoms and actively help people to express their own ‘subjectivity’ (Yeatman, 2009), in order to have choice and control over their lives. This leads to a radically different view of the place of risk in community care, for it is no longer just a negative factor or danger in the care process, but also a tangible expression of clients’ subjectivities, including the opportunity to take certain risks. The longstanding concept of the ‘dignity of risk’ returns as part of a new relationship between the client and service provider, which requires an agreement about risks. And further to this change the client has a new obligation as well, namely to understand their responsibilities and the implications of their choices, including their exposure to risks to themselves and others.

Following the release of the White Paper Our Health, Our Care, Our Say (UK Department of Health, 2006), the UK Department of Health set about a process of developing an approach to supported decision making in social care (or community care as it is known in Australia), which brought together the management of risk and active involvement of people in decision-making about their care. To our knowledge this was the first systematic approach to addressing this problem in the context of complex and high dependency care in homes and communities. The result was Independence, choice and risk: a guide to best practice in supported decision making (UK Department of Health, 2007).

The UK guide to supported decision making defines its purpose this way:

People need to be fully informed about the potential consequences of the choices open to them, so that they can take into account any risks involved and manage them. They may need help to do this, so practitioners need to ensure that people have accurate and appropriate information in a form that they genuinely understand, in order to make their best decisions. It is equally important that these decisions are documented.

(UK Department of Health, 2007, p.12)

And further:

Managed risk cannot and should not be eradicated just because individuals have come into contact with social care services. Some risks cannot be completely removed or managed, however much support the person may have.

(UK Department of Health, 2007, p.13)

And finally:

This includes ensuring that the right balance is struck between enabling people to lead independent and dignified lives with the need to avoid and prevent unnecessary harm to themselves or others.

(UK Department of Health, 2007, p.13)

Back in Victoria these issues of risks and rights were debated openly for the first time in 2005, in a series of public seminars organised by the Victorian Office of the Public Advocate under the banner of Risk and Rights. These forums set out to examine the complex and dynamic relationship between risk and autonomy for people with disabilities (including the frail aged and people with mental illness) in the domains of social or community care.

In Australia the argument for enhancing individual freedom and choice, bringing together, albeit uneasily, stakeholders of different policy views and ideological persuasions, had come to be a dominant issue in many public policy domains as diverse as industrial relations, welfare reform, health insurance, education and even the provision of student services in the nation’s universities.
In 2007 the Victorian Government introduced a *Charter of Human Rights and Responsibilities*, the first statute of its type in Australia. This Charter sets a mandatory framework for all government agencies to consider in undertaking all their functions relevant to the freedom and well-being of citizens.

For some years now the former Department of Human Services had shown leadership in the development and promotion of coordination and cooperation in primary care, through its development of common approaches to assessment, referral, protection and communication of patient and client information, and through its coordinating role in addressing multiple and complex needs. The development of a common care and risk decision making framework would seem to be entirely consistent with these strategies. However, it could also be argued that a common framework for supported decision making could be seen as incompatible with the history and development of the State’s service system, given the strong roles of the different service sectors. Each sector has its own significant history, culture, legal context, service infrastructure and professional interests.

Consideration of this kind of approach will also be informed by our finding that there is a tension between adopting corporate, ‘top down’ procedural and standardised approaches to managing risk, alongside the desirability of strengthening the skills and capacity of front line professionals and service agencies to manage risk in the particular contexts in which they work (as discussed in Chapter 5). This tension is analysed in a review of risk management in community care in the United Kingdom by Mitchell and Glendinning (2008), and this review is recommended as a very useful overview of the key issues in that country, many of which are common to Victoria.

Notwithstanding these factors it could be argued that Victoria needs to consider a common framework for addressing the reconciliation of the statutory obligations of service providers to reconcile rights and risks in decision making in community care.

### A framework for decision making in community care

#### Objectives of a common framework for care planning and decision making

- To provide a common approach to risk decision making in community care as the basis for working practices, and encourage practitioners and organisations to adopt this common framework into their policies, their agreements with other agencies, and their own cultures and working practices.
- To effect the development of a common set of principles for organisations to use as the basis for supporting people in making decisions about their own lives and managing, in terms of their capacities, any risk in relation to those choices.
- To support the principles of individualising community services and empowering service users through managing choice and risk transparently, and enabling a fair appraisal of the decision process, if required.
- To develop common approaches to balancing necessary levels of protection and preserving reasonable levels of choice and control, in order to help people achieve their potential without their safety, or others’ safety, being compromised.

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3 Note these proposals are drawn from *Independence, choice and risk: a guide to best practice in supported decision making*, UK Department of Health, May, 2007. There are other models but this framework has been subject to considerable research and consultation in the United Kingdom and shares the same underlying philosophy and values which guide Australian public policy and relevant institutions.
Key elements of a framework

The development of a clear and precise set of terms, definitions, in a common language would be a useful starting point, given the wide disparity of the concepts, tools, procedures, and practices currently used in community services.

This work should also clarify the distinctions between different fields of risk which are relevant to community care, so that organisations start from a common base with respect to terms as different as clinical risk, reputational risk, occupational health and safety risks, client risks, community risks etc.

In this context a framework would address the following:

1. Objectives of the framework
2. The concept of reasonable risk
3. The legal context within which the framework operates
4. Operational guidelines
   - Assessment
   - Care planning
   - The roles and responsibilities of service users, case managers and direct service providers
   - Risk agreements with service users
   - Decision making, capacity, substitute decision makers, carers and family members
   - Interpreting reasonable risk
5. Shared service plans and agreements
6. Documentation and recording
7. Tools for assessment and decision making

The functions of a supported decision tool

The UK Department of Health model implemented in 2007 is also very useful starting point for developing a working model for Australian and state conditions. This tool was designed to guide and record the discussion when a person’s choices involve an element of risk. It would be particularly helpful to a person with complex needs or if someone wants to undertake activities that appear particularly risky. It can be amended to suit different service user groups, and different contexts.

Further, it can be completed by the practitioner with the person or by the person themselves with any necessary support (including the use of communication aids/ pictures where necessary). It is important that, in discussing any risk issues, the person has as much information as possible (in an appropriate form), and fully appreciates and genuinely understands any consequences arising from his/her decisions.

The tool could be adapted for use within existing needs assessment and care planning processes. It also has potential application for any organisation or individual providing advice and support services to people who are seeking to purchase services rather than apply for subsidised services.

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4 Note these proposals are copied and/or adapted from Independence, choice and risk: a guide to best practice in supported decision making, UK Department of Health, May, 2007. There are other models but this framework has been subject to considerable research and consultation in the United Kingdom and shares the same underlying philosophy and values which guide Australian public policy and relevant institutions.
The United Kingdom model stresses that balance and proportionality are vital considerations in encouraging responsible decision-making. Reasonable risk is about striking a balance in empowering people who use services to make choices, ensuring that the person has all the information, tailored to their specific needs, in the appropriate form, to make their best decisions. And risk needs to be explored in context for each individual. Risk is dynamic and may fluctuate – for example, a small task such as making a cup of tea may suddenly place an older person recovering from a broken hip at an increased risk of falling. A good approach to risk in social care bases itself on human rights and it is important that the individual be given timely support to make decisions that best suit their needs.

Using the tool, practitioners need to:

- ensure that the person has the right support to express their wishes and aspirations
- assume capacity unless otherwise proven
- consider the physical and mental health of the person and any specialist services they need or are already receiving

Issues for the practitioner to consider when using the tool:

- respecting and enhancing the dignity of the service user
- diversity, race and culture, gender, sexual orientation, age
- religious and spiritual needs
- personal strengths
- ability/willingness to be supported to self care, in terms of:
  - opportunities to learn new skills
  - support networks
  - environment - can it be improved by means of specialist equipment or assistive technology?
  - information needs
  - communication needs - tool can be adjusted (Braille, photo’s, simplified language)
  - ability to identify own risks
  - ability to find solutions
  - least restrictive options
  - social isolation, inclusion, exclusion
  - quality of life outcomes and the risk to independence of ‘not doing’.

Concluding Comments

It will be clear to readers familiar with Victorian community services that this approach adopted in the UK could fit well with developments in this State, particularly those arising out of the Victorian Charter of Human Rights and Responsibilities, the strong support for a policy focus on individualised service provision, and the requirements of the principal statutes guiding disability services, mental health and aged care. In addition the former Victorian Department of Human Services invested heavily in developing and supporting networks and partnerships in various sectors and service systems, and piloted Primary Care Partnerships, which sought to enhance shared approaches to service delivery through coordination measures such as the SCOT tool. All these features of the Victorian context support consideration of a common decision making framework.
9.2.2 STRATEGIES FOR RISK MANAGEMENT ACROSS COORDINATED AND INTEGRATED SERVICES IN COMMUNITY CARE—ADDRESSING THE PROBLEM OF SHARED RISKS.

The Issue

The future of community services care will be defined by increasing complexity and risk as the levels of acuity, disability and chronicity of the problems confronting community services will increase. These changes will demand increased levels of collaboration and ‘shared care’ arrangements across all sectors. Yet the risk management approaches and systems used by most agencies and services are based on business models which fail to address shared, or systemic, or whole of industry risks. They reinforce blame avoidance and risk shifting to weaker parties, and reduce incentives for collaborative and integrated service provision.

The evidence from this project would suggest that while some local organisations work together informally to develop common approaches to risk in order to achieve better coordination and integration, formal agreements on risk management are rare. At the completion of this project only one formal risk sharing strategy was reported by the ninety chief executive officers, program managers and frontline workers interviewed. For most workers in community services the assumption that risk management is an individual organisation responsibility is so strongly entrenched that alternative approaches are not contemplated, except in longstanding high trust relationships between local workers and managers. Common frameworks, which could provide a vehicle for standardising approaches to definitions, establish common levels of tolerance for risk, and foster measures for the reduction of risk, were virtually non-existent. While many participants reported and valued good collaborative relationships with other services and clients, in fact risk management generally discouraged trust and risk sharing in most services.

And while the structure and organisation of community services will be subject to change, particularly in the context of these pressures, it is reasonable to assume that the main features of the Victorian service system will remain—that is a continuing mix of federal, state, and privately funded programs delivered through a range of agencies, which arrangements will continue to require high commitments to integration of services at operational levels. Therefore it is probable that the previous boundaries between aged care, disability and mental health services will become more porous, and as providers take on more diverse functions this will lead to even more interdependent working relationships with other providers.

Why are trusting and risk sharing relationships so difficult to achieve?

The recognition of these issues and problems is not restricted to human services. CPA Australia (2002) acknowledges that given the significance of collaborative and cooperative problem solving now necessary across government departments, and the focus on partnerships and networks in the solution of community problems, there still appear to be major impediments to the development of shared risk management strategies.

These impediments include:

- difficulties in defining and presumably separating roles and responsibilities
- differing cultures
- privacy considerations
- probity considerations
- sensitive Commonwealth-State relations
- resourcing

( CPA Australia, 2002)
Hood, Rothstein and Baldwin (2004) identified these issues as significant problems to be solved in order to advance the United Kingdom's modernisation of government strategies. Kurunmaki and Miller (2004), working out of the ESRC Centre for Analysis of Risk and Regulation in the LSE, identified many risk related problems with the processes of modernising the relationships and partnerships between health and social care services in the United Kingdom. This finding is consistent with our evidence that there are few agreed and workable models for managing risks in partnerships between health and community services at local operational levels in Victoria, and probably nation wide.

However, as CPA Australia points out, shared approaches to managing risks are difficult to achieve at all levels, particularly in service relationships marked by risk shifting and blame avoidance. The development of a common supported decision making framework may help, but as well as that we believe the issue of risk sharing management requires distinctive attention.

This project demonstrates that risk relationships in community care are already complex. In today's contexts a matrix of interrelated services develop around individual clients, and as a result the effective management of risk is of mutual interest to a number of different service providers. However, as we outlined in Chapter 3 and 7, organisation specific risk management strategies discourage the risk sharing and trust required for complex service delivery and, as well as that, active participation and decision making by service users.

Most participating organisations identified differences between their approach to risk management and that of other service providers with whom they had a working relationship as partners, collaborators or members of an interdependent service team. A significant majority of CEOs, program managers and front line workers saw the sharing of risk with other providers as problematic for them and for their organisations. Only one example of a formal and effective risk sharing procedure or agreement was reported in 140 interviews. While there were a number of references to informal agreements between managers and workers with longstanding local working relationships, there are no accepted models of cooperative risk sharing available to service organisations. The prevailing logic of corporate risk management programs is to protect each individual organisation against risk, which, in turn, leads to the perception of other organisations as sources of risk. As Hood and Rothstein (2000, p. 26) conclude in their advice to the British Parliament 'systems that put too much stress on limiting downside business risk at organisational level can trigger risk-displacement processes among different organisations that create nil (or negative) 'public value'.

This process of displacement appears to be happening in community care in Victoria.

In summary we suggest the evidence of this study demonstrates different sectors confront distinctive risks and common risks, but out of this develops different views of risk and the use of different risk management technologies. At the same time different organisations in the same sectors may have different risk cultures and risk tolerance thresholds. The lack of sector wide risk definitions and risk responses contributes to the perception and reality of an unequal distribution of risks within a service system or network. This problem reduces cooperation and is detrimental to service integration and the standards of service provided. And finally the competitive contracting environment, as has existed in Victoria for two decades, may foster tensions between service providers who are working together in complex shared care arrangements, particularly when these arrangements carry high levels of shared risks.

These issues constitute barriers to trusting, collaborative and risk sharing relationships with other services.

What could be done to overcome such barriers?

**Strategies for risk management across coordinated and integrated services in community care**

Significantly, in our view, this question has not been addressed in the promotion of partnerships and collaborative programs by various departments of the Victorian Government, with the notable exception of the 'integrated family violence strategy'. While partnerships have been identified as
the key to solving many of the state's community problems, particularly in health and welfare, it appears the underlying assumption is that organisations entering into formal or informal partnerships will share resources, skills, functions, activities and infrastructure, but not risks.

This position is not surprising, for while it is possible for autonomous organisations to reach agreement about a wide range of shared functions, activities, costs and outcomes, it is much more difficult to reach agreements about shared liability for possible adverse incidents, negligence, failure of duty of care and the reputational implications of these problems. It was clear from the interviews conducted for this project that service providers had different thresholds for their tolerance of risk, and these differences sometimes led some services to absorb greater responsibility for risk which ideally should have been shared with their partners; or, conversely, some clients did not receive the service they and some of their carers considered was appropriate.

A realistic perspective on these issues would suggest they will never be solved without a clear articulation of the issues around the management of risk in community care. Unlike public-private partnerships for large infrastructure projects, where the most important risks can be costed and agreement on their allocation reached before adverse events actually occur, the major risks in community care are not primarily financial, but intangible and unique to the contexts in which they arise.

Given this background what would need to happen to develop risk management practices which supported (rather than undermined) collaborative and integrated approaches to community care?

1. **Funding departments would support collaborative risk sharing arrangements in their contracting practices.**

   Such a shift in contracting practice would involve the following:
   - Clear procedures and protocols for joint working, including clear roles and responsibilities.
   - A clear understanding of each organisation's accountability, and obligations to the other services.
   - Agreed policies and procedures for delivering the service package to which everyone contributes, including responses to problematic events.
   - Agreed documentation for the needs assessment process, care planning, risk assessment, risk monitoring and review.
   - Information sharing policies with partner agencies which balance confidentiality and the need to manage risks.
   - Timely processes for resolving complex funding issues or disagreements.
   - Processes for managing agreements on complex high risk situations and cases.
   - Processes for conflict resolution.

2. **Collaborations and partnerships would identify and formalise the need to share risks in the development of their collaborative working agreements**

   - Collaborating organisations identify and acknowledge each participant's risks and their understanding of those risks.
   - Collaborating organisations identify the shared risks arising from the collaboration or partnerships.
   - Where feasible these risks are assessed in terms of the impact, probability and costs.
   - Participating organisations undertake to work with and mitigate these shared risks across the service agreement or partnership i.e. a shared risk management plan is developed.

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• Where possible agreement is reached for apportioning financial impact if adverse outcomes occur.
• Where possible agreement is reached on the management of the consequences of adverse outcomes, for clients and patients, community, media and regulatory inquiries.

3. Over time develop legal processes would be developed which support shared responsibility between providers and providers and service users.

As previously noted the common law of torts with respect to negligence and professional malpractice is based on the courts’ testing and analysis of individual practice against accepted professional standards. The recent and rapid growth of interdisciplinary and collaborative practice, and the increased involvement of service users, while now increasingly accepted in health and welfare domains, has not, according to Lahey and Currie (2005), led to any significant changes in the way courts interpret professional obligations or the common law grounds for findings of negligence and culpability.

Further there are few, if any, attempts to codify standards in integrated practice, and issues of shared or collective negligence or malpractice have not been tested in our courts. As Lahey and Currie (2005) point out in their paper on interprofessional practice, there is considerable uncertainty about the way liability in interprofessional practice will be dealt with in the Canadian courts. Their analysis seems to be very applicable to the way individual and organisation liabilities are tested in Australian courts.

Drawing on Lahey and Currie’s work a number of useful implications for community services can be defined.

First risk sharing practice in community care must recognise and operate within the requirements of negligence law. In particular, this means clear record keeping and accurate documentation of decisions taken, the parties to those decisions and the roles and functions of the different actors, including of course the service user. In the event of litigation the court must be able to trace the responsibilities of individuals and teams. Collaborative work and risk sharing are not invitations to reduced record keeping. In this context ‘centralised’ documentation through electronic common records is both an efficient way to maintain integration and cohesion, but also a means to account for and learn from adverse incidents and outcomes.

Second professionals and service providers would be advised to support the gradual building of standards and guidelines for collaborative care and sound risk sharing practices. While there is a considerable absence of such work in community care, it means that the courts are likely to use traditional benchmarks based on narrow and individualised practice to make judgments about negligence. Consequently professional bodies, government agencies, and regulatory agencies that support integrated and collaborative practice have an interest in supporting the development of standards for this kind of practice. In Australia this work is slow to get off the ground.

Third Lahey and Currie (2005, p. 215) suggest, with reservations, that legislative reform could advance resolution of the uncertainty that exists around risk sharing practice and partnerships. Legislating for standards in partnership or team based risk sharing work would have this effect, although it is difficult to achieve when practice changes so rapidly (particularly with respect to advances in knowledge and the emergence of new ways of working in complex community care), and there may be considerable disagreement between different professions and service sectors (2005, p. 215). Nonetheless, while governments systematically call on community health and welfare providers to work in partnerships to address policy change, it is reasonable to expect that public agencies and their regulatory bodies would find ways, such as guidelines and standards, to more actively support policies which require more risky practice and risk sharing.

Conclusion

In summary public policies that require organisations to enter risk sharing relationships with service users and other providers can expose those organisations to heightened risk, particularly institutional risks such as negligence and threats to reputation. These risks are seldom acknowledged by funding departments, and are largely ‘unexplored space’ in terms of the law of
liability, professional standards and corporate risk management strategies. Given the role of
government in promoting these new ways of working, and their increasing significance in
community care, it is reasonable to expect government support to advance professional,
administrative and possible legislative solutions.

**Addendum: three examples of risk sharing relationships in Victoria**

**Public-Private Partnerships**

Three basic strategies underpin all corporate risk management programs—risk reduction and
prevention, risk shifting and risk spreading (Moss, 2002). According to Moss spreading of risks
which cannot be prevented or significantly reduced is the most common and important strategy.
Risk spreading can take many different forms, but one of the most common of these are public
private partnerships for the funding and management of high cost and high-risk infrastructure
projects. The agreed concepts driving these risk spreading contracts is that risks ‘go to the party
best able to control them’, and the ‘planned transfer of risks from the public sector to private
parties is a major part of the forecast benefits from the private funding of public infrastructure’

While there is considerable debate in both the United Kingdom and Australia as to the actual
public benefit of these partnerships (refer Fitzgerald, 2004, for an analysis of this question in
Victoria), the general objectives and potential benefits of public-private partnerships are not in
dispute. Public-private partnerships provide some useful guides for partnerships in social care,
although in social care, the spreading of risks often involves sharing of the same risks. Further in
social care it may not be possible to precisely distinguish between the responsibilities taken on by
service users and different service providers. These problems are compounded by the absence
of mechanisms for defining standards for collaborative and partnership based practice, or the
even more difficult process of reaching any agreed public position about the levels of risk that can
be transferred to service users. Unlike major infrastructure projects there are no administrative or
legal frameworks for allocating precise levels of responsibility to the members of partnerships for
issues arising from their shared practice, or easily resolving problems of liability for a number of
providers and a service user (Lahey and Currie, 2005).

**The Victorian Multiple and Complex Needs Project**

There are no easy answers to the problems of shared risk, but they are being confronted every
day in contemporary community care. An experimental project in Victoria, which was designed to
develop improved and coordinated ways of supporting people with complex needs living in the
community, has tested some approaches to the problem of sharing risks (Victorian Department of
Human Services, 2004b). The project commenced in 2004 after an extensive period of
consultation and research about service responses to predominantly high-risk adults with
complex needs living in the community. The project was established with its own legislation,
including an independent review panel for the oversight of complex and coordinated care plans,
an assessment service and a team of care coordinators who worked with services across the
health and welfare sectors in the support of high need and complex clients. The legislation also
required the participation and consent of service users, and gave authority to the preparation of
detailed care plans that specified the role and contribution of each of the agencies or services.
This program was a deliberate attempt to establish a transparent collaborative approach to
coordinated care which required the management of significant risks. After five years of operation
some relevant findings emerged, but unfortunately they were not part of the formal evaluation.

In summary some elements of the structure, processes and practices of this project appear to be
important in encouraging service providers and, to a lesser extent, service users, to enter risk-
sharing relationships. These include an explicit approach to the identification of risk developed
within a common care plan; the role of an independent panel to oversee the collaborative
process and to endorse and approve the risk taking actions of service users and service
providers; capacity for a shared process for making judgements about risk; extensive use of
specialised expert advice in making decisions about risk; and capacity in the project to financially
support service providers to take on extra functions and risk exposure.
None of these elements, on their own, are new or surprising. In this project they also carried costs that would be unsustainable across the breadth of mainstream community care. However they give some indication of the way a shared approach to the management of risk can be facilitated in community care.

The Victorian Integrated Family Violence Risk Management Strategy

Another example arises from the Victorian State Government’s commitment to developing a whole of government approach to family violence. This strategy includes all participating agencies, the police, courts, emergency responses, counselling, advocacy and accommodation and has been developed in conjunction with all stakeholders. Given that operational risks are central to the project and the relationships between services and between services and service users, it was agreed that risk management was a key to the goal of integrating the State’s responses. The resultant risk strategy seeks to frame a series of risk relationships that are transparent and integral to shared, safe and effective responses to family violence. While this approach sets a very different framework to that of organisation specific strategies, participants have supported the strategy as they see it as essential to meeting their goals. In addition a training program for the risk strategy has been positively received across many of the different agencies involved in family violence, which supports the view that service providers welcome a high profile professional approach to managing risk in their work.

It is significant that the services participating in this project have very different roles and responsibilities, and very different systems of governance. Clearly there are major variations in the traditions, legislative frameworks, cultures and practices of the police force, the courts and community-based services for counselling, emergency housing, advocacy and support. These variations mean that the language, experience and approaches to risk and blame have traditionally been different. In this context the generally positive response to the integrated risk management framework is noteworthy.

9.2.3 RISK MANAGEMENT AS AN INTEGRAL PART OF HUMAN SERVICE PROFESSIONAL EDUCATION AND TRAINING

The Issue

Many of the front line workers and program managers interviewed for this project were seeking effective professional, clinical and ethical frameworks for their approach to the management of risk, as well as to administrative procedures. In effect, they largely did this work on their own, finding little guidance from their qualifying degrees and certificates, the professional literature, or most of the on-the-job training and development activities available to them. For reasons we outline below, we consider risk management should be informed by professional as well as corporate and administrative sources of knowledge.

For many professionals, particularly in clinical medicine, forensic services and child protection, risk assessment and risk management are accepted elements of their clinical and professional expertise. However, for many other professionals in community services, risk management belongs to the corporate and administrative domains of their organisations, and is seen as more related to compliance and governance than their organisation’s primary purposes. As has been reported in the literature and in the findings of this project, this has led some professionals to see risk management as an alien and even hostile activity, restricting their professional agency and their clients’ options. For many experienced practitioners, there did not seem to be any clearly accessible bridges which linked management and governance responses to risk to their core purpose and practice.
Why is risk management generally not seen as a positive part of professional practice in community care?

(1) Risk management and ‘new public management’
Niklas Rose (1998, p. 184; also 1996a; 1996b), suggests that the professional subjectivities of people in the helping professions have been transformed as a result of the changes to work practices brought about by risk management in particular, and new public management in general. Professionals now have to identify the particular risks clients or situations bring and then develop administrative procedures to modify, prevent and monitor these risks (Castel, 1991; Rose, 1998). Rose further argues that human service professionals ‘have been allocated accountability not so much for the cure or reform of clients, patients and other problematic individuals, but for their administration according to the logic of risk minimisation’ (1996b, p. 349). For Rose risk management is not only separate from professional practice, it in fact changes that practice.

Many researchers also argue that risk management, together with other elements of ‘new public management’, have significantly diminished individual professional discretion, autonomy and therefore agency, while greatly increasing administrative monitoring and supervision. The outcome is to redirect professional identities around managerial rather than therapeutic skills (McDonald, Postle and Dawson 2008; Munro, 2004, 2010; Webb, 2006). Stephen Webb (2006, p. 143-4) argues that social work, for example, is now characterised by ‘technical planning and rational problem solving’, as opposed to ‘relationship building’ or ‘therapeutic work’, and that these changes mark ‘a shift from interpretation and sensibility to problem solving and risk management techniques’. From a variety of perspectives practice based research in the United Kingdom has increasingly identified a tension between the management of risk and professional practice (for example see Carey, 2007; McDonald, 2006; Purkis and Bjornsdottir, 2006; Stanley and Manthorpe, 2004; Taylor, 2006; Waterson, 1999).

Culpitt (1999) argues that in the realm of community services, case management has become the preferred technology for managing risk. He claims that within less than two decades it has displaced the healing, supportive and empowering relationships of casework. Culpitt also observes that the ‘movement away from the validation of the “helping relationship” is an aspect of governance—the mechanism by which welfare clients, collectively, are “disciplined” away from dependency towards risk’ (1999, p. 39).

(2) The professional focus on risk assessment over risk management, and the rise of clinical governance
Risk assessment has been of considerable significance in clinical medicine, forensic services, mental health, and child protection. The professional literature has given considerable attention to risk assessment as an important emerging professional function. We found that there is a more positive and extensive professional literature on risk assessment than on risk management. In 1999 Parsloe edited two editions of Research Highlights in Social Care entitled Risk Assessment in Social Care and Social Work (both volumes were published in 1999) which drew together a range of practice papers and research reports on risk assessment, largely relating to adults in community care. Examples of these papers used to inform risk assessment for this project include Beaumont, (1999) and Langan (1999); and separately Manthorpe (2000) in the Blackwell Encyclopaedia of Social Work.

Stalker (2003) supports Carson’s view (1995, 1997) that social work and psychiatry have focused on risk assessment at the expense of risk management. Parsloe (1999c) takes a different view suggesting that the small number of professional studies on risk management may be because this is a new term rather than a new activity. Whatever the explanation, we would have to agree with the view that, there has been relatively little professional literature on the practice of risk management in community care for the helping professions. Given the extensive critical literature on risk management cited in this report, it suggests that many academics and researchers have adopted the view that risk management is a construct imposed on the helping professions from ‘outside’, and the result is that it is often viewed with suspicion. Some writers, as we reported in
Chapter 1, suggest that modern risk management emerged with the advent of neoliberalism and new public management. We have to point out that this is a proposition which appears to ignore the traditional role of institutions as highly engineered and resource intensive risk management services long before the advent of modern approaches to community care.

Within these differing views about the impacts of risk on professionals and the focus on risk assessment, the literature consistently supports the observation that the pressure to identify, control or transfer risk has come to represent a growing political imperative for most governments, their contracted agencies, and the professions (O’Malley, 2004; Fine, 2005). Politicians and public agencies, in particular, are intensely concerned about risk. Adverse incidents in community care are of considerable interest to the media and the public, and are much less hidden from scrutiny than were adverse incidents in institutions. In this context Flynn (2002, p. 161), discussing the rise of ‘clinical governance’, defines as a particular problem of modern society the tension between ‘the individual professional’s capacity to make decisions based on internalised norms and expert knowledge rather than conforming with instructions or codified rules’. The evidence from this project confirms this tension and we report on how it is perceived and addressed by workers, their managers and their executives.

(3) The emergence of more integrated and positive approaches to risk in professional practice and community care

However, some other research that explores the perspectives of individual workers, including our own, finds a more complex and less pessimistic picture (for example see Aleszewski, Harrison and Manthorpe, 1998; Carson, 1997; Carson and Bain, 2008; Godin 2004; Titterton, 2005; and from this project Green and Sawyer, forthcoming; Sawyer 2009; and Sawyer, Green, Moran, and Brett, 2009), which demonstrate that frontline workers still work hard to use their professional judgement and agency to meet clients’ needs and manage risks, rather than relying on bureaucratic and self-protective procedures.

Three texts, focused on risk and practice, have developed the perspective that risk assessment and risk management should be a ‘natural’ part of the role and expertise of the helping professions, particularly in high risk community care. They are Risk and Risk Taking in Health and Social Welfare, by Mike Titterton (2005); ‘Professional Risk and Working with People’ by David Carson and Andy Bain (2008); and a more general text on community care Safeguarding Adults in Social Work by Andy Mantell and Terry Scragg (2008). For these writers community care of vulnerable people has to be about managing risk, because the work of protective care which used to be undertaken by highly regulated hospitals and institutions now has to be addressed by a matrix of community services working in various kinds of formal and informal partnerships. Culpitt’s analysis, which sees case management as the vehicle for the move away from healing to surveillance is misleading, because it does not acknowledge that community care is inherently more fragmented and risky than institutional care, demanding a case managing capacity that institutions carried in their infrastructure and systems.

Nonetheless the training of community care professionals has not adequately addressed the implications of these changes for the complex work of supporting vulnerable people in their own homes and other local settings. In this context a number of writers have suggested that services for adults in community care could learn a great deal about approaches to both risk assessment and risk management from child protection, a view supported by Stalker (2003). Carson and Bain (2008) and Titterton (2005) define risk assessment and risk management as interdependent processes, which position would now be the prevailing view of most professionals working in high risk domains such as child protection. Also most government publications on strategic approaches to risk now emphasise the interrelated significance of risk assessment, risk management and evaluation.

Professional education and risk management

Reconciling risk and professionalism

Considering this multiplicity of different interests in risk, Taylor-Gooby (2002, p. 110) suggests that ‘the context in which risk is perceived and understood exerts a major influence on the way
people understand it and how they respond to it’. Equally importantly, he argues that ‘risks are not dealt with as abstracted choices which enter consciousness independently from the processes of apprehension by a human actor’ (Taylor-Gooby, 2002, p. 110). In this report we identify these ‘processes of apprehension’ and their impacts on a range of participants in community care. We found that there are many different perceptions and interpretations of risk, related to the particular risk cultures in organisations, and the roles and contexts of the principal actors. Unravelling the different contexts of our participants, and the functions which shaped their roles and responsibilities, offers a complex and layered understanding of the dynamic and often conflictual nature of community care.

The interviews we conducted with front line workers and their managers in this project demonstrated a number of key issues which support this analysis.

- Workers are exposed to a wide range of risks, some of which are predictable and manageable (or avoidable) and some of which are not manageable without significant intervention, often involving restricting the client.
- Increased levels of client need, complexity and acuity in all the community care sectors, inevitably increases the range and level of risks to be managed.
- As a result community care requires more complex and interdependent care arrangements between services in a range of sectors; between services and their clients and patients; and between services and informal carers, family members and friends.
- So while risk assessment tools and risk management procedures are considered useful by most professional workers, individual judgment in unique and unforeseen contexts continues to be part of the practice of these workers.
- And these judgments will not always be informed by evidence alone, but also by understanding based on experience, reflection, intuition and complex analysis of unique situations.

Most of the front line workers and their managers participating in this project were developing their own risk decision making frameworks, based not only on their organisations’ policies and procedures, but also their professional values, ethics, experience, and intuition. As we have reported they developed their own risk ‘rationalities’—ways of making sense of the conflicting situations they faced not just in exceptional circumstances, but in the day to day decisions necessary in community care. Many of these workers had a strong sense of their professional identity, and risk management was an integral part of that professional identity, not just an externally imposed set of administrative procedures and restrictions.

Traditionally many helping professionals operated in controlled environments - hospitals, clinics, institutions, community service centres, and prisons. These settings were characterised by strong disciplinary hierarchies and rules, and the systems and procedures of the ‘institution’ which were part of an ‘infrastructure’ for the management of risks.

Of course the situation today is very different. While hospitals remain central to the health system, more and more of the action is being transferred to the community. Deinstitutionalisation, non-institutionalisation, hospital in the home, early discharge, day procedures, new policies promoting the rights and choices of people with disabilities, ageing in place and many other programs, have transformed the late modern human services system, particularly in Victoria, the site of this project.

These changes set the context for today’s community services and have major implications for front line helping professions, especially social workers, nurses, occupational therapists, psychologists, doctors and other allied health professionals.

In considering the implications of these changes it is useful to note the following positive developments:

- high levels of devolution of services to local and community levels
- significant increases in the diversity of service organisations
- extensive government support for innovation, especially in the interests of efficiency
• greater focus on early intervention and prevention
• new roles for professionals, including greater diversity of functions and skills required
• greater sense of agency for workers working alone and in small teams
• opportunities for workers to develop more holistic, organic and local service response to need
• and the development of new flexible inter-agency and inter-disciplinary working arrangements

From a more institutional and traditional perspective, however, many professionals see the following problems:
• loss of institutionalised structures to protect professional practice
• loss of professional career ranges which were a feature of large institutional settings
• loss of senior professionals
• professionals reporting to generic, sometimes non-professional, managers
• working with administrative titles such as ‘case manager’
• new and more accountability requirements and related administrative procedures
• increased documentation and defensive record keeping
• and the increasing dominance of risk and risk management, and responsibility for risk, as part of their professional roles

We have concluded that the breadth and significance of these changes have consequences for reconsidering the role of risk and risk management in the training of the relevant human service professionals.

Implications for the way the helping professions approach risk management
Risk management should be a much more significant part of the professional training and professional development of today’s human service workers, whose practice contexts are very different from twenty years ago. And while the corporate and managerial approaches to risk, which have dominated human services in Victoria and Australia, have been very successful in changing organisational perspectives and awareness of risk, this has been at the expense of the integration of risk management into professional practice. The dominance of these approaches may have even de-skilled workers in their ability to identify hazards and find solutions in particular contexts. The child protection service sector is an example of an arena of high risk practice where risk management is much more integrated into professionals’ practice. There is no reason why the same could not occur in community services for vulnerable young people and adults.

As a consequence the kinds of professionals needed now are:
• resourceful workers managing risk in complex and volatile contexts with many different actors
• capable of confronting complex problems and finding integrated solutions
• accountable and equipped for the legal and administrative demands of community-based practice, while at the same time confident of their capacity to manage idiosyncratic and fluid situations
• equipped to work collaboratively and in partnership with a wide range of other stakeholders, not only other professionals but also clients, family members, carers, community interests and substitute decision makers
• capable of managing multi-faceted risks in contexts where there is significant disagreement about ‘acceptable’ risk

Conclusion
To this point the key bodies governing the professional training of human service workers have shown little readiness to integrate risk management into their undergraduate curriculum and post-
graduate qualifications. Those professional human service workers who undertake training in risk management are likely to be instructed by consultants or dedicated risk managers in their organisations. Given the fact that risk management has largely been driven by contracting, new public management, and major adverse incidents, this is not surprising. However the future of community services will be a future increasingly dominated by complexity and risk, and professionals will have to adapt to this reality in their practice, as was so creatively demonstrated by the participants in this project.

We conclude there is a strong case for the human service professions to address this issue in both undergraduate and post-graduate programs.

9.2.4 DEVELOPING POSITIVE RISK CULTURES IN COMMUNITY SERVICE ORGANISATIONS

The issue

Most participating organisations identified differences between their approach to risk management and that of other service providers with whom they had a working relationship as partners, collaborators or members of interdependent service teams. They would not necessarily define these as differences in organisation cultures, but they did see differences in risk aversion, risk taking, readiness to solve problems about risk (especially for clients), and differences in rigidity or flexibility in procedures. While only a small number of the participating organisations articulated a distinctive risk culture, almost all of the participants recognised there were different approaches to managing risk in community care. Few of the participating organisations articulated a clear strategy for shaping their ‘risk cultures’ in the context of their mission, objectives, policies and programs.

When executives, program managers and front line workers discussed these issues many identified a divide between the increasingly defensive, procedural and process dominated approach of corporate risk management on the one hand, and the ethics and ideals of their organisation and professionalism on the other. So the ‘culture’ of their formal risk management approaches, if it was articulated, was often seen as antithetical to professional ‘culture’ and the ‘spirit’ or ‘tradition’ of their organisation, especially in community services organisations. In the discussion of the different risk rationalities of the workers, it was clear many workers, particularly professional workers, developed their own risk cultures, or what we have called risk rationalities, in order to deal with this perceived problem.

At the Victorian Managed Insurance Authority’s (VMIA) inaugural state conference on risk in October 2009, it was noticeable that a number of speakers addressed this problem, identifying both the apparent detachment of risk management from practice, and the impact of negative risk cultures (often referred to as risk aversion) on innovation and effectiveness. It appeared that some of the problems for public agencies identified by Hood and Rothstein (2000) were emerging here, not only in public agencies, but also in commercial and not for profit organisations.

Why is it difficult to develop a positive risk culture? The evidence of this project and the literature

We can identify some of the reasons for this problem from our findings and from the literature. First today’s risk management emerged from serious and dramatic events in the financial world, the commercial world, and professional worlds. In health and human services the increased exposure and reporting of professional malpractice or adverse incidents in hospitals, mental health, child protection, and aged care changed the way these sectors perceived risk. Risk management was seen to be about these high impact adverse events. We discuss this background to today’s risk management in Chapter 3.
Second, and as a result of the above issues, modern risk management emerged as corporate and administrative responses to protecting both public and commercial organisations from dangers or hazards which would not only have adverse consequences for individuals, but also for the reputation and standing of the organisation. These approaches led to the development of many tools and procedures which reinforced the idea that risk management was the domain of managers and directed to controlling not only primary risks but also secondary or institutional hazards and risks (Power, 2007; Rothstein, 2006; Rothstein, Huber and Gaskell, 2006). So, professional practice and risk management were perceived to be about different issues and in conflict with each other. There is now an extensive and broadly based research literature which finds that risk management impinges on the values and professional agency of individual workers. These perceptions, as seen by our participants, are outlined in detail in Chapter 5 in the discussion of what we have called the ‘critical risk rationality’ of a number of the participants.

Third both the evidence of this study and the literature suggest that the models of risk management used in many services have adverse consequences for public services. When service organisations become focused on their own risks they are more likely to want to transfer risks to other parties, including sometimes their clients, who may be less equipped to manage them and their consequences. These strategies to manage risks may obscure the systemic nature of these risks, undermine public sector and professional values, weaken the role of public services to address common interests and systemic problems, and reduce trust between agencies (Hood and Rothstein, 2000; Hood, Rothstein and Baldwin, 2004; Hutter, 2005; Power, 2007).

Fourth the Victorian Government has identified human rights and the individualisation of services as key directions for public policy. Unlike the United Kingdom, however, there has been little recognition of the significant consequences arising from these policies for the management of risk. In effect, thinking through the place of risk in policy has not occurred, because it is associated with corporate governance and regulatory compliance rather than the realisation of effective services (see UK Department of Health, 2007).

Risk management cultures and models, based on the protection of organisations from threats to their reputations and liability, can distort the roles of public sector organisations which have to focus not only on organisational risks but also on their obligation to the common good, innovation and effective service delivery, and their role in addressing whole of industry and systemic risks. It is for these reasons that a number of regulatory bodies in the public sectors of the UK (e.g. UK National Audit Office, 2000; UK HM Treasury, 2004; UK Cabinet Office, 2002), Canada (e.g. Treasury Board of Canada, 1999, 2000) and Australia (e.g. Victorian Auditor General, 2003, 2004) have endeavoured to distinguish the distinctive issues confronting public sector services in the successful management of risk. Public agencies and regulatory bodies from these countries have become increasingly concerned that ‘the managing of risk in the public service often became synonymous with avoiding risk, which also implied avoiding innovation’ (Treasury Board of Canada Secretariat, 1999). We would conclude that addressing this problem requires, among other things, the development of risk cultures which recognise and address the tensions arising from the management of risk in public services such as community care. We consider it significant that at the inaugural VMIA state conference on risk previously mentioned, the development of risk cultures which do not inhibit innovation and service goals was an important theme.

What factors frame and support a positive risk culture?

An organisation’s risk culture will be influenced by many factors. Amongst the most important are the following:

- The vision, mission and values of the organisation, which set the stage for its explicit or implicit risk culture, and frames the entity’s tolerance for risk (or what the risk professionals call the ‘risk appetite’).
- The degree to which management and workers are encouraged to see risk as integral to their own practice at all levels, which in turn determines whether or not the risk culture is relevant and useful in terms of their roles and functions, or alien to their roles and functions.
The external environment of the organisation, especially in terms of relationships with funding bodies or government departments, regulatory bodies, and community interests, will also be central to the risk culture. A hostile or distrustful working relationship with funding or regulatory bodies will significantly impact on a service provider’s risk culture.

In addition, the external environment, as defined by the public and political ‘understanding’ of acceptable risk, together with political and media reactions to adverse incidents, the degree of tolerance for ‘mistakes’, and the readiness to blame and punish, all have a strong influence in shaping risk cultures.

In the context of all these kinds of defining issues, leadership, trust, shared vision and sense of security of staff at all levels, are also critical to the shaping of risk culture in service organisations.

On the basis of the evidence of this project, the research literature and the public documents addressing this issue, we make the following observations:

First risk management needs to be developed as part of operations at all levels of an organisation—boards, strategic planning, business planning, program development, training and service delivery. This was seldom the case for the participating organisations of this project, most of which had risk management systems at governance levels, and then at some operational levels, but not in the context of a coherent risk culture. Most organisations seemed to be constructing their risk management as a response to externally imposed compliance requirements, rather than as something they developed as integral to mission, strategic objectives, effective operations and accountable practice.

Second articulating risk as central to creativity, innovation, and effectiveness as well as safety, protection of reputation and liability, is essential to a positive risk culture. At the VMIA risk conference continual reference was made to the importance of ‘embedding’ risk management as both a positive and defensive issue at all levels. In this context we find the uses of the term ‘embedding’ both misleading and unhelpful. The term perpetuates the concept of risk management as belonging to and defined by (and therefore embedded by) management and it negates the fostering of more worker-owned and context-specific practices of risk management, especially in front line community care. It makes more sense to build on existing practice and consciousness of risk, as well as introducing new understandings and knowledge from the commercial world.

Third some risk consultants are now suggesting that introducing risk management into job descriptions and duty statements is a significant way of reinforcing risk management as an integral part of operational roles and practice.

Fourth a positive risk culture is enhanced if in the processes of debriefing, case reviews, and auditing reviews the impacts of both positive and adverse risk management are analysed and discussed. Recognising positive risk taking as part of review at planning levels, program development and practice levels reinforces a strong and legitimate risk culture.

Fifth portraying risk as a dynamic factor in the organisation’s capacity to respond to change, learn from positive and negative events, and apply new knowledge, all reinforce the significance of creating a strong and broadly articulated risk culture. Risk management is part of achievement and positive performance as well as the necessary protection from dangers and hazards.

(Note: Many of these points were discussed at the VMIA Risk Conference, 2009.)

Concluding Comments

Significantly, a number of researchers (Carey, 2007; Castel, 1991; Godin, 2004; McDonald et al, 2008; Munro, 2004, 2010) emphasised that many contemporary processes in risk management, in particular audit tools, such as ticking boxes are relatively easy to achieve but can be deceptive and give a false sense of assurance to an organisation. Some workers in this study also indicated that these technologies were time consuming and unhelpful, particularly when they were more
interested in building their own capacities to identify, assess and act on risk, rather than depend on routine procedures and check lists.

On the other hand other workers with more positive risk rationalities reported differently, suggesting that risk procedures required them to review situations, take heed of changes and provide alerts they could follow up with their own enquiries. Our conclusion is that formal processes and procedures alongside judgment and intuition, all have a role to play, but the formal processes are likely to let an organisation down if they become routinised and formulaic, substituting for workers’ capacity to make assessments and judgements related to different contexts. Overall, however, almost every professional worker in this study engaged with risk management processes, and whether this engagement was positive or negative, depended significantly, although not exclusively, on their organisation’s risk culture.
APPENDIX 1 – INTERVIEW SCHEDULES

General Questions for Background Research with Organisations – (STAGE 1)

What is your governance structure? (i.e. What is the legal standing of your organisation?)

How important to your organisation is managing risk? Generally, and in day to day running?

What are the main risks that your organization has to manage? (Probes: risks to clients/consumers? Risks to workers? Risks to organisation? Risks to public?)

What impact have Occupational Health and Safety regulations and requirements had upon the way that your organization delivers its services?

Has your organisation developed a specific risk management plan for services? Why was it developed, or has it not been necessary?

Do you use the Australian Standard, known as ANZS 4360?

(If appropriate) When was the risk management plan set up? What led to its creation? (Probes: were there any precipitating events, issues etc.?)

(If appropriate) Does your organisation have a specific committee or working group that deals with risk management issues?

How does your organization respond to adverse incidents? Are there procedures for learning from adverse incidents? If so, what are they?

Are there any potential clients that your organisation is unable to provide services for, because of risks? How does your organisation make that decision?

Do you limit services to eligible clients because of risks?

What has been your organization’s experience of managing relationships with other agencies around delivery of services, both formally and informally?

Is your organization managing many contracts? (Probes: have you been managing subcontracts, are you subcontracting? Managing funds for individuals, managing care packages?)

Does your organisation face any unresolved issues around risk?

Are there any issues around risk and risk management that we haven’t raised but that you can think of?
In-depth Interview Guide for Program Managers (STAGE 2)

Introduction – orienting questions
[Opening question about the program]
1. Tell me a little bit about the program you manage – (purpose, client population, roles of staff)

2. What are the major issues you face in managing this program?

3. In the context of these issues, can you tell me about your general experience of managing risk in your program?

4. What are the main risks for your program?

5. Are there any necessary or unavoidable risks involved in the delivery of services? What would be an example?
   - Are there particular risks that you’re working hard to prevent?
   - Are there other risks that you might want to preserve? [Unpack concept if necessary, but don’t lead; e.g. positive risk-taking, choice, learning through experience]

6. What policies and procedures does your program have in place to manage risk?
   - [Probe] Do you have any way of monitoring, analysing and following-up these risks? Who does this?

Organisational response to adverse incidents
7. How does your organization respond to adverse incidents? Are there procedures for learning from adverse incidents? If so, what are they?

8. Do you use risk screening tools or risk assessment instruments? If so, what are they?
   - Have you modified these to suit your own needs? How effective have these been?

Service delivery – impact on clients
9. Do you think that the focus on risk (risk assessment and risk management) has any effect on clients’ needs, opportunities and outcomes?

10. Have there been any occasions when you felt there was a conflict between your organization’s risk management requirements and the needs and aspirations of clients?

11. Have there been any occasions when you have felt that it was too risky to take on a particular client, or that you were unable to provide the services requested by a client because of risk? [Draw out specific examples]

12. When you have a client involved with other agencies at the same time as yours, who carries the risk or is it divided amongst agencies? How does this work? [Draw out specific examples.]

Occupational health and safety
13. What impact have Occupational Health and Safety regulations and requirements had upon the way that your organization delivers its services? Have these regulations affected the way that your staff members carry out their jobs? If so, in what ways?

Prospect of litigation
14. Has the threat of litigation affected the way you deliver services?
Concluding reflections on the impact of risk management
15. From your own experience as a manager, reflecting on the past 10 years or so, how would you assess the changing impact of risk management on the delivery of services in your own organization? [For example], have there been any changes in the way services are delivered to clients? Has the criteria for accepting clients into the service changed at all?

OR [if the person has not been a manager for very long]

Do you think there’s been an increasing focus on risk assessment and risk management [or: rules and regulations to prevent things going wrong] in your field of work over the past decade? If so, how do you understand these changes?

16. Are there any issues around risk and risk management that we haven’t raised but that you think are important?
In-depth Interview Guide for Front-line workers

**Introduction – orienting questions**

1. Tell me a little bit about the work you do (client group, interventions, professional background, how long in the position)

2. What are the major issues you face in your day-to-day work?

3. What are the main risks you encounter in your work?
   [Terminology prompt – ‘risks’ = worries, insecurities, dangers, concerns about safety]

4. Can you tell me about your general experience of dealing with risk in your everyday interactions with clients?
   [Terminology prompt – ‘risk’ = OH&S concerns, working conditions, ‘difficult’ clients, keeping the community safe, dangers or threats to your organisation]

5. What sorts of risks or dangers have you experienced yourself when delivering services? How have you dealt with these? [Draw out specific examples.]

   Does your organisation provide any supports or resources to help workers deal with risks?

6. Are there any risks that you can’t avoid, that are just part of the job?

7. Are you aware of policies and procedures that your organisation has in place to manage risk [to keep everything safe]?

   [If applicable] Are these policies and procedures useful in your day-to-day work?

**Organisational response to adverse incidents**

8. How does your organization respond to adverse incidents [when things go wrong]?

   Are there procedures for learning from adverse incidents [these events]? If so, what are these?

9. Does your organization use risk screening tools and/or risk assessment instruments?

   Do you use them in your work with clients? If so, what are they? Are they helpful in the work you do?

   If someone else uses them, do you have access to them?

**Service delivery – impact on clients and workers**

10. Have risk management requirements [or: these rules and regulations your organisation has to keep everything safe] affected what you do in your work? If so, in what ways?

   [Probe, if applicable – You might want to think about any changes to the way services have been delivered over the past ten years. Ask about positive and negative experiences, if appropriate.]

   Have risk management requirements [or: these rules and regulations your organisation has to keep everything safe] affected the way that you provide services to clients? If so, in what ways?

11. Have clients ever asked you to do things that you felt unable to do because of risks?
12. Have there been occasions when you felt there had been a conflict between your organization’s risk management requirements [or: these rules and regulations your organisation has to keep everything safe] and the needs and desires of clients? [Draw out specific examples.]

13. Do you feel that the focus on safety and risk (i.e. risk assessment and risk management) has any effect on clients’ needs, opportunities or aspirations? Could you give examples?

14. [Ask only of professionals, case managers etc.] When you have a client involved with other agencies at the same time as yours, who carries the risk or is it divided amongst agencies? How does this work? [Draw out specific examples.]

**Occupational health and safety**

15. What impact have Occupational Health and Safety regulations and requirements had on the way you deliver services?

**Concluding reflections on the impact of risk management**

16. [If applicable] Do you think there’s been an increasing focus on risk assessment and risk management [or: rules and regulations to prevent things going wrong] in your field of work over the past decade? If so, how do you understand these changes?

17. Are there any issues around risk and risk management [or: rules and regulations for keeping everything safe] that we haven’t raised but that you think are important?

18. Is there anything that you would like to see changed in the way that your organisation handles risk and risk management [concerns about safety]?
In-depth Interview Guide for Clients

1. What would be a normal day for you?
   - What do you do?
   - Do you work?
   - How do you spend your time?
   - Where do you go?

2. Do you receive any help or support? And where does this help come from?

3. What are your main concerns or worries?

4. Do you worry about things that could go wrong, or things that could hurt you?

5. Do you worry about things that could go wrong for someone important to you, or things that could hurt someone important to you?

6. Tell me a bit about [name of service]:
   - How long have you been involved with [name of service]?
   - What do you get from [name of service]?
   - How do you feel about it?
   - Is it an important part of your life?

7. Are there things that you would like to do, but you’re not able to? What would make a difference?

8. Do the services you receive help you do the things you want to do? (Ask for examples)
   - Have you ever been stopped by services from doing things you want to do? (Probe for examples and explanations – e.g. agency capacity, agency policy [activity perceived as too risky], worker issues)

9. Has a service ever threatened to pull out/not attend for a particular reason? If so, can you tell me about this experience?
   - Have you ever been refused services by an agency/organization?
     - What were the reasons?
Interview Guide for Carers and Family Members

1. Tell me a bit about your day-to-day life in caring for your family member/ friend:
   • What would a ‘normal’ day be like for you?
   • What kind of help or support does your family member/ friend need?
   • What are your main concerns or worries in caring for your family member/ friend?
   • Does your family member/ friend confront any particular dangers and hazards?
   • Do you confront any particular dangers or hazards as a carer?

2. Do you receive any help or support to care for your family member/ friend? Who provides this help?
   • Does your family member/ friend receive any help or support? Who provides this help?

3. Tell me a bit about the services you use to help care for your family member/ friend:
   • How long have you been involved with [name of services]?
   • What do you get from [name of services]?
   • How do you feel about these services?
   • Do these services provide the kind of help that you need in caring for your family member/ friend?
   • If not, what kind of help would you like to be able to receive?

Tell me a bit about the services your family member/ friend receives:
   • How long has he/she been involved with [name of services]?
   • What does he/she get from [name of services]?
   • How does he/she feel about these services?
   • Do these services provide the kind of help that he/she needs?
   • If not, what kind of help would he/she like to receive?

4. Have you ever had any difficulties in accessing appropriate services? If so, could you tell me about this experience?

5. Do you have any comments or thoughts about the way services manage risk (i.e. attempt to keep everything safe for their clients, clients’ families and staff), either for your family member/ friend or for you?

6. Do you feel that your concerns are ‘heard’ and taken seriously by services?

7. Has a service ever threatened to pull out or not attend for a particular reason? If so, can you tell me about this experience?

Have you (and your family member/ friend) ever been refused services by an agency/ organization?
What were the reasons?
Interview Guide for CEOs/Senior Managers of Advocacy/Support Organisations

Introduction
1. Tell me a bit about the organization you manage (purpose, membership, staffing, roles of staff, funding, relationships with other services and organizations)
   - What does your CHARTER say about your role and relationship with families and carers?

Members' (carers', friends', associates') concerns
2. What are the main issues or concerns that emerge in your meetings and discussions with members?

[Use as prompts] Are there concerns about:
   - Accessing services (initiating referrals/ requests)
   - Rules and regulations involved in service delivery (which may include e.g. risk management strategies, privacy legislation)
   - ‘Being heard’ as a carer/ family member in the context of ongoing service delivery?

Try to elicit examples of these concerns.

3. Specifically, we’d like to ask you about the risks, dangers and hazards that carers face when caring for their family member, and also those faced by the family member.

So, first, what risks, dangers or hazards do your members or carers confront in caring for their family members or friends?
Secondly, what risks, dangers or hazards do those family members themselves face?

4. Do you think your members see or interpret these difficulties as risks?
   - If not, how do you think they perceive them?

Risk management in community services
5. (Now we’d like to seek some of your views about these issues.) Do you have particular views about the way services manage risks to their clients, their staff, the community and your members (carers/ friends/ associates)?

6. Have you noticed any changes in the management of risk in the services you are most familiar with?
Tell me about these changes. Why do you think these changes have occurred?

7. Are there any changes you’d like to see in service provision?

Advocacy role
8. Are you involved in advocating/ advising/ lobbying/ putting forward suggestions on matters of risk to services or government agencies?

9. Are there any statements, research findings or other documents on these matters that you would be prepared to share with us?
Participant Information and Consent Form, Stage One

Site: [Insert Site Name]

Full Project Title: Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

Principal Researchers: Professor Judith Brett and Mr David Green

Associate Researcher(s): Dr Tom Keating, Ms Claudia Trasancos, Dr David Sykes, Dr Anthony Moran

This Participant Information and Consent Form is 5 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. Once you understand what the project is about, and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project. You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to examine the impacts of risk management for community services and their clients. It will study the unforeseen impacts and costs of risk management, identify the problems, and explore the ways risk management can achieve its goals without reducing services and limiting the lives of clients. The study involves Victorian Department of Human Services (DHS) funded community organisations providing services in the aged care, mental health and disability sectors in metropolitan, regional and rural Victoria. These organisations have been suggested by DHS and/or the Victorian Office of the Public Advocate (OPA) on the basis of their known involvement with risks in the service of their clients, and their experience of developing policies and strategies to manage risk.

The first stage of the project involves background research with 20 DHS funded community organisations in the aged care, disability and mental health sectors. In the second stage of the project a total of 60 people – managers, front-line workers and clients - will be interviewed from some of those same organisations.

Previous experience has shown that the handling of risks is of considerable significance to everyone involved in delivering and receiving community care. The literature and impressionistic evidence suggests these trends: diverse and ad hoc approaches to risk assessment are common; sometimes priority is given to high at the expense of low risk clients, but equally importantly clients who are perceived to be high risk may find difficulty getting services; risk reduction strategies include restricting clients’ activities and experiences; risk management
increases administrative supervision and diminishes professional discretion; some services are
developing innovative approaches to risk management which address safe practice and client
rights.

You are invited to participate in this research project because we are interested to hear about the
experiences of your organisation in managing risk in the delivery of your services. This research
has received funding and support from the Australian Research Council, DHS, and OPA.

3. Procedures
If you agree to participate in stage one of this project, one or more researchers from our team will
visit your organisation at a time convenient to you to discuss strategies, methods, protocols,
techniques etc. that you use for the management of risk in service delivery. We would like to have
meetings with key people in your organisation – for example, Managers/CEOs, workers to see
how you deal with and manage risk. If appropriate we will ask to look at public and non-
confidential documents related to the management of risk in your organisation. In these informal
discussions we are seeking to understand your organisation’s risk management policies and
practices. We are not seeking your personal views. At this stage of the project we are not
requesting formal interviews. However, we may approach you again at a later time to see whether
you would like to participate in the interview stage of our project.

4. Possible Benefits
While we cannot guarantee or promise that your organisation will receive any direct benefits from
this project, it is hoped that this research will assist organisations, front-line workers and clients to
make choices that lead to informed practice and judgement about risk, and facilitate positive
pathways of dignity, respect and self reliance.

5. Possible Risks
We do not envisage that participation in this project involves any risk to you or your organisation.
Our project does not involve invasive or harmful procedures, potential or otherwise. The study is
not seeking any information which is confidential to your organisation or which identifies particular
clients or patients. The focus of the research is on the policies and practices of your organisation
with respect to risk assessment and risk management, and the impacts of risk on the services
your organization delivers.

6. Privacy, Confidentiality and Disclosure of Information
Any information obtained in connection with this project and that can identify your organisation or
any people within it will remain confidential. All data will be used in a non-identifying manner. The
names of individuals and organisations involved in the study will not be used in any publications.
Data collected from individuals and field notes from background research at organisations will be
retained for a period of 20 years in a secure locked room in the School of Social Sciences at La
Trobe University, and will be transferred to the university archives if it is deemed no longer
possible for the School of Social Sciences to continue to securely store the materials. Computer
based materials will be password protected.

7. Results of Project
At the end of this research project we will produce a publicly available summary of findings. If you
wish we will send you a copy of the summary of findings to your nominated address. We will also
produce a series of articles for publication in academic journals and for presentation at
professional conferences. Findings will be presented at workshops for managers, workers and
clients.
8. Further Information or Any Problems
If you require further information or if you have any problems concerning this project you can contact the principal researchers Professor Judith Brett or Mr David Green, or Dr Anthony Moran.

The researchers responsible for this project are: Professor Judith Brett, (03) 9479 2691; Mr David Green, (03) 9479 2793; Dr Tom Keating, (02) 6055 7768; Ms Claudia Trasancos, 5793 6400; Dr David Sykes (03) 9603 9567; and Dr Anthony Moran, (03) 9479 1671. Each of these researchers will have voice-mail for after hours contact.

9. Other Issues
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact Ms Genevieve Nolan, Executive Officer, Department of Human Services Human Research Ethics Committee, on tel. (61 3) 9637 4239. You will need to tell Ms Nolan the name of one of the researchers given in section 8 above.

10. Participation is Voluntary
Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

Upon consideration you may decide not to participate in this research. We are authorised by DHS to give you the undertaking that participating or not participating will have no affect on your funding or any other elements of your relationship with DHS.

11. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the Department of Human Services, Victoria, and the Human Ethics Committee of La Trobe University, Victoria.

12. Reimbursement for your costs
You will not be paid for your participation in this project.
Consent Form, Stage One
Site: [Insert Name]

**Full Project Title:** Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

I have read, or have had read to me, and I understand the Participant Information.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant’s Name (printed) .................................................................
Signature ................................................. Date

Name of Witness to Participant’s Signature (printed) .................................
Signature ................................................. Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher’s Name (printed) .................................................................
Signature ................................................. Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

*Note:* All parties signing the Consent Form must date their own signature.
Revocation of Consent Form

Site: [Insert Name]

Full Project Title: Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise my relationship with my organisation, or any aspects of my organisation's relationship with DHS.

Participant's Name (printed) .................................................................

Signature Date
Participant Information and Consent Form, for Front-Line Workers
Site: Name of DHS funded organisation

Full Project Title: Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients
Principal Researchers: Professor Judith Brett and Mr David Green
Associate Researcher(s): Ms Claudia Trasancos, Dr Janine Bush, Dr Anthony Moran

This Participant Information and Consent Form is 6 pages long. Please make sure you have all the pages.

1. Your Consent
You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. Once you understand what the project is about, and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background
The purpose of this project is to examine the impacts of risk management for community services and their clients. It will study the unforeseen impacts and costs of risk management, identify the problems, and explore the ways risk management can achieve its goals without reducing services and limiting the lives of clients. The study involves Victorian Department of Human Services (DHS) funded community organisations providing services in the aged care, mental health and disability sectors in metropolitan, regional and rural Victoria. These organisations have been suggested by DHS and/or the Victorian Office of the Public Advocate (OPA) on the basis of their known involvement with risks in the service of their clients, and their experience of developing policies and strategies to manage risk.

The first stage of the project involved background research with 20 DHS funded community organisations in the aged care, disability and mental health sectors. In this second stage of the project about 60 people – program managers, front-line workers and clients - will be interviewed from some of those same organisations.

Previous experience has shown that the handling of risks is of considerable significance to everyone involved in delivering and receiving community care. The literature and impressionistic evidence suggests these trends: diverse and ad hoc approaches to risk assessment are common; sometimes priority is given to high at the expense of low risk clients, but equally importantly clients who are perceived to be high risk may find difficulty getting services; risk reduction strategies include restricting clients’ activities and experiences; risk management increases administrative supervision and diminishes professional discretion; some services are developing innovative approaches to risk management which address safe practice and client rights.
You are invited to participate in Stage Two of this research project because we are interested to hear about your experiences as a worker with your organisation in managing risk in the delivery of services, and your own experiences of risk as a worker delivering services to clients.

This research has received funding and support from the Australian Research Council, DHS, and OPA.

3. Procedures
If you agree to participate in this project, you will be asked to take part in an in-depth interview of approximately 1 to 1.5 hours, conducted at a time and place most convenient for you. The interview will be audio-taped and later transcribed. We want to ask you about your experience of and feelings about the risks, dangers and hazards you face in your job, and also your thoughts and feelings about managing risk with your clients.

4. Possible Benefits
While we cannot guarantee or promise that you will receive any direct benefits from this project, the potential benefits to you as workers and providers of services is that you will have a better understanding of issues of risk management on the delivery of services, including the balance that needs to be managed between your own safety, and the safety, needs and desires of your clients.

5. Possible Risks
We do not envisage that participation in this project involves any risk to you. Our project does not involve invasive or harmful procedures, potential or otherwise. The study is not seeking any information which is confidential to your organisation or which identifies particular clients or patients. The focus of the research is on your experiences with applying the policies and practices of your organisation with respect to risk assessment and risk management, and the impacts of risk on the services your organization delivers.

It is not envisaged that any potential or actual harms will come to you from participation in this project.

Our interviewers are well trained and sensitive, and you will not be asked about deeply personal matters, but rather about your perceptions of risks, hazards and dangers that you face, how you feel about them, and how services deal with them. We also want to ask you about the ways that risk management affects your work with clients. We stress that participation is voluntary and that you may withdraw from the project and are free not to answer questions or provide details. Your responses are treated as confidential and will not be disclosed in ways that might identify you. As we are interviewing managers, workers and clients from the same organisations, we have taken steps to ensure that recruitment of interviewees will preserve anonymity. While we have asked managers to pass this information and consent form on to you, we will not inform them or anyone else that you will or will not take part in the interviews. The interview will take place in a location of your choice.

6. Privacy, Confidentiality and Disclosure of Information
Any information obtained in connection with this project and that can identify you, your organisation or any people within it will remain confidential. All data will be used in a non-identifying manner. The names of individuals and organisations involved in the study will not be used in any publications.

Data collected from individuals and field notes from background research at organisations will be retained for a period of 20 years in a secure locked room in the School of Social Sciences at La Trobe University, and will be transferred to the university archives if it is deemed no longer
possible for the School of Social Sciences to continue to securely store the materials. Computer based materials will be password protected.

7. Results of Project
At the end of this research project we will produce a publicly available summary of findings. If you wish we will send you a copy of the summary of findings to your nominated address. We will also produce a series of articles for publication in academic journals and for presentation at professional conferences. Findings will be presented at workshops for managers, workers and clients.

8. Further Information or Any Problems
If you require further information or if you have any problems concerning this project you can contact the principal researchers Professor Judith Brett or Mr David Green, or Dr Anthony Moran.

The researchers responsible for this project are: Professor Judith Brett, (03) 9479 2691; Mr David Green, (03) 9479 2793; Ms Claudia Trasancos, 5793 6400; Dr Janine Bush (03) 9603 9567; and Dr Anthony Moran, (03) 9479 1671. Each of these researchers will have voice-mail for after hours contact.

9. Other Issues
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact Ms Genevieve Nolan, Executive Officer, Department of Human Services Human Research Ethics Committee, on tel. (61 3) 9637 4239. You will need to tell Ms Nolan the name of one of the researchers given in section 8 above.

10. Participation is Voluntary
Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. This will not affect your employment with the organisation in any way.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

Upon consideration you may decide not to participate in this research. We are authorised by DHS to give you the undertaking that participating or not participating will have no affect on your organisation’s funding or any other elements of your own or your organisation’s relationship with DHS.

If you would like to participate please contact [name and details of research officer]

11. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the Department of Human Services, Victoria, and the Human Ethics Committee of La Trobe University, Victoria.

12. Reimbursement for your costs
$40 reimbursement for travel, incidental costs and inconvenience will be offered to each interview participant.
Consent Form, for Front-Line Workers

Site: Name of DHS funded organisation

**Full Project Title:** Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

I have read, or have had read to me, and I understand the Participant Information.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) ……………………………………………………
Signature        Date

Name of Witness to Participant’s Signature (printed) ……………………………………………
Signature        Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher’s Name (printed) ……………………………………………………
Signature        Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

*Note: All parties signing the Consent Form must date their own signature.*
Revocation of Consent Form, for Front-line Workers
Site: Name of DHS funded organisation

Full Project Title: Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise my relationship with my organisation, or any aspects of my organisation’s relationship with DHS.

Participant’s Name (printed) .................................................................

Signature                                             Date
Participant Information and Consent Form, for Carers/Family Members

Site: [Insert site name]

Full Project Title: Managing Risk in Community Services: A preliminary study of the impacts of risk management on Victorian services and clients

Principal Researcher: Professor Judith Brett, Mr David Green, Dr Anthony Moran

Associate Researcher(s): Ms Claudia Trasancos, Dr John Chesterman, Dr Anne-Maree Sawyer

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1. Your Consent

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This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

Keeping people safe is an important part of the job of community services and health services.

This project is about how these services manage safety, and the way they can avoid problems that might affect clients' safety or other peoples' safety. In this project we call these problems risks and we are trying to understand these risks, and what services can do about them. Sometimes services change the way they work because of these problems and risks, and these changes are called risk management. This study is about these risks and what we do about risks.

Sometimes you may feel that services do not do enough about clients' safety, or they do too much, either at home or in your local community. Sometimes carers and workers also feel not enough is being done to keep them safe on the job. This project is trying to find the best ways of keeping people safe and making sure services do a good job as well.

This information was passed on to you by [name of advocacy/support organisation] as someone who might be interested and might have ideas about these issues.

For this research project we have conducted interviews with CEOs and senior managers, program managers, frontline workers and clients in aged care, disability and mental health services in Victoria.

We now wish to add a further dimension to this research. Specifically, we are interested to hear about your experiences as a carer/family member in accessing and communicating with service providers and health and welfare workers.

This research project has received funding and support from the Australian Research Council, Department of Human Services (Victoria), and the Office of the Public Advocate.
3. Procedures
If you agree to participate in this project, you have the option of:

- Taking part in a one-on-one interview of approximately 1 to 1.5 hours, conducted at a
time and place most convenient for you, or
- Participating in a focus group of up to 5 carers/family members from your advocacy/
support organisation.

In either case, discussions will be audio-taped and later transcribed.

We want to ask you about your experience and feelings concerning the various ways that the
community services with which you are involved manage and deal with risks and potential risks.

4. Possible Benefits
While we cannot guarantee or promise that you will receive any direct benefits from this project,
improvements in the ways that services are delivered and risks measured and responded to may
be possible beneficial outcomes.

5. Possible Risks
We do not feel that any potential or actual harms will come to you from participation in this
project. However, we recognise that questions about your experiences can be personal. Our
interviewers are well trained and sensitive, and you will not be asked about deeply personal
matters, but rather about the way you see the risks, hazards and dangers faced by clients, family
members and community services, and what these services do about them.

Your answers are treated as confidential. We stress that participation is voluntary and that you
may change your mind and withdraw from the project. Also, you are free not to answer questions.

6. Privacy, Confidentiality and Disclosure of Information
Any information obtained in connection with this project and that can identify you, your
advocacy/support organisation or any people within it will remain confidential. All data will be
used in a non-identifying manner. The names of individuals and organisations involved in the
study will not be used in any publications.

Data collected from individuals and field notes from background research at organisations will be
retained for a period of 20 years in a secure locked room in the School of Social Sciences at La
Trobe University, and will be transferred to the university archives if it is deemed no longer
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based materials will be password protected.

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At the end of this research project we will produce a publicly available summary of findings. If you
wish we will send you a copy of the summary of findings to your nominated address. We will also
produce a series of articles for publication in academic journals and for presentation at
professional conferences. Findings will be presented at workshops for managers, workers, clients
and clients’ carers/family members.
8. Further Information or Any Problems
If you require further information or if you have any problems concerning this project, you can contact the principal researchers Professor Judith Brett, Mr David Green, or Dr Anthony Moran.

The researchers responsible for this project are: Professor Judith Brett, (03) 9479 2300; Mr David Green, (03) 9479 2793; Ms Claudia Trasancos, 5793 6400; Dr John Chesterman (03) 9603 9567; Dr Anthony Moran, (03) 9479 1671; and Dr Anne-Maree Sawyer, (03) 9479 3186. Each of these researchers will have voice-mail for after hours contact.

9. Other Issues
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact Mr Jeffrey Chapman, Executive Officer, Department of Human Services Human Research Ethics Committee, on tel. (61 3) 9096 5239. You will need to tell Mr Chapman the name of one of the researchers given in section 8 above.

10. Participation is Voluntary
Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

The names and contact numbers for the research team are included in Section (8).

11. Ethical Guidelines
This project will be carried out according to the National Statement on Ethical Conduct in Human Research (March 2007) produced by the National Health and Medical Research Council of Australia, the Australian Research Council and the Australian Vice-Chancellors’ Committee. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of the Department of Human Services, Victoria, and the Human Ethics Committee of La Trobe University, Victoria.

12. Reimbursement for your costs
$40 reimbursement for travel, incidental costs and inconvenience will be offered to each interview participant.
Consent Form, for Carers/Family Members

Site: [Insert site name]

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I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

**Participant’s Name** (printed) ……………………………………………………

Signature               Date

Name of Witness to Participant’s Signature (printed) ……………………………………………

Signature               Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

**Researcher’s Name** (printed) ……………………………………………………

Signature               Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

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Revocation of Consent Form, for Carers/Family Members
Site: [Insert site name]

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I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with my service provider.

Participant's Name (printed) .................................................................

Signature                      Date
REFERENCES


Victorian Managed Insurance Authority (2009a) *Risk management guide: For community service organisations*. Melbourne: Victorian Managed Insurance Authority


