

## **Risk management and individualised care in the community**

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### **Abstract**

Today, in Australia, the majority of people with disabilities live in the community. They receive help from a range of services that are expected to keep them safe and also to protect their workers and the broader community. From the mid-1980s - following deinstitutionalisation and the shift to community-based care - the management of risk has become increasingly central to the day-to-day operations of human service agencies. Influenced by corporate models of risk management, most human service agencies have approached “risk” in fundamentally negative terms - and thus “risk management” involves procedures to minimise, eliminate or transfer identified harms or dangers. However, the emphasis on the provision of individualised care in Victorian disability policy and legislation since the early 2000s introduces a new culture of risk into human service delivery and creates potential tensions with established approaches to risk management. We argue that the individualisation of care demands a positive view of risk and risk-taking, balanced with safety, rather than a predominantly negative framing, and calls for workers to engage with risk as an integral aspect of practice. Utilising two practice examples from a qualitative study of risk management and community care, this paper explores the way in which the capacity of workers to deliver individualised care is significantly influenced by organisational approaches to risk management. We conclude with several suggestions to facilitate the implementation of individualised models of community care.

**Keywords:** Risk; Risk Management; Individualisation; Community Care; Disability Policy

### **Introduction**

Over the past two decades in Australia and other western states, the pressure to identify, control and transfer risk has presented a growing political imperative for governments and their contracted organisations delivering community care (Kemshall 2006; Power 2004; Rose 1998; O’Malley 2003). As a consequence, the policies, practices and procedures of human service agencies are being shaped not only by

service goals and program guidelines but increasingly by the need to manage identified risks (e.g. Green 2007; Godin 2004; Kemshall 2002; Titterton 2005).

Drawing on an empirical study of the impacts of risk management on the practices of human service agencies, this paper explores the potential tensions between the objectives and practices of risk management and those of individualised service provision. We begin with a brief theoretical overview of risk, followed by a framing of the contextual factors underlying the growth of risk management in community care, and the aims and ideals of individualised service provision.

### **Sociological theories of the rise of risk**

Broadly, contemporary forms of risk have been understood in two main ways by sociologists. The first follows Beck's "risk society" thesis, which claims that the growth of risk consciousness is associated with a new order of risks emerging from around the 1970s and produced largely by scientific and industrial advances, together with the new individualised conditions of life in late modernity in which individuals, disembedded from families, traditional households, communities, and lifelong employment, are now forced to live more flexible, fluid lives (Beck 1992; Beck and Beck-Gernsheim 2001; Giddens 1990, 1991).

The second explanation - and the most useful in terms of our present discussion - follows the governmentality thesis. Drawing on the work of Foucault, it claims that our growing preoccupation with risk is implicit in the broad range of neo-liberal reforms associated with post-welfare states. Policies and programs designed to provide collective social protection have given way to those that encourage individual responsibility and mutual obligation (Kemshall 2006). Social policy is now imbued

with ideas of personal responsibility, and the prudential citizen is exhorted to “manage his/her risks largely through the labour market” (Kemshall 2006: 61). Risk has thus been transferred from “big government” to community partnerships, families and individuals. The governmentality approach explores the way in which these new rationales and techniques of regulation engender new responsibilities and obligations in people’s lives. Applied to the world of community care, this means that services and clients are encouraged to self-regulate (see Rose 1996) – and it also means a new range of responsibilities for frontline professionals. For example, case managers in disability services now administer budgets and related risks associated with their clients’ funding packages, a “new” responsibility introduced into practice within the last two decades.

### **Contextualising the rise of risk management in human service agencies**

The increased focus on risk and risk management in human service agencies over the past two decades has emerged in the context of three major interrelated social, economic and public policy changes. First, the advent of deinstitutionalisation and the shift to community care produced a range of new and intensified risks. Community care is delivered primarily in unregulated sites - in private homes, public housing estates and community centres - which means that today’s frontline workers are exposed to greater dangers than their predecessors, who operated in more highly regulated and predictable settings in institutions and hospitals. Managing risk has therefore become integral to the practices of community-based professionals, many of whom work in small teams or practice alone.

Coinciding with deinstitutionalisation, the second major factor concerns the advent of New Public Management (NPM). The introduction of market-based models of service

provision into the public sector, the privatisation of some services and competitive tendering for government contracts by others, increased demands for accountability from various bodies (governments, funding agencies, insurers and consumer groups) and fostered new approaches to governance and administration, including the introduction of formal requirements to manage risks (see Braithwaite 2000). In this context, the development of risk management systems in community care has been strongly influenced by corporate models and, as a consequence, has focused on its “forensic functions” (Douglas 1992: 27) - the setting up of formal systems and protocols to guide practice, establish accountability and apportion blame when things go wrong (Hood and Rothstein 2000; Munro 2004). In case of an adverse event, an agency can then defend itself by claiming “due diligence”, demonstrating that the correct procedures were followed, despite the outcome (Munro 2004: 1090). These corporate-oriented functions of risk management tend to foster predominantly negative conceptions of “risk” focused on anticipating, reducing, transferring or eliminating identified risks. In human service agencies this approach privileges the protection of clients and upholds organisational reputation, sometimes at the expense of client autonomy and choice (Titterton 2005).

The third major change - and the focus of this paper - concerns the growth of individualised or person-centred approaches to care over the past decade (Fine 2005; Yeatman 2009). These approaches have been shaped by two distinct but related developments: a re-assertion in social policy of the classical liberal belief in the freedom and responsibility of individuals to manage their own lives, together with the growth of political and moral discourses centred on human rights, social inclusion and participation.

As Michael Fine (2005: 257) suggests, in individualised models the construction of care is “reshaped” at the level of interpersonal relations:

In place of the hierarchical pattern in which care is seen as requiring the assumption of responsibility and control by the carer, and passivity and gratitude by the care recipient... a more engaged, active, conception of the relationship, is emerging, based on the recognition of the rights of both parties as individuals. Care... needs to be seen... as the outcome of a relationship between the different parties in which mutual respect, and the fostering of the capabilities and autonomy of the recipient are foremost.

In Australia, the provision of individualised services has been articulated as a key objective in public policy and legislation, most explicitly in the disability field. For example, the Victorian *Disability Act 2006* states that planning should “be individualised” (s.52(2)(a)) and “facilitate tailored and flexible responses to the individual goals and needs of the person with a disability” (s.52(2)(j)). In this context, the *Act* also states that individualised services “should be provided in a way which reasonably balances safety with the right of persons with a disability to choose to participate in activities involving a degree of risk” (s.5(3)) (see also State Government of Victoria 2002).

### **Individualised service provision**

In individualised service provision, the worker engages with the client as “a unique centre of subjective experience” (Yeatman 2009: 16), facilitating the client’s self-understanding in terms of his/her needs, desires and goals, including those associated with risk-taking. This creates space for genuinely open and honest dialogue between client and worker: negotiating over “risk”, dependence and independence in relation to risk-taking by the client; building in protection against risks; and meeting the worker’s legal, professional and organisational responsibilities. Developing an active,

reciprocal dialogue invites interdependency and partnership between worker and client and the working out of a “risk agreement”.

The way in which “risk” is conceptualised and operationalised within a given agency significantly influences the capacity of workers to deliver individualised services to their clients (see Stalker 2003: 218-26). We argue that the practice of individualised community care demands a positive view of risk and risk-taking, balanced with safety, rather than a predominantly negative framing. Drawing on an exploratory study of risk management and community care, this paper presents two contrasting case examples as a means of exploring the interface between an organisation’s risk management culture and the service delivery relationship between worker and client. Each case is discussed in terms of its implications for individualised service delivery.

### **Methodology**

The data discussed here are drawn from interviews undertaken as part of a larger study to explore how risk management policies have been interpreted and translated into practice by community-based services in Victoria. The study involves twenty-four services across three fields – disability, aged care and mental health. A total of 127 interviews have been conducted with Chief Executive Officers and senior-level managers, program managers, frontline workers, clients and carers.

This paper utilises two case examples selected from interviews with twenty-one program managers and frontline workers from the six participating disability services. These interviews were semi-structured and one-two hours in length; participants 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 on their work with clients.

All interviews were tape recorded or digitally recorded and later transcribed, with pseudonyms used to protect participants' identities.

## **Findings**

In this section, we present two case examples to illustrate the way in which a service's risk culture may shape care at the interpersonal level. These examples were selected to highlight the very different outcomes for client and worker in each situation. The first explores a shared process of problem-solving, in which potential risks are negotiated and managed in a spirit of partnership and positive engagement with risk. In the second example, the prioritising of a "high risk" client over a vulnerable client leads to a situation where the latter's needs are disregarded, further heightening his vulnerability and placing him at risk.

### **"Risk" as Protective and Empowering**

Anne, a program manager from a large non-government agency, related the situation of a female "participant" in her early fifties with muscular dystrophy, "whose body is failing her miserably". This woman, whom I refer to as "Robyn", 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... there are emergency services but if people can't come, 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.

Anne expresses respect for Robyn's needs and her individuality and has considered her point of view by creating space for her to speak openly about her concerns. The relationship between worker and client is framed as an "inter-subjective process" involving mutual respect (Yeatman 2009: 23). In this context, Anne facilitates Robyn's decision-making and autonomy, which is empowering for both worker and participant. In line with the agency's philosophy and ethos, "risk" is seen as inherent in community care and integral to the practice of care, and is also constructed as both empowering *and* protective. On the empowering side, often referred to as "dignity of risk", the client is viewed as having the right to risk-taking, independence and choice; Robyn 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 protective side, workers are bound to ensure that "certain things" are organised to reduce potential risks, thus upholding their "duty of care" in terms of professional ethics and organisational policy. Robyn is conceptualised as a partner in the care she receives; this is demonstrated through the active negotiations over how risks are to be managed and the agency's very deliberate use of the term "participant" instead of "client". Robyn's opinions are sought and discussed openly – "it's about agreeing on risk" and "getting permission" to manage it in specific ways, illustrating again that "risk" is integrated into practice.

### **"Risk" as Excluding and Disempowering**

Lena, a case manager from a public disability agency related an episode in which she felt that the risk management response of her senior managers ("big management") had severely jeopardised the wellbeing of her client, "George". Lena had a caseload of "justice clients" – individuals with an intellectual disability and an offending history.

Without consultation, “big management” terminated George’s placement in one of the organisation’s facilities. His accommodation was to be used for another client who had recently re-offended and was considered “high risk” and in need of urgent containment. Lena had placed George there on a temporary basis several months previously. He was due to leave in six weeks’ time and had been involved in his own transition plans. George had a background of significant social and emotional deprivation and trauma, and had endured periods of homelessness in the past. He tended to spend several nights each week in the facility, then “disappear” for two or three days at a time; however, he always returned because he had formed a supportive relationship with a worker there – this degree of connection was “incredible” for him, according to Lena. In terminating his placement, Lena argued that “big management” failed in their “duty of care”:

[They] decided that he needed to leave because he’s not there often enough... but they failed in their duty of care to him and the risk that he posed to himself and the community by being all of a sudden homeless; they didn’t weigh that up at all. They basically thought, “He’s not there enough”. They failed to ask any of his workers... how this would impact on him and they failed to look at the biggest rule that we work by... with people with intellectual disabilities... Any decision that that person has to make or you have to support them to make... you need to give them time to process it.

Lena was asked to inform George that he had to leave, though she had no part in the decision; in response George “went... absolutely wild” and made death threats against her. This rejection, as it were, reinforced his experience of displacement and lack of trust in others, and also undermined his trust in the organisation and his case manager, as she explained:

No-one in my Management even contemplated how horrific that would be to a man who has sustained incredible trauma in his life; he’s a refugee, he’s totally displaced, lost his family, has no trust in anyone and the only trust I’ve been able to develop in him has taken a long, long time, so it was really, really poor management... it was about losing trust in me because he thought I was chucking him out because I had to tell him, so

what that did to the relationship and the work that I've been doing with him... it was awful.

In this example, a range of new risks were created through the agency's risk-averse stance (see Stalker 2003: 220). George's individual needs, his particular vulnerabilities and the context of his care were not recognised by the senior managers. Contrary to the principles of individualised care, he was not considered as "a unique centre of subjective experience" (Yeatman 2009: 16) nor placed at the centre of service delivery. Further, as noted above, the relationship between case manager and client was rendered vulnerable, and the case manager's sense of self "discounted" by "big management" through their failure to consult her about a client she knew very well (Yeatman 2009: 19). Rather, the needs of the organisation, in terms of upholding reputation and public image, seemed to hold sway and were prioritised. Risk was not integrated into practice, as in the previous example; neither was there an open conversation about the potential risks involved in the situation and how they might be managed.

## **Discussion**

The nature of organisational cultures and their practices of risk management are critical to the delivery of individualised community care as demonstrated through the two case examples discussed here. We have argued that a positive view of risk is needed in order to fulfil policy and legislative requirements, along with the growth of organisational cultures that support risk-taking balanced with safety.

A positive approach to risk and risk-taking accepts that some degree of risk is inherent in community care, thus normalising the experience of risk, whilst evincing a view of the client as "an active citizen with rights and responsibilities" and as an expert of his/her particular life circumstances (Stalker 2003: 223). This approach is

fundamental to the client's independence, social participation and overall quality of life. In the "risk-taking" model, clients' needs and risks are considered through an integrated approach that takes into account both "dignity of risk" and "duty of care" as demonstrated in the first case example (see Titterton 2005).

Given the political and social imperatives underlying the provision of individualised community care, there is great need for an "organisational conversation" about risk and how it is managed. It is clear from our research that such conversations are taking place in some agencies, but this is not widespread. To introduce positive risk-taking into practice, organisations must become self-conscious of their particular risk management culture and how it affects clients' experiences of service delivery. They must also develop an understanding of the differences between corporate models of risk management and the risk management needs of health and welfare services (see Hood and Rothstein 2001). This could be facilitated through professional development and supervision, and practice forums in the workplace involving workers from each level of the organisation, including senior managers. Furthermore, it is important that training in the theory and practice of risk management be introduced into the curriculum of professional courses, such as social work, to equip new graduates with conceptual tools to participate in this "conversation".

Early findings from the larger research project, on which this paper draws, show that "risk" is conceptualised differently according to the context in which the individual works (Power 2004: 19). For example, in line with their responsibilities, senior managers were often primarily, though not exclusively, concerned with institutional risks associated with the organisation's reputation, governance and accountability systems, and relationships with other agencies (see Rothstein et al. 2006). In the context of intense regulatory pressures, competition for funding and recruitment of

staff, and increased demands for services, managers of community-based services are wrestling with a broad and complex range of institutional risks, all of which are inextricably bound up with “direct” risks to clients and workers. It appears that this array of pressures creates very real barriers to the development of risk management cultures that foster individualised models of care.

In reflecting on the governmentality approach, the emphasis on individualised service provision brings about new and complex responsibilities for self-regulation on the part of frontline professionals. Notwithstanding the organisational culture of risk management, the individual worker is nevertheless compelled to reconcile, or attempt to reconcile, his/her risk management responsibilities in terms of legal, professional and agency requirements, whilst also meeting the particular individualised needs of the client. In addition, as Yeatman (2009: 108) argues, not only “professional” skills are required, but also “a practice of self-reflection and self-knowledge that enables him or her to know when s/he is contributing to opening up or closing down intersubjective process.” A major shortcoming of the governmentality approach, as with other macro-sociological (top-down) theories of risk, is that it does not provide a good fit with the meanings and uses of “risk” on the ground. These theories operate at too general a level to capture the complexity of workers’ lived experiences and so obscure the agency of workers in interpreting, negotiating and managing risk in their everyday working lives. In-depth interviewing, as demonstrated here, enables insights into the complex and active reasoning processes that workers engage in when analysing risks and making professional judgements about clients’ situations.

## **Conclusion**

Since the end of the last century the call for greater participation, choice and control for clients in community care has exposed a tension between the right to risk-taking on the one hand, and the imperatives of managing the institutional (or corporate) risks confronting these services on the other. If public policy is to support the view, consistent with a human rights perspective, that people have the right to live their lives to the full as long as they do not impinge on the freedom of others, it follows that services should not only reduce restrictions on their clients' freedoms but actively assist people to express their own "subjectivity", as Yeatman (2009) defines it. This leads to a radically different view of the place of risk in community care. It is no longer limited to the hazards and dangers in the care process, but requires a tangible expression of clients' rights, including the right to make choices that may open up risk. The longstanding concept of "dignity of risk" returns as part of a new relationship between the client and service, which requires an agreement about risks, and this brings new obligations to clients as well - to understand their responsibilities and the implications of their choices, including any risks.

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