A Challenge to Evidence Based Practice: 'Re-shaping the Risk agenda'

An 'evidence-based' agenda

The 'evidence-base' for risk is failing both service users and practitioners.

A frequent question asked when risk projects or risk training is being commissioned usually follows the lines of: 'Is the risk assessment tool evidence-based?' Do those who ask the question even know why they are asking it, or what they are expecting from an evidence-based tool? Or, have we really managed to brainwash a great number of our service managers and practitioners in the 'research cool' way of doing things? What is a so-called evidence-based piece of paper supposed to give you that a non evidence-based format will not? In the advertising and marketing rich society we live in, there should be a sharp sales-worthy pitch to make in response: 'Yes, of course it's evidence-based, use the 'all-new shiny research-tested risk assessment tool' and you can achieve a y% reduction in risk incidents, z% less suicides, and elimination of many factors you may not yet of thought of, than if you use a locally grown risk assessment tool.

'New Labour Risk Free UK plc' thrives on the rhetoric that 'community care' is the policy of choice, because it promotes greater individual freedoms, while ensuring public safety through raising the bar of expectations on mental health services to that of risk elimination or risk recrimination. 'Media roasting' and additional 'administrative targets' are the weapons of choice to unleash in the face of any failure of the public services to fulfil expectations. Service providers in turn are subliminaly encouraged to adopt 'evidence-based practice' as the way to avoid becoming the focus of attention in the feared media headlines.

The 'evidence-base' for working with risk is on very shaky ground, being focused largely on the negative: the number of body bags needed to meet the statistics of death, and the negative factors that may indicate the potential for further incidents. At least it is consistent in one respect, that it will stigmatise every person it is rigorously applied to! We may also confidently extrapolate that if practitioners are expected to spend so much of their time filling in extensive forms, we can say with reasonable certainty that risk assessment forms have been filled in! Once again the focus of audit will tell much about the quantity of administrative throughput achieved, but little if anything of the quality of service delivered or received. A decade or more of knee-jerk reactions to rare but tragic events has surely achieved one significant outcome: administrators have seized the clinical agenda and shaped it in such a way that clinical staff have primarily become administrators.

This article is more about 'informed opinion' and less on the data and statistics of failure. Giuliani (1), the former Mayor of New York City, reflects the merits of this stance while not taking away from the value of objective facts when he suggests that not all decisions have to follow the same process,

some are clearly objectively based on fact, but innovation frequently arises out of intuition. New and individualised insights, which can only arise from creativity and innovation, are essential elements of good practice for 'working with risk'. They are also paramount if we are serious about engaging service users in the conversations about the experiences of risk, and the potential for constructive risk-taking.

Contrary to the between-the-lines messages of misguided policy statements we cannot predict the unknown, or the carefully guarded or spontaneous actions of human behaviour. Similarly, we are unable to produce the statistics of success, as we do not know the number of homicides or suicides prevented by good practice. The evidence we do have indicates a positive message if you wish to look for it - the homicide rate in the mental health population has remained consistently low across the last 50 years, compared with a rising homicide rate in the general population (2).

Imagine for a few moments that your life is free from risks: you are unburdened by the need to make decisions based on competing choices, free of the worry of seeking information that may be incomplete or unsafe. Everyone greets you with a smile, yet you remain unsuspicious of their motives. We are all safe because we are all the same, think the same, do the same die of boredom the same. Is this the nightmare outcome of following the 'evidence-based' message to its full conclusion?

Now imagine again that your life is free from risks: where you do not have to make decisions because others do it for you, don't seek out information because little will be offered anyway, don't worry about choices because there aren't any. Everyone else is concerned with your safety, and theirs! If you are not already, then you have just become a service user, and you are now the reason why everyone else is so concerned about safety and eliminating your risk, whether or not you see yourself as any form of risk.

A 'BLAME CULTURE' AGENDA

"Where was community care when another mad psycho was released to kill innocent victims?"

In the field of mental health, the perceptions of the public, legislators, managers and even practitioners all seem to mitigate against the taking of risks:

- We generate a climate of fear
- Focus the spotlight on rare but tragic events
- Focus on a history of failings
- Heighten the fear of getting things wrong
- Promoting a 'culture of blame'

In reality, our approach to risk is driven by negativity and defensiveness; shaping our priorities, and influencing the design of tools we use to identify and manage risk, largely through a 'caution first' attitude. Langan and Lindow (3) report that workers identified: " the shift towards more defensive practice within a climate characterised by the following elements: inaccurate media hype about 'mental illness' and dangerousness; a culture of blame where professionals are held accountable,

whatever the rights and wrongs of the situation, should anything go wrong; and society's insistence that all risks should be contained and managed." (p.10).

Whilst nobody wishes to see another statistic of tragedy, we should be more explicit about the risks involved in restrictive practice, particularly failure to effectively involve and empower service users (4). In cold reality, we are subtly improving our ability to drive people away! Concepts such as 'positive risk-taking' and 'working with service user strengths' receive lip-service at best. Phrases appear in policy statements almost mid-sentence, and then they are gone, with little serious articulation of what they mean, or how they can and should be promoted as essential to practice: "Consideration also needs to be given to the user's social, family and welfare circumstances as well as the need for positive risk-taking." (5).

"A society that needs to perpetuate a culture of blame only serves to destroy the seeds of confidence before they have an opportunity to flourish." (6).

The result of the above statement for many practitioners is the stifling of creativity, and a reliance on the narrow well-trodden solutions. For example, the change from a person having a depot injection at the clinic to having it at home is not 'creativity'; it is a stronger sense of 'control'! Helping the person to take more control of their own medication decisions is 'creativity', but it is hard work and challenging. However, practitioners more frequently become driven more by a stronger fear of things going wrong, which comes to greatly outweigh the opportunities that may help people to really move on.

"*The quashing of personal aspirations can only serve to contribute to the potential for serious risks and damaging consequences*." (6).

The above statement becomes 'the lot' of the service user. At best, dreams and wishes may be tolerated and briefly discussed, but will not be the prime mover for shaping the priorities to be worked on. Dace and Smith (7) is an example illustrating this state of affairs: whereby we all share a dream to go on holiday, in fact it becomes the focal point of the year for many of us. However, what is simply taken for granted by most of us is rather more problematic to achieve for a service user. Firstly, a holiday may not be affordable on state benefits, necessitating an application for funding. Most funding agencies will ask for a risk assessment. Risk assessments rarely permit a 'no risk' category, so at least a 'low risk' is indicated. The funding agency, perceiving (falsely) the presence of risk, and reject the funding application. For the service user another dream is crushed as the outcome is no holiday for another year.

Whilst we are all subject to assessments of risk in our daily lives (e.g. applications for loans or insurance), mental health risk assessment is in a different league for perpetrating intrusion, stigma and barriers to achieving the aspirations that most people work for or take for granted. This is not an argument for rejecting the concept of risk assessment in mental health, but we do need to instigate a process of redesign to achieve reasonable and constructive 'working with risk' (8)

A 'RISK BUSINESS' AGENDA

Mental health services have become characterised by a progressive shift, from the dominance of clinical judgement, to that of administrative decision-making. (9).

Over the last decade risk assessment appears to have become less concerned with formulating good clinical judgement and more focused on providing defensible decisions. A 'tick-box' culture prioritises a summary of the negatives in someone's life, with little attention to the 'context' in which events may have taken place. Characterised by 'where is the risk assessment', or 'have you completed the risk assessment'! Through a process of evolution 'the tick' has been elevated to an unprecedented level of importance. The design of our risk assessment tools has been hijacked by people who do not usually have to implement their own creations in daily practice. In short, if it is designed by bureaucrats and built by administrators, it is most likely to be crashed by practitioners!

In the study by Langan and Lindow (3) a few of the professionals suggested risk assessment is " a very defensive process and with very limited scientific backup that formally assessing risk actually does make a difference clinically." (p.12). Furthermore, “risk assessment was emphasised at the expense of risk management." (p.25).

What is the most important risk priority for practitioners? The risk of people receiving a sub-standard level of service contact, or the risk of a form not being completed? A rhetorical question or reflections on reality? Roy (10) raises a concerning influence, that practitioners are challenged to make a further assessment: that of the risk to themselves of getting a decision wrong. However, anecdotal evidence suggests that, in the eyes of the courts, it is better to have done a risk assessment that is wrong than none at all. The court will not criticise a practitioner for getting it wrong if there is recorded evidence of considering the relevant issues! This is an important consideration, but we may be forgiven for thinking the highest priority is being accorded to getting the boxes ticked, whether or not a risk incident or near miss has occurred.

> Clinical issues become increasingly influenced by non-clinical agendas, and by expectations generated external to the helping relationship. (9).

Our discourse on risk often claims to be responding to the service user's needs, but in reality plays to the gallery of a public safety agenda. The media inform the public, the government need to be seen to react (for votes), the targets and priorities are passed down. The people most involved on the ground, are least involved in the debate i.e. service users and practitioners. It becomes very confusing just whose risk is being assessed and managed for whose benefit.

Incidents and inquiries can be sharp lessons for causing practice to become tighter and more cautious. How can we encourage staff to retain a sense of the importance of positive and constructive risk-taking in the face of things having gone wrong? Risks will still have to be taken, but they can become more based on negative drives, rather than positively thought through motivations.

Suicide prevention is a case in point, where the external target-oriented agenda holds a strong influence on individual and team practice. The strongest message perpetrated from the statistics is that of setting the targets has concentrated minds on the issue, leading to a gradual reduction of

incidents. Nobody can argue against the intentions, but the focus of attention appears very narrow. Reducing the numbers is vitally important, but just how much attention is being paid to helping a greater understanding of the experiences that bring people to a conclusion to take their own lives? Government rhetoric sounds more about target groups and figures, less about understanding of the causes!

Shifting the agenda: a case illustration

Mehmet's Story:
1980's: characterised by substance misuse, aggression, homelessness, containment, service disengagement [A picture of restrictive risk management].
1990's: characterised by housing, personal relationships, working with Mehmet's priorities, service engagement [A picture of constructive risk management].

An example of bridging the gap between the picture of restrictive practice, and one of a constructive and collaborative approach to practice. It is not a panacea for risk elimination nothing ever can be. Two further hospital admissions occurred during the 1990's, but they were comparatively much shorter and better managed. The housing department was a clear source of friction and concern in the picture of Mehmet during the 1980's, necessitating threats to his tenancies and his reciprocal threats to staff. During the 1990's they had remained unaware of his fluctuations in mental state, as a more supportive set of relationships had provided protective factors in place of previous sources of anger and frustration.

Mehmet's story provides an example of the more realistic expectations of risk minimisation, and is far from being an isolated example.

A 'strengths-based' agenda

'Deficits' provide a block to personal progress; whereas 'strengths' are real resources, personal sources of 'motivation', sign-posting positive 'change', the basis for engaging trusting working 'relationships'.

Most people will engage with a service that is offered in a flexible way in response to their perception of their needs. We can not constructively take risks if we do not have a full appreciation of the 'strengths: abilities, resources, and wishes and dreams' of the person. When faced only with a comprehensive picture of 'failings, deficits, difficulties and problems' we are not likely to see the potential to take risks with positive outcomes, we are more likely to be restricted in our vision (11).

This needs to be the primary approach to our work, not just a fleeting acknowledgement in our more usual preoccupation with things going wrong, and the need to be solving problems in a way disconnected from the service user's sense of reality. A strengths approach emphasises a more constructive view of risk: a uniquely challenging aspect of the work, to positively engage service user's viewpoints and experiences, in a collaborative approach to identifying and managing the impact and consequences of different courses of action. It is reasonable, not negligent practice!

A 'POSITIVE RISK-TAKING' AGENDA

The language of 'positive risk-taking' is an important starting point for connecting the agendas of service users and those of service providers. It strongly reflects the positive side of the concept of risk that we all aspire to benefit from, as a normal aspect of life.

Constructive reflection should focus on: taking a chance or a gamble opportunity gain choices making decisions personal control autonomy responsibility collaboration learning, growth & change lived experience

To help formulate a definition of what 'positive risk-taking' means in everyday practice the following should be taken into consideration:

- 'Positive risk-taking' is not negligent ignorance of the potential risks. Nobody, especially service users, benefits from allowing risks to play their course through to disaster.
- 'Positive risk-taking' is about real empowering of people through collaborative working, and a clear understanding of responsibilities that service users and services can reasonably hold in specific situations.
- It is based on the establishment of trusting working relationships, whereby service users can learn from their experiences, based on taking chances just like anyone else. It is about understanding the consequences of different courses of action; making decisions based on a range of choices available, and supported by adequate and accurate information.
- It is about knowing that support is instantly available if things begin to go wrong, as they occasionally do for us all.
- 'Positive risk-taking' can occasionally be distinguished between its short-term and long-term differences, whereby short-term heightened risk may need to be tolerated and managed for longer-term positive gains. It can also be about explicit setting of boundaries, to contain situations that are developing into potentially dangerous circumstances for all involved.
- As a concept, 'positive risk-taking' needs to be appreciated and understood from the different perspectives of the service user, informal supports, and services - how they define or interpret a risk and its potential benefits will not always be congruent or compatible.(8)

Good practice 'guidelines' (12):

- Service user/carer perspectives
- A focused definition of risk-taking
- Identify potential gains & consequences
- *Reasoned* collaborative decision-making
- Changing the *patterns* of history
- Working with *'strengths'*
- Negotiated plan and reasonable safety nets
- Responsive *support* mechanisms
- Broader *understanding* of the concept (throughout the team & organisation)
- Culture of *learning*, not blame

How do we take risks in our daily lives? Generally, through careful consideration of what we want, what we need to do, what our strengths are, and an awareness of the potential consequences of different actions.

Linking balanced and accurate risk information to the individual's personal motivations for change can increase the likelihood of positive gains. It is about making reasoned collaborative decisions, and

being more explicit and transparent about the process of risk assessment and management. We need to develop good quality tools to guide and support practice; less of the priority on measures for generating statistics for audit. There is a place for challenging audit and clinical governance departments to produce the statistics and feedback the messages that practitioners and service users need to know to support good practice, not just the failures of the process.

A 'NORMALISING RISK' AGENDA

Experiencing risk is an everyday normal event, challenging us to live with and adapt to levels of uncertainty. We need to design the tools that help to guide and capture this reality for service users. Denial of risk-taking does not mean it goes away, or that it is not happening, as we all take risks every day. Denial means they are more likely to occur in an unsupported manner with outcomes more determined through 'unconsidered' chance. We need to recapture a trust in clinical judgement supported by good practice guidelines. We also need a clearer articulation of what is meant by individual accountability for practice, allied to a shared responsibility in teams for decisions, and vertically through organisations for challenging the current negativity that only serves to instil fear and sap motivation. If we deny people opportunities for growth and change, we give them good reasons to mistrust so-called helping interventions.

"*If you don't risk anything you may risk everything!*" [Source unknown]

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