Making good risk decisions in mental health and social care

Steve Morgan, Practice Based Evidence

In the second of a series of two articles, Steve Morgan proposes a framework for good risk decision-making in mental health and social care services.

A risk identified is a risk predicted and hence safely managed; but when this simplified course of events fails to happen then someone "is to blame".

We are in an age of 24-hour news coverage. The media and advertising industries know that risk and fear sell: they provide and shape the stories, and drive the potential for litigation. Health and safety, while born of good intentions, has arguably emerged as a phenomenon that stifles creativity. All of these considerations create the inevitable demand for risk assessment.

Risk assessment in health and social care services has become focused on the task of filling forms. The underlying bureaucratic assumption is that the greater the number and frequency of risk assessment forms the safer we will all be; and the drive to be comprehensive, evidence-based and avoidant of litigation means the forms become longer and more complex. No account is taken of the time required to complete the administrative requirements and targets. This approach also conveniently demands acknowledgement of the so-called evidence base, yet produces no evidence to prove that more completed forms equals a safer environment or reduced numbers of incidents. The flaw in this logic is that a risk assessment is not an end in itself, it is not the completed form that changes circumstances, it is the risk decisions and how they are enacted.

It is not the case that risk assessment is a redundant activity; we need a clearer articulation of how identifying, analysing and managing risk information in the context of individual circumstances should lead to good quality risk decisions. These detailed decisions put into action are what will bring about change in pursuit of safer practice and outcomes.

Influences on risk decision-making

What is a reasonable decision? The broad legal definition suggests it is a decision that, given the same information and circumstances, a similar person or group of people would most likely have made. We need to demonstrate that we have followed a recognised process, that we have analysed the available information and come to reasoned conclusions. There is rarely a right or wrong decision in these circumstances, just a balanced and reasoned decision. It would be unreasonable, in the realms of human behaviour, to always demand absolute certainty; the final decision will be influenced by many considerations.

1. Positive risk-taking.

The first part of this article focused on describing this concept[1], and this approach should provide a sound basis for developing a reasonable process for arriving at good risk decisions. We all take risks in our lives on a daily basis, and we do so through considering information about choices available to us. It is not a matter of whether we take a risk or not, it is a matter of how we take risks, and the process we use in coming to our conclusions. People who experience illness or disability, or are labelled with particular diagnoses should not automatically be deprived of the opportunities that we all take for granted.

2. The blame culture

To what extent does the fear of getting something wrong override our instincts to try a particular course of action? Poor experience of an inquiry process, or knowledge of how colleagues have become ill and demotivated by a lack of support during investigations, will significantly influence our thresholds for making certain types of decisions.

3. The evidence base

Evidence in the context of risk is entirely negative. We know the numbers of deaths through homicides and suicides, and we have research to tell us what factors to look for to prevent aggression and violence or suicide. So the evidence base is entirely about what has gone wrong and what could go wrong, offering nothing of any value to support balanced decision-making. The evidence base will naturally drive defensive practice, which though needed in many cases, is equally unhelpful in many other cases. We need a fuller picture of a person's strengths and protective factors alongside their potential risk factors if we are to make more meaningful, balanced and informed decisions.

4. Hindsight and prediction

The focus on risk assessment and ability to review in fine detail when things go wrong leads to a false assumption that we can predict, and hence prevent risk. Years of risk research, narrow in focus as it is on aggression and violence, has achieved very little in improving our ability to predict risks in the wider complexity of the workplace. Yet, with each inquiry the benefit of hindsight seems to distort history, as it processes information through the prism of the knowledge of the final outcome.

5. Intuition

A further influence of the emphasis on "the evidence" is to mask a vitally important tool that all of us use to varying degrees, that is intuition or gut reaction. Whilst an evidenced decision will appear objective and less easily challenged, we work in the realms of human behaviour which is much more nuanced and unpredictable than research protocols can often handle. We work on a subtle level of feelings and impressions, without the clear evidence to back up

our concerns or possible actions. Intuition is based in experience, but we must exercise caution as it can be based in subconscious prejudices also. The use of intuition or gut reaction should not be suppressed, but should be openly declared as an influence that needs further investigation. It is never the final assessment and influence, and should not be communicated as such. It is a tool born as much out of personal experience as professional considerations, and thus is not limited to only those professionals who have been working for longer periods of time.

6. Cultural bias

Our prejudices emerge through many different influences and can often be denied but subconsciously still at play. They will influence decisions we make, so a better decision will result from more open acknowledgement and reflection on these biases. By culture I also mean team culture, where numbers of people from similar experience and backgrounds can reinforce their commonly held biases, or the power of the group can even result in more extreme views.

Gardner[2] sets out clear examples of where fear, blame and the conflict between feeling and reason have resulted in decisions that may even defy logic. He reminds us how fear can contradict the evidence, with the example of many Americans choosing to drive in the year after the 9/11 atrocity than fly in planes, despite all the evidence stacking up that deaths on the road far exceeded those through flying. Furthermore, he concludes with much evidence that those of us living in developed countries are presently safer than anyone else in history, yet more paranoid about what could go wrong.

Positive risk-taking decisions

The word "risk" has become very potent and emotive. For many service users it has become one of the most significant barriers to them achieving personal goals and more active participation in a meaningful life. The thought of someone with a significant illness or disability taking risks is not openly denied, but covertly there is more emphasis expected on services to consider legal and professional tools in a risk averse way. Whatever the label or diagnosis people have personal strengths and resources, and are usually willing to accept their share of responsibility in achieving what they want in collaboration with service providers.

What is required is a balanced consideration of the information, choices and support available to resource the plans that increase the possibility of success. However, services equally have the responsibility to thoroughly investigate and reason why a risk should not be taken.

A risk decision-making tool

The checklist in the box is offered as a structured approach to risk decision-making, and is recommended to be followed in the sequence as presented in the box (it also appears in a published format[3]). It has been widely used by the author in different clinical and non-clinical teams to aid decision-making. The focus is on positive risk-taking, and it will usually reason why and how a risk can be taken, but may just as equally reason why the risk should not be taken in some instances.

In relation to the issue of consistency, it is recommended that the checklist could provide the same process for an individual in circumstances requiring an urgent decision, and a team with more time available for discussion and analysis in a collaborative review. Where appropriate, the tool should also be used collaboratively and creatively with service users and carers. The issue is about demonstrating you have followed a process in coming to a decision. It is designed to support and implement a process, but it is just as important that the enacting of that process be appropriately recorded. The published tool is designed to prompt and capture collaborative discussions, most frequently in review settings; but the checklist can be used flexibly to provide appropriate sub-headings for recording other decisions. A recorded decision is not necessarily a good decision as of itself; but a decision not recorded, carried around in someone's head, is going to have very limited benefits however good it may intrinsically be. HCRR

A STRUCTURED APPROACH TO RISK DECISION-MAKING

- Is the required decision reactive (to what the person is doing or plans to do) or proactive (to be initiated more by the service providers)?
- Is the service user's understanding and experiences of risk clearly understood (it may be very different from the professional's assessment of the risks)?
- Is the carer's (as appropriate) understanding and experiences of risk clearly understood (it may at times contradict that of the service user)?
- What behaviours are identified as being risky (in relation to the specific circumstances of the decision)?
- What is the clear definition of the risk that is being taken? (The emphasis is on the detail)
- What are the positive desired outcomes to be achieved through taking the specific risk (short and/or long-term)?
- What strengths can be identified and used in pursuit of a positive risk-taking plan (including personal qualities, abilities, achievements, resources, motivations and wishes)?
- Are there any clearly defined stages to be accounted for in a risk-taking plan?
- What are the potential pitfalls and estimated likelihood of them occurring? (Important for demonstrating that alternatives have been evaluated in the risk decision-making process)
- What are the potential safety nets (including early warning signs, crisis and contingency plans)?
- Has this course of action been tried before, and if so what were the outcomes?
- If tried before, how was the plan managed and what can now be done differently (what needs to, and can change)?
- How will you develop a formulation from the above information (to present a reasoned decision that weighs up the alternatives considered)?
- Who agrees (and importantly disagrees) with the plan?
- How will progress of the plan be monitored?
- When will the plan be reviewed?

References

1. Morgan S (2010), "Positive risk-taking: a basis for good risk decision-making", *Health Care Risk Report* vol 16, no 4, pp20–21.
2. Gardner D (2009), *Risk: the science and politics of fear.* London: Virgin Books.
3. Morgan S (2007), *Working with Risk: Trainers and Practitioners Manuals.* Brighton: OLM-Pavilion. See www.practicebasedevidence.com