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### **Conference contribution :**

Coffey, M. (2015). *Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment care planning*. 21st International Network for Psychiatric Nursing Research,

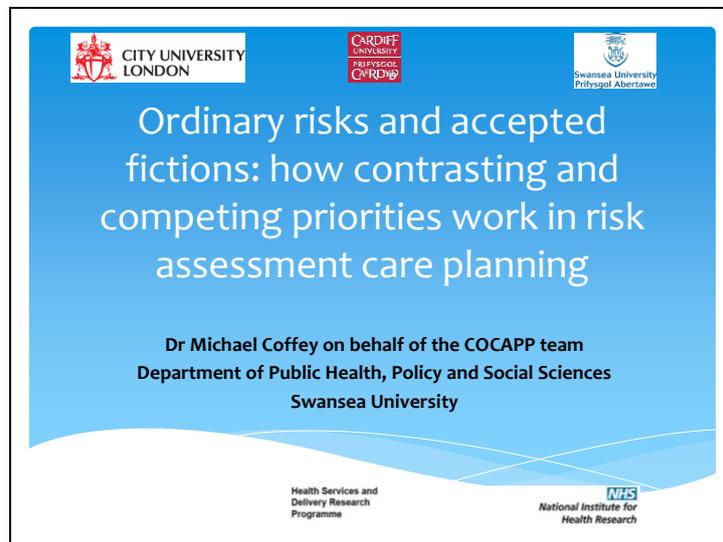
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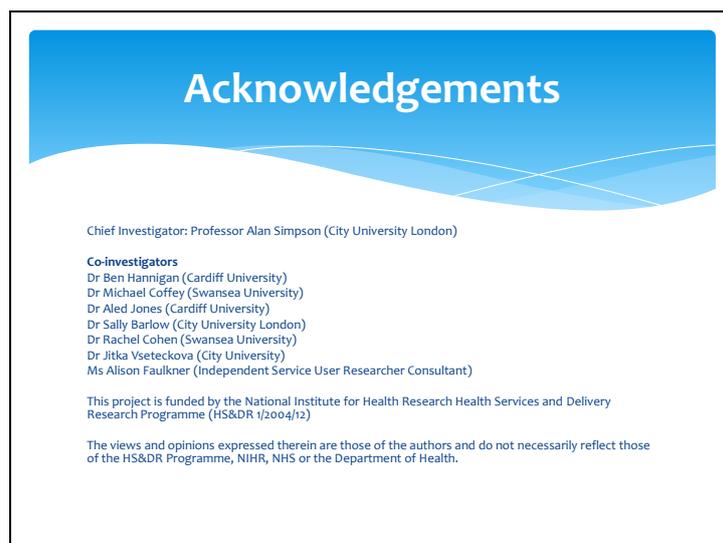
Coffey, M. on behalf of the COCAPP team (2015) Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment care planning. 21st International Network for Psychiatric Nursing Research conference 17th and 18th September 2015 Manchester Conference Centre.

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In this paper I present a further analysis of COCAPP data focusing on safety and risk in care planning and care co-ordination.

Slide 2



Slide 3

## Background

- \* Risk assessment in CPA/CTP
- \* Risk deliberations carry significant weight
- \* Predictive power of risk assessments is poor
- \* Risk seen to be embodied in the person
- \* Do risk ideas allow for recovery?



A key requirement of care co-ordination in the CPA and in the Welsh CTP is that of risk assessment. There is little doubt that some form of risk and safety process is needed in mental health care but uncritical adoption of existing risk processes in care planning raises a concern that the limitations of these approaches are not openly recognised.

There are potentially serious implications for patients from risk assessment processes in that they carry significant weight in determinations of continued liberty and for workers in that they represent the means to avoid blame for untoward events. So there may be a tension here between outcomes that promote independence say and those that shield workers. Even where workers are chiefly and primarily concerned with protection of the person or others there remains significant anxieties that they may also be held accountable for events that are largely unpredictable.

In this sense then risk assessment is itself a contested area of mental health care. Significant efforts continue to add knowledge to the practice of risk assessment with a great deal of the focus placed on developing actuarial and hence supposedly more scientific mechanisms for identifying and predicting future risk behaviours (Boardman and Roberts 2014, DoH 2007, Gray et al, 2011). Swanson (2008) however has noted that the predictive accuracy of risk assessment in mental health care is fraught with problems such that even the best actuarial tools perform substantially below that which is commonly acceptable in other branches of medicine.

It has been argued too that for workers it seems that risk is embodied in the mentally ill person who is seen as chief actor in creating dangerous events. More rarely the risks the person themselves are presented with are considered. These risks include iatrogenic risks, meaning those linked with the provision of care. The more obvious of these are posed by psychotropic medicine such as irreversible side-effects (Busfield, 2004; Whitaker, 2004). Kelly and McKenna, (2004) further noted those risks presented by the community itself in

the form of discrimination, stigma and possible physical attack. Risks presented by intense scrutiny and follow-up by workers have also been shown to be a concern for people using services (Coffey 2012). Current risk assessment practice seems to reinforce a type of professional knowledge elitism. More generally it has been noted that risk practice prioritises professional judgement over lay judgements often with the claim that lay judgements are prone to subjective influences which professionals are considered to be somehow immune to themselves.

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

Slide 4

Means and Standard deviations of subscales of the RSA													
RSA subscales		Burgundy		Artois		Champagne		Dauphine		Languedoc		Provence	
		Mean (SD)	N										
Life Goals	Service User	3.55 (1.06)	70	3.48 (1.00)	65	3.38 (.97)	63	3.43 (1.00)	53	3.31 (1.00)	81	3.30 (1.10)	68
	Care Coordinator	3.73 (.70)	37	3.68 (.72)	38	3.79 (.52)	31	3.54 (.83)	33	3.82 (.60)	28	3.70 (.55)	34
Involvement	Service User	2.96 (1.12)	69	2.89 (1.11)	58	2.70 (1.11)	56	2.93 (1.09)	46	2.66 (1.12)	81	2.86 (1.22)	69
	Care Coordinator	2.90 (.66)	37	3.01 (.81)	38	2.92 (.73)	31	2.99 (.84)	33	3.23 (.63)	28	2.86 (.56)	34
Diversity Of Treatment Options	Service User	3.06 (1.08)	71	2.99 (1.20)	67	3.05 (1.12)	65	3.21 (1.12)	53	2.70 (1.04)	83	2.91 (1.16)	73
	Care Coordinator	3.23 (.76)	37	2.96 (.87)	38	2.94 (.70)	31	2.98 (.91)	33	3.24 (.64)	28	2.74 (.51)	34
Choice	Service User	3.65 (.89)	74	3.66 (.90)	69	3.66 (.83)	70	3.69 (.98)	55	3.72 (.86)	87	3.39 (.98)	74
	Care Coordinator	3.92 (.65)	37	3.76 (.64)	38	3.70 (.62)	31	3.46 (.68)	33	4.04 (.50)	28	3.58 (.74)	34
Individually- Tailored Services	Service User	3.27 (1.06)	66	3.27 (1.00)	64	2.99 (1.06)	60	3.21 (1.07)	52	3.05 (1.12)	84	2.95 (1.21)	71
	Care Coordinator	3.10 (.80)	37	3.18 (.77)	38	3.11 (.75)	31	3.49 (.86)	33	3.42 (.69)	28	3.08 (.64)	34
Total	Service User	3.33 (.95)	71	3.27 (.96)	66	3.13 (.87)	63	3.31 (.96)	52	3.12 (.94)	86	3.10 (1.03)	73
	Care Coordinator	3.41 (.61)	37	3.35 (.68)	38	3.35 (.56)	31	3.31 (.75)	33	3.57 (.56)	28	3.25 (.46)	34

1	2	3	4	5	N/A
Strongly disagree					Strongly agree

Two observations prompted us to examine our data on risk assessment a little closer.

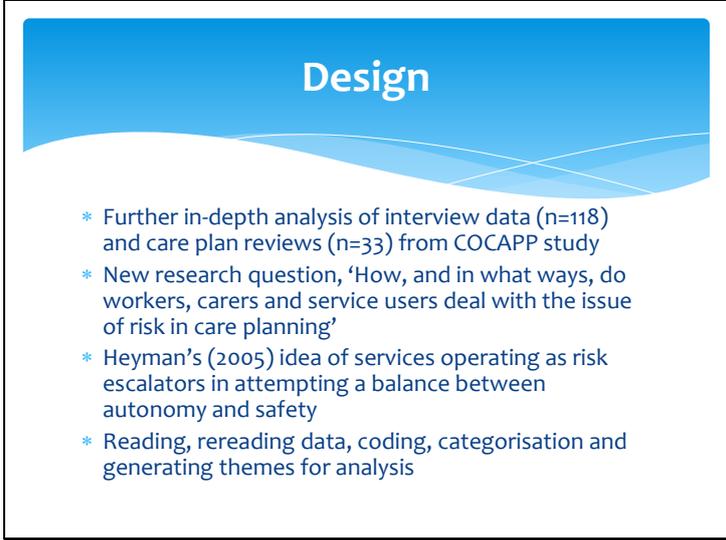
1. Our survey data on COCAPP from the Recovery Self Assessment scale shows that in general SUs score items lower than CCs suggesting a consistent if slight tendency for providers of services to rate provision more positively than those receiving it. These also show that for the most part workers rated involvement higher than service users

So perhaps a hint here that there is a mismatch in expectancies around elements of recovery and care planning.

2. A more general finding from the Framework Analysis in COCAPP suggested differences in experiences in relation to risk assessment practices highlighting risk as an area for further exploration.

Given these two indicators we set about conducting a further analysis of the data we collected on risk in care planning.

Slide 5



**Design**

- \* Further in-depth analysis of interview data (n=118) and care plan reviews (n=33) from COCAPP study
- \* New research question, 'How, and in what ways, do workers, carers and service users deal with the issue of risk in care planning'
- \* Heyman's (2005) idea of services operating as risk escalators in attempting a balance between autonomy and safety
- \* Reading, rereading data, coding, categorisation and generating themes for analysis

For this current paper all interview data (n=118) and care plan review data (n=33) related to risk assessment and management from the COCAPP study were extracted and subjected to an extended in-depth qualitative analysis. In our interview schedules we asked SUs (n=33) the following

Do you feel your safety has been considered in your care planning and coordination?  
Prompts: How has your safety been addressed in your care plan or by your care coordinator?  
Have any other aspects of safety or risk been discussed with you?

Other participants (Senior managers, senior practitioners, carer co-ordinators and family members n=85) were asked a version of this question too.

We also developed and used a standard template for reviewing care plans to identify information on recovery and personalisation. The relevant information for this analysis was drawn from questions on whether there was evidence of the persons views being taken into account in the risk assessment and the risk management elements of the care plan.

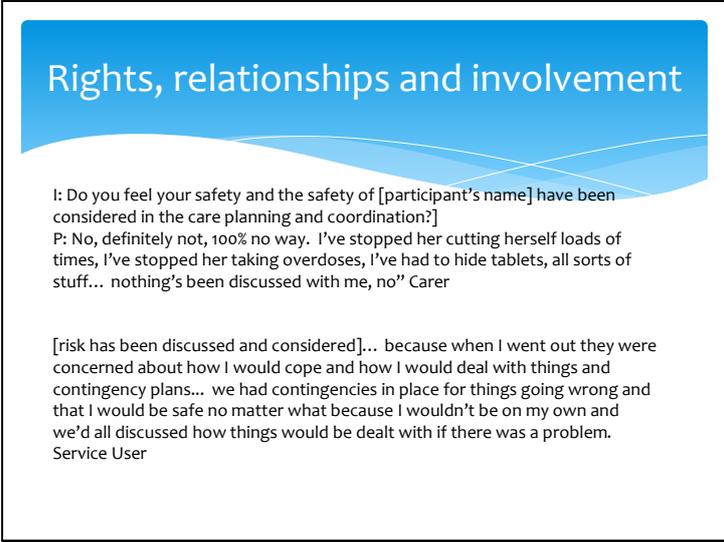
Our analysis involved three members of the team independently reading and re-reading these data, coding and categorisation of the material, and then interrogation of this data based upon a new research question.

The research question was, how and in what ways do workers, carers and service users deal with the issue of risk in care planning? Using this research question to examine our categories we developed our analysis to construct themes focusing upon the communicative relations as presented in our data. Informed by Heyman's (2005) conceptualisation of services working in ways akin to a risk escalator we interrogated our categories to generate two key themes from our data.

The concept of the risk escalator focuses on the key dichotomy of striking a balance between autonomy and safety. A risk escalator is defined as “a system, designed or emergent, which is oriented towards managing a defined health risk, and which is made up of a set of sub-systems, ordered in terms of different trade-offs between autonomy and safety, through which service-users may move” (Heyman, 2005:44).

The themes generated by this approach were ‘rights, relationships and involvement’ and ‘the moral work of risk practice’

Slide 6



**Rights, relationships and involvement**

I: Do you feel your safety and the safety of [participant's name] have been considered in the care planning and coordination?

P: No, definitely not, 100% no way. I've stopped her cutting herself loads of times, I've stopped her taking overdoses, I've had to hide tablets, all sorts of stuff... nothing's been discussed with me, no" Carer

[risk has been discussed and considered]... because when I went out they were concerned about how I would cope and how I would deal with things and contingency plans... we had contingencies in place for things going wrong and that I would be safe no matter what because I wouldn't be on my own and we'd all discussed how things would be dealt with if there was a problem.  
Service User

Our further analysis of participant responses suggests two themes which we have initially and tentatively labelled ‘Rights, relationships and involvement’ and ‘the moral work of risk practice’

I'll explain the reason for the titles here and show some examples and would be interested to hear views on our choices.

This theme of Rights, relationships and involvement includes data where participants are concerned to highlight both good and inconsistent relationship issues in risk assessment practice, both sides of the coin of involvement and the relevance of this to rights for recovery.

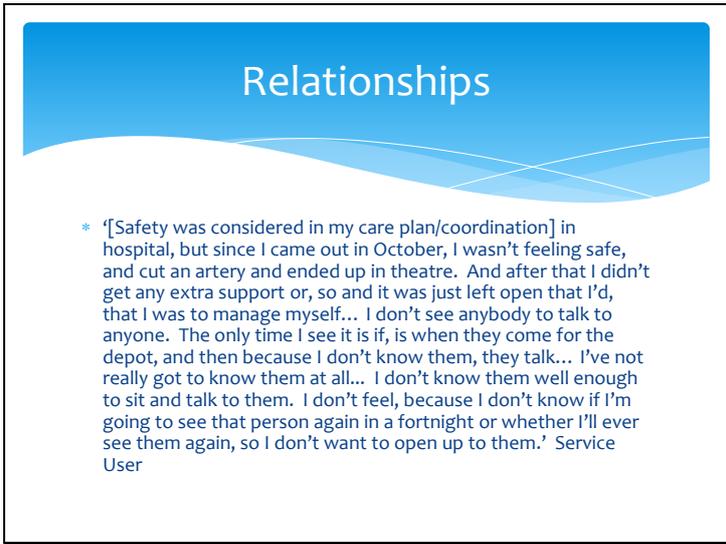
On this slide I present contrasting accounts from participants of their experiences of risk assessment practices. Here we see one carer expressing something close to exasperation that whatever risk assessment and management practice is operating it is largely unknown to the person and clearly not managing the risk behaviours that are being experienced.

I contrast this with the potential of involvement expressed by a service user in another site who has clearly been involved in discussions and plans for managing threats to their safety. Here we see the potential of involvement if treated as a fundamental right in all aspects of care co-ordination can work to engage and perhaps if improve the safety for people with significant and enduring mental distress.

The picture is not universally negative from service users on involvement but it has to be noted that as many as 4 times more people provided negative accounts of not being involved in their risk assessments – versus those providing more positive accounts of involvement. This is further substantiated when we look at actual care plans across our 6 sites

Out of a total of 33 care plans reviews we found 12 showing that views were considered in risk assessment. 4/12 however did not extend this inclusion to the risk management plan. So 21 careplans showed risk assessments conducted but not involving the views of the person or in a smaller number of cases (4) that no risk assessment documentation had been completed. In some areas (CV, AB) there was no evidence at all of views being considered in any care plans reviewed and one area (AWP) showed this had been done for all 4 care plans reviewed.

Slide 7

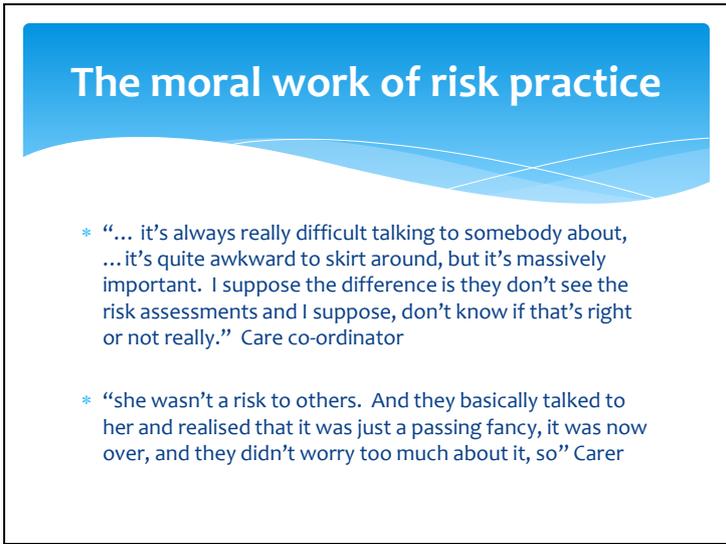


**Relationships**

\* '[Safety was considered in my care plan/coordination] in hospital, but since I came out in October, I wasn't feeling safe, and cut an artery and ended up in theatre. And after that I didn't get any extra support or, so and it was just left open that I'd, that I was to manage myself... I don't see anybody to talk to anyone. The only time I see it is if, is when they come for the depot, and then because I don't know them, they talk... I've not really got to know them at all... I don't know them well enough to sit and talk to them. I don't feel, because I don't know if I'm going to see that person again in a fortnight or whether I'll ever see them again, so I don't want to open up to them.' Service User

Relationships – A recurrent theme in the main COCAPP data was the relevance and importance of relationships in care planning and care co-ordination. Not surprisingly this was reflected too in our data on risk. Relationships are key to feeling safe, being able to trust the worker with your concerns and knowing how they might react and interact. Recovery opportunities would seem to be limited in a situation where the worker changes from visit to visit or relationships have not fully developed. Here we see too that issues with continuity between inpatient care and community follow-up can create problems of trust and perhaps even contribute to fears about safety.

Slide 8



The slide features a blue header with the title "The moral work of risk practice" in white text. Below the header, there are two bullet points, each containing a quote. The first quote is attributed to a "Care co-ordinator" and the second to a "Carer".

**The moral work of risk practice**

- \* "... it's always really difficult talking to somebody about, ... it's quite awkward to skirt around, but it's massively important. I suppose the difference is they don't see the risk assessments and I suppose, don't know if that's right or not really." Care co-ordinator
- \* "she wasn't a risk to others. And they basically talked to her and realised that it was just a passing fancy, it was now over, and they didn't worry too much about it, so" Carer

Moral work can be seen to be talk in which care co-ordinators display their professional judgement and position their work as reasoned with the best interests of the person in mind. The moral stance in this sense is taken to be social derived, contingent and determined in interaction with others. The presentation of work and being seen to be doing the best one can with limited resources and with the likelihood of highly unpredictable outcomes is a moral accomplishment of workers in talking about this area of work.

Care co-ordinators who participated in our study were keen to claim that risk assessment is key to their care planning practice. Allusions to involvement featured in some of this talk though the opposite in which care co-ordinators claim not to involve people as a paternal decision to protect them from further distress was much more commonly reported.

Where involvement is mentioned it was often positioned as an aspiration to be achieved rather than something that is commonly practiced and accompanied by the caveat 'if appropriate'.

There is a sense here that workers called to account in a research interview are highly attuned to the possibility that their work may be criticised as not following best practice in relation to ideals of involvement. As a result moral work in their answers is required and they rarely fail to provide it.

Care co-ordinators and to some extent carers and family members appear to position risk assessment work as a highly moral if largely unsatisfactory attempt to arrive at decisions on how to manage safety. These decisions however rarely involve the person and in many cases the most service users can expect is to be told that a risk assessment exists though this too appears to be relatively rare.

Many care co-ordinators say they involve people but this appeared to be little more than involvement of the person for the purposes of answering assessment questions. It is not clear that the purpose of these assessments is ever made clear to service users.

Family members were very keen to place the emphasis of risk as being centred on risk to self rather than risk to others, but also that risk was something temporary and transient. So risk is not to be seen as something permanent and not something that implicates the character or identity of the person. 'A passing fancy' works here for this purpose and for emphasis the speaker indicates that professionals are not overly concerned themselves with the risk. Service users too of course do moral work – note for instance the classic Parsons sick role requirements and in mental health risk is often positioned as occurring outside the control of the individual.

Slide 9

## Contrasting priorities

- \* Workers priorities
  - \* Administrative
  - \* Concern about upset
- \* Family/carer priorities
  - \* Plans for safety
  - \* Point of contact and response
- \* Service users priorities
  - \* Preserving liberty



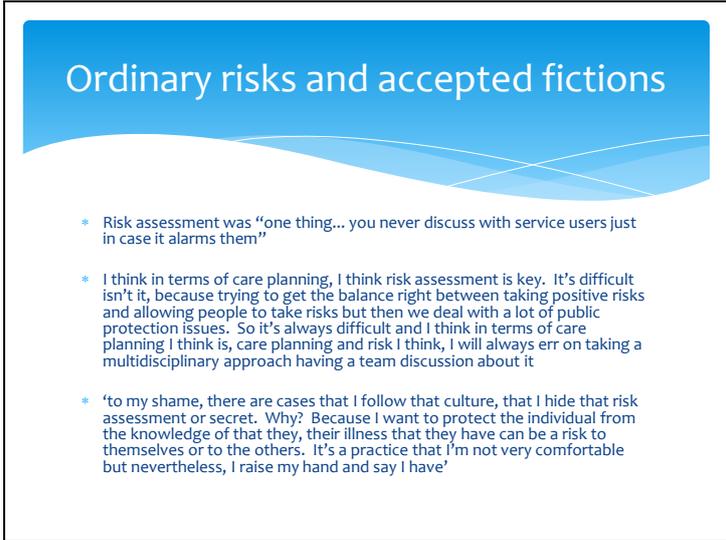
We see contrasting and at times competing priorities from workers, family members and service users in relation to how risk is dealt with in care planning and care co-ordination.

Workers seem most concerned about the administrative task of risk assessment. This may be related to organisation pressures seemingly outweighing a focus on involvement. It could be said too that much of what workers are concerned with is demonstrating that they are addressing requirements for risk assessment as a means to avoid blame for further untoward events. Workers also report a concern to avoid upsetting the service user with discussion of past risk behaviours or indeed plans for responding to future events. They appear to be aware that they aspire to involvement but in many cases they don't practice it in relation to risk assessment practice.

Family members who participated in our study were keen to know that plans for ensuring the safety of their relative did exist although they frequently were unaware of the content of any plans, were not involved in developing them and appeared to take it on trust that these plans had been prepared. In some cases family members had no interest in having copies of the care plan but they were concerned to have a point of contact should they need help urgently and that a quick response in the event of untoward events would be forthcoming.

Service user participants were aware that assessments of their safety might be sufficient grounds for loss of liberty or more treatment compulsion.

Slide 10



Ordinary risks and accepted fictions

- \* Risk assessment was “one thing... you never discuss with service users just in case it alarms them”
- \* I think in terms of care planning, I think risk assessment is key. It's difficult isn't it, because trying to get the balance right between taking positive risks and allowing people to take risks but then we deal with a lot of public protection issues. So it's always difficult and I think in terms of care planning I think is, care planning and risk I think, I will always err on taking a multidisciplinary approach having a team discussion about it
- \* 'to my shame, there are cases that I follow that culture, that I hide that risk assessment or secret. Why? Because I want to protect the individual from the knowledge of that they, their illness that they have can be a risk to themselves or to the others. It's a practice that I'm not very comfortable but nevertheless, I raise my hand and say I have'

Risk is a significant concern for workers but is not openly discussed with service users for the most part who are often unaware of the content of risk assessments. This appeared to limit the potential for greater involvement by service users and carers in exploring and managing their own safety and for positive risk-taking as an aspect of their recovery.

One consequence of not discussing risk openly was that service users and carers were uncertain if risk was being planned for adequately and this itself can raise their anxieties about what workers are doing for them.

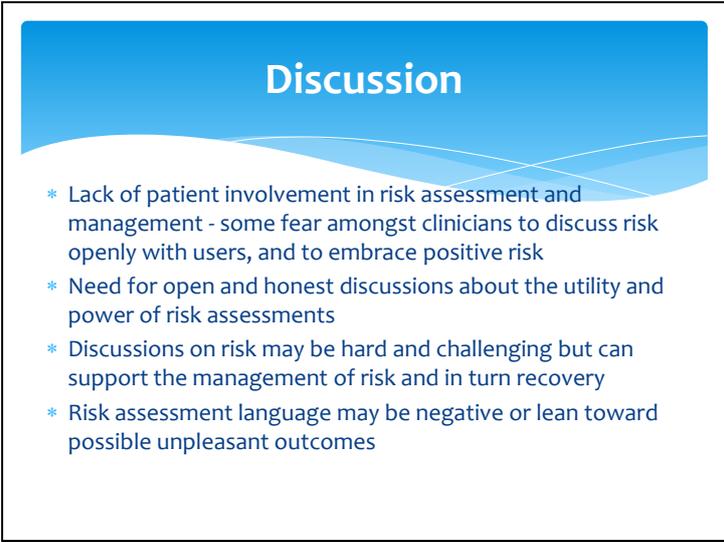
There is also the concern that opportunities for the ordinary or everyday risks that people should encounter are being limited by a care system that works to exclude people from deliberations of serious risks and ultimately may restrict opportunities for growth and recovery. Workers are clearly aware that the system is naturally conservative and risk averse but often deploy devices such as their ultimate get out in the use of the 'public protection' card as means to demonstrate their moral work.

Risk assessment and management practices appear to operate in ways that suggest the use of accepted fictions about these practices. Accepted fictions are those stories that workers, families and service users produce or rehearse for various purposes in the day to day work of mental health care. Accepted fictions appear to centre on aspects of mental health care that are either transparently ineffective or for which the contested knowledge about them is known but largely ignored. One such accepted fiction I contend is related to risk assessment practice. For the most part workers are concerned with demonstrating that risk assessment has taken place but rarely if ever question the practice, it's efficacy or the purposes it serves. These fictions take various forms and range from the claim that discussing risk and involving people in attempts to address safety issues will cause upset and worsen their conditions. To my knowledge no evidence of this exists and it is difficult to come to a conclusion other than this largely operates as a protective screen for workers who find (or imagine that) such conversations (are) difficult.

Another fiction may relate to the supposed predictive and/or the protective value of risk assessment itself. This is not to say that risk assessments should not take place but rather that they must do so with greater awareness and honesty of their limitations.

A further accepted fiction in relation to risk assessment practice is illustrated by workers claiming that they are continuously assessing risk. The question arises is which risks do they mean and how can they make this practice more obvious and therefore open to scrutiny for the purposes of establishing what works or otherwise? By keeping hidden those aspects of risk assessment practice that are claimed to be continuously in operation it becomes much more difficult to be clear that anything is happening at all.

Slide 11



**Discussion**

- \* Lack of patient involvement in risk assessment and management - some fear amongst clinicians to discuss risk openly with users, and to embrace positive risk
- \* Need for open and honest discussions about the utility and power of risk assessments
- \* Discussions on risk may be hard and challenging but can support the management of risk and in turn recovery
- \* Risk assessment language may be negative or lean toward possible unpleasant outcomes

Lack of involvement of people in their own risk assessments denies them opportunities to learn about their safety and to be part of the plan to maintain their own safety.

Workers are clearly worried about the current emphasis of risk practice and can see the potential in a different approach to risk ('I think as a worker that you always can be aware of risk. And I think at times we, I suppose we can be quiet fearful of taking risks with clients, because obviously we feel responsible for client's actions, I suppose. And sometimes I think we probably need to do more about supporting people to take responsibility for their actions. So it's a difficult one really.')

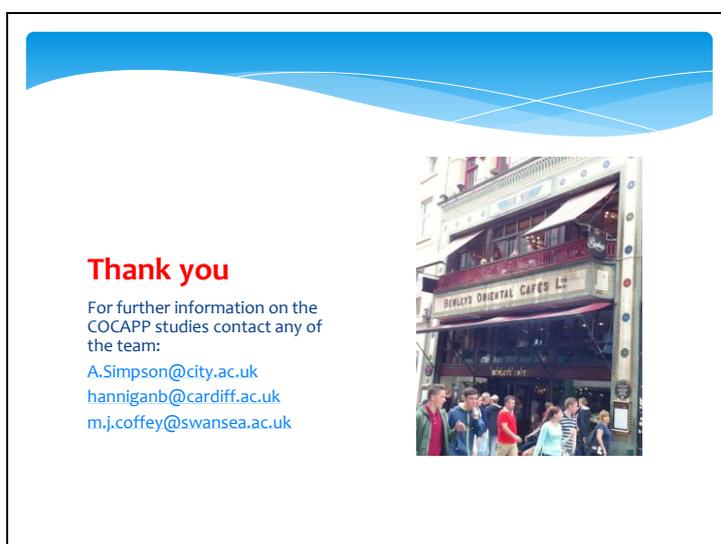
I suggest too that some thought be given to the practice of maintaining accepted fictions of risk assessment practice in mental health care. Perhaps these serve certain purposes but mental health care needs to be more critically aware of its limitations and the types of expectations that risk assessment may give rise to. Engaging in conversations with people about their risk assessments which go beyond simply asking questions for the purposes of completing them is needed.

Discussions with service users and their families may be difficult for sure. However most care co-ordinators are trained mental health professionals and it is well within their skill-set to be able to handle discussions sensitively. It seems to be that the default is not to have these

discussions rather than addressing them as an opportunity for greater involvement and participation in managing their own care.

Care co-ordinators also note the challenge inherent to risk assessment practice itself, that is the language may be negative and inclined towards unpleasant outcomes which makes it difficult for workers to present this to the person (this could be a possible recommendation, using positive language and perhaps writing risk assessments to the person for example “when we met you told me that you sometimes think about ending your life, this is a concern for me and I have suggested that together we put this plan in place involving ....”) or indeed writing care plan in the first person to change the emphasis to one of ownership and personal control e.g. ‘I sometimes think about hurting myself...’

Slide 12



A focus on risk emanating from service users may neglect risk they are exposed to and appears to work against opportunities for risk taking as part of recovery-focused work. Conversations on risk appear to be neglected and assessments kept from service users. Relationships are an important mediator in treatment decisions. Poor relationships between workers and service users inhibit risk communication.

There can be no recovery without upfront, honest but sensitive discussions about risk and safety.

The adoption of person-centred safety planning (Boardman and Roberts 2014) may help this but questions still remain about the achievement of involvement and collaboration in existing care planning practices.

To achieve recovery outcomes it would seem that risk and safety planning should be seen as central to involvement and collaboration efforts and not a separate process otherwise there is a real chance that risk assessment and management plans operate as a shadow care plan with much more influence and bearing than the plan the person has been given access to.

Coffey, M. on behalf of the COCAPP team (2015) Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment care planning. 21st International Network for Psychiatric Nursing Research conference 17th and 18th September 2015 Manchester Conference Centre.

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