The Challenging Concept of Risk

Introduction

As a concept, risk is widely established in our daily language and activity, but its manifestations in practice vary greatly. Consider:

- The business and financial sectors
- Betting on the horses
- Unprotected sex
- Hospital admission and discharge
- Tightrope walking
- Marriage.

The indication of risk is interpreted and defined very differently in each of the above activities. In your consideration of working with people experiencing serious mental illness, it is important to understand what you mean by the risks that have to be identified and managed. The professional and personal attitudes formed from training and experience, combined with an understanding of risk, will help to shape our approach to working with different levels and frequencies of risk.

Your ***conceptualisation of risk*** should examine how you categorise the different risks you may encounter. Do you view risk as:

- An entity, in terms of a tangible event and outcome; for example, a threat of violence resulting in injury?
- A process made up of interrelated functions; for example, a behavioural response to life events, brought about by particular social interactions, which could be identified and avoided?
- A predictable, and thus preventable, characteristic of human behaviour?
- An unpredictable, and thus impulsive, characteristic of human behaviour?

The practical manifestation of risk in mental health can often appear to be embedded in a conflict. For the practitioner, the reality is attempting to find a middle ground between:

- On the one hand, there is the need for cautious ***defensive practice***, based on an assumption that restriction will prevent some incidents.
- On the other hand, there is a desire to promote ***positive risk-taking***, based on the assumption that freedom of choice within an environment of support may reduce the need for some incidents.

Furthermore, when we shift our attention away from the realms of mental health, we may appreciate that risk is central to most aspects of human activity. We all ***exercise choices***: who to meet? Where to go? How to get there? What to do? One choice eliminates others

and binds us in relative terms to the consequences of that choice. We choose pathways in life we wish to follow, and we change directions according to internal and external influences. Our responses to risks help to shape us as individuals, with different degrees of autonomy and personal identity. In essence, risk can be seen to possess positive qualities that can greatly shape our own development.

We may think of sky-divers or racing drivers as slightly perverse in the choices they make, yet there are very few of us who do not openly or secretly hold their challenges and achievements in awe. We may even fantasise what it would be like for us to face the same challenges. Yet when a person is identified as having a mental illness, the media, government, and society are unified in conferring on the managers and practitioners of mental health services a duty of care, which in practice becomes a predominantly restrictive function. A service user is generally viewed as someone for whom risk is a negative entity, with dire personal consequences as the inevitable outcome. The opportunity to develop through constructive *positive risk-taking* is often denied or suppressed by a preoccupation with the negative aspects of risk to self and others.

Positive Risk-Taking versus Defensive Practice

The concept of risk, in the practice of individual clinicians, is embedded in a philosophical conflict. Recognising the needs of the service user does not always sit easily with the wider emphasis on protecting the public from their real and perceived fears. Procedural arrangements frequently impact on individual liberties, but catastrophes require that something should be done. While many practitioners recognise the benefit of supporting service users to learn by taking chances and risks, they feel overwhelming pressure to avoid errors. The prevailing climate in contemporary society continues to be one of attributing blame when things go wrong. This is not simply a facet of mental health, as any cursory glance at the press will indicate. The fear of criticism and blame leads to an all too frequent, but understandable, retreat into *defensive practice*.

We should be more explicit about the risks involved in *defensive practice*, particularly the failure to effectively involve and empower service users. The defensive walls of the physical institution are easily replaced by the defensive walls of a bureaucratic system.

Should *positive risk-taking* be seen as a basic service user right, particularly as choice is something enjoyed by most of us? It should be seen as a healthy part of community care, rather than as negligence or gambling with high stakes. It is the weighing up of different choices, gauging consequences, engaging the opportunities for support that emphasise learning rather than failure. It is an essential part of care and support, which should be the mechanism that resists an ongoing tightening of procedures in the false expectation of the elimination of risk. The favoured approach should involve focusing on the more realistic goal of risk minimisation.

Perpetrator or Victim?

Central to any *positive risk-taking* approach should be a genuine eliciting of the service user's real and perceived experiences of risk. The media and public image of the service user is that of perpetrator of risks to self and others. Whereas, a glance at the history of almost all service users indicates they are far more likely to be victims of risk, from a wide range of sources, most alarmingly on occasions from what are more frequently considered to be sources of care and support.

The following represents a range (not exhaustive) of sources of risk to users of mental health services:

- Childhood sexual and physical abuse
- Adult domestic violence
- Threats and attacks from the local community
- An unsympathetic and fearful public
- Social isolation
- Loss of social and economic status through the stigma associated with mental health problems
- Threatened or real loss of home
- Distressing contacts with the criminal justice system
- Relapse of illness and hospital admissions
- Loss or deprivation of basic freedoms and human rights
- Suicide attempts
- Deaths through neuroleptic medication
- In-patient abuse and assaults, from patients and staff
- Exploitation by misguided or criminal community workers.

We talk of integrating people into the community, but we often overlook just how threatening that community can be for a vulnerable person carrying the multiple burden of illness and stigma. Each of the above categories is an extremely rare event, but cumulatively they begin to give an impression of what a service user may have to face, either in reality or in their perceptions. When managing risk these should be dismissed at your peril. Acknowledgement of these issues goes a long way to establishing the kind of engagement that may support more effective and collaborative risk management.

Elements of an empowering process

An empowering process works with a service user placing them and their experience at the centre of such a process. The following are some of the considerations you may put into practice:

- Information is power, so share it
- Empathic understanding of how and why an individual responds to their own experience of risk
- Collaborative discussions of the links between past, present and future

- Joint identification of early warning signs
- Negotiation, with the service user holding the deciding vote
- Open and creative use of the procedural arrangements required to be used, informing the service user of their central importance as a person in all plans
- Access to flexible and responsive support, and choices
- Practicing risk as a mutual learning process.

Defensive practice

The high costs of tragic outcomes present moral and ethical challenges to all service providers. When a culture of blame prevails, practitioners will inevitably feel pressure to guard against the potential for scapegoating and blame. *Defensive practice* is the most likely method of aiming to cover essential responsibilities, attempting to offset legal repercussions, or at least offering a damage limitation approach to minimising individual and organisational criticism.

Difficult decisions have to be faced on a daily basis: balancing the risk of discharging a hospital in-patient against the risk of not admitting someone else who is relapsing in the community. Hospital bed management becomes a constant challenge of weighing up the risks.

However, painting a negative picture of *defensive practice* is too simple. The reality is one of service providers having to make difficult decisions about a small minority of people who present very real dangers to themselves and others. The public have a right to expect that services will do all within their power and ability to ensure such risks are identified and properly managed. If such management is seen by some as a negative type of defensiveness, this should not detract from the need to restrict and detain in these rare circumstances.

It remains the best interest for some people to be detained when such high risks are identified, rather than suffer the inevitable consequences of a preventable tragedy. The aftermath for some will result in longer detention, increased stigma, and perpetual caution and restrictive responses. However, the danger is equally of concern that *defensive practice* results in over-caution, with a tendency to restrict on the basis of minimal risk potential. Infringements of civil liberties cannot be allowed to go ignored, or simply subjugated by a priority for public protection at all costs.

Where would you place yourself on a *Positive Risk-Taking* v *Defensive Practice* continuum? Can you clearly reason to yourself (and to colleagues) where you locate yourself?
In reality, it should be in different places for different risks, at different times, and with changing circumstances. Who said managing risk was easy!

PERSONAL NOTES ON *'FEAR, BLAME & RISK AVERSION'* VIDEO and THIS ARTICLE