

SYNOPSIS

**MANAGING RISK IN COMMUNITY SERVICES:
A PRELIMINARY STUDY OF THE IMPACTS OF RISK
MANAGEMENT ON VICTORIAN SERVICES AND
CLIENTS**

**ARC LINKAGE PROJECT FINAL REPORT
2006-2009**



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School of Social Work and Social Policy**

Industry Partners

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THE PROJECT AT A GLANCE

WHY DID THE ARC FUND THIS RESEARCH?

Community services are now required to meet the needs of vulnerable and dependent people who used to be cared for in hospitals, institutions and aged care facilities. As a result, governments, funders, regulators and the community are demanding improved governance, greater accountability and effective management of a wide range of increasingly complex risks.

Some stakeholders, however, consider that risk management, while a necessary part of good practice and good governance, is adversely impacting on both services and clients. Advocacy groups and the Victorian Public Advocate have reported that the management of risk can impinge on the rights and dignity of service users.

As there was no systematic research on these issues in Australia, the ARC approved this project to commence in 2006.

WHAT DID WE DO TO EXPLORE THESE ISSUES AND QUESTIONS?

First, we conducted in-depth interviews with 52 senior executives and managers from 24 public or not-for-profit community services based in metropolitan Melbourne and two regional centres. These services represented three sectors – disability, aged care and mental health, including five that provided a wide range of services to address many different needs.

Second, we interviewed 19 program managers, 40 frontline workers, and 34 service users. Finally, we met with 6 support/advocacy organisations for carers and conducted one-on-one interviews and focus groups with 21 family carers.

In total, 166 people participated in these interviews.

WHAT WERE THE MOST SIGNIFICANT FINDINGS?

Increasing and changing operational risks

Senior executives and managers, program managers and frontline workers reported that their work had become more complex, risky and hazardous, as a wide range of community services were expanded and developed to replace highly regulated and largely institutional forms of care.

As a result of this rapid growth and the fragmentation of these services, a wide variety of different risk definitions, tools, and procedures have been adopted to assess and manage operational risks.

Organisational and institutional risks

Every senior executive reported that risk management had become highly significant in terms of governance, policy and management issues over the last decade, as well as a growing operational issue. These executives were most concerned about risks at the *organisational level*, especially those associated with funding, financial management, governance, accountability systems, relationships with other agencies, reputation, and recruitment and retention of staff. They reported strong pressure to give priority to protecting their organisation against these risks. In the international research literature such risks are referred to as *secondary* or *institutional* risks, which have intensified the focus on risk shifting, blame avoidance, and reduced trust between organisations. As a further result, shared or systemic risks have been pushed into the background as executives focus on protecting their organisations.

Sharing risks

The idea of 'sharing' risk, or working on common or systemic risks with other service providers, even in the context of partnerships and collaboration, was unfamiliar territory to the participants in this study. Risks were generally defined within the individual operations of each organisation. As a result most program managers and frontline workers felt that risks were not 'shared' but 'divided' amongst agencies in very specific ways; for example, in terms of the particular role or function of the given service. Furthermore, several participants identified specific tensions and inherent difficulties in the nature of sharing risk and risk information with other agencies, including the need to uphold client confidentiality.

Risk cultures

Although we had not set out specifically to study the risk cultures of our participating organisations, many participants identified distinctive elements of their approaches to risk, and differences in the way other agencies managed risks. The degree to which organisations and workers articulated a risk culture, particularly a positive risk culture, appeared to be related to:

- (1) The significance of openness and trust amongst frontline workers themselves and between frontline workers and managers across different levels of each organisational hierarchy.
- (2) The importance of providing opportunities in the workplace for reflection on organisational processes of managing risk, including questions about the impacts of risk management procedures on clients and also on workers.
- (3) Recognition of the importance of integrating risk management into the roles, functions and values of workers.

Risk rationalities amongst program managers and frontline workers

Most program managers and frontline workers described how they had developed their own ways of thinking about and negotiating 'risk' and the risk management policies and procedures of their work places. Professional workers in particular thought about the ways they could align these policies and procedures with their professional frameworks and their views of what constituted ethical practice. Risk management is not simply a given; thus many developed their own analyses of the way in which formal risk management procedures 'gelled' with their professional roles and identities. We defined these complex reasoning processes as 'risk rationalities' and found three broad types which we classified as 'positive', 'critical' and 'compliant'.

WHAT DO WE SEE AS THE MOST SIGNIFICANT IMPLICATIONS OF THIS STUDY?

1. Lack of common approaches to risk

This project has demonstrated a significant lack of shared approaches to community care, even within sectors, with respect not only to risk assessment and risk management but also to the related goals and processes of care planning, notably individualisation and participation of service users in decision making.

2. Lack of models for sharing common and systemic risks

Essentially, the risk management approaches and systems used by most agencies and services are based on corporate models which fail to address systemic or whole of industry risks, reinforce risk shifting to weaker parties, and reduce incentives for collaborative and integrated service provision.

3. Risk management is poorly integrated into professional practice

While risk management is now seen as an integral part of the day to day professional work of engineers, surgeons, scientists and other professionals, many professionals interviewed for this project saw risk management as a set of quasi legal and administrative requirements which had adverse consequences for their professional purpose, that is with respect to their working relationships with their clients and in constraining their own professional judgment and agency.

4. Lack of a common focus on positive risk cultures

Most participating organisations identified differences between their approach to risk management and that of other service providers with whom they had a working relationship as partners, collaborators or members of interdependent service teams. They did not explicitly define these as 'cultural' differences, but identified differences in risk aversion, risk taking, readiness to solve problems about risk (especially for clients), and differences in rigidity or flexibility of procedures. While only a small number of the participating organisations articulated a distinctive risk culture, almost all of the participants recognised there were different organisational approaches to managing risk in community care.

THE FULL REPORT OF THE PROJECT OUTLINES POSSIBLE APPROACHES TO THESE ISSUES, AS WELL AS DETAILED DISCUSSION OF THE FINDINGS LISTED ABOVE IN THE CONTEXT OF RELATED INTERNATIONAL RESEARCH.

INTRODUCTION

The origins of this project

Managing Risk in Community Services: A Preliminary Study of the Impacts of Risk Management on Victorian Services and Clients is a major exploratory project, which commenced in 2006 as a joint collaboration between the School of Social Sciences and the School of Social Work and Social Policy together with two major public agencies as 'industry partners', the Victorian Department of Human Services and the Victorian Office of the Public Advocate. Specifically, the study investigated how service providers and professionals adopt and adapt risk management to service goals and ideals, along with the impacts of risk management on clients, patients and carers.

Whilst there is an extensive international literature on the impact of risk management on community-based health and welfare services, particularly from the United Kingdom (e.g. Alaszewski, 1998; Alaszewski, Harrison and Manthorpe, 1998; Godin, 2004; Kemshall, 2002; Rose, 1998; Stalker, 2003; Titterton, 2005), there has been no systematic study of the subject in Australia.

The following objectives were defined for the project:

1. To document the recent history of risk management in Australian public administration, commencing with the identification of risk as a major imperative for public and private organizations in the late 1980s. This historical account will focus on the development of risk policies and practices at national and state levels.
2. To investigate the processes by which the practices and technologies of risk management have been taken up and translated into the practices of community service organisations. This part of the project will focus on Victoria.
3. To test the contention that there are dysfunctional interactions between the values, objectives and practices of community services and the values, objectives and practices of risk management.
4. To examine the ways community services, professionals and clients adopted and adapted risk management to their service goals and ideals.

The context defining this project—the significance of risk for community services

Since the 1990s the pressure to identify, control and transfer risk has become a growing requirement for all governments and, as a consequence, for the businesses and organisations they contract to deliver services to the community. Community services and their workers in frontline health, protective and community care programs, their clients and patients, families and carers are in the thick of this change. The demand on services to manage and control risks has become a powerful factor in their work. However in Australia little is known of the impacts and consequences of these changes, especially from the viewpoints of the major stakeholders in community care.

This project is timely because it comes after three decades of major changes in public policy, which have in turn radically altered the scope and role of community services in Australian society. Many of the protective, healing, rehabilitative and caring functions of hospitals and institutions have been transferred to non-residential community based services (AIHW 2001). Services once delivered in bed-based facilities have been packaged into a wide range of community health, community care, support, and protective programs, and contracted to a wide range of public, private and non-government agencies.

Over these three decades all incumbent governments have enjoyed bi-partisan support for the expansion of community care; and while some deinstitutionalisation programs have been criticised on the basis of inadequate planning and/or limited transfer of resources, these changes were generally supported by all major stakeholders. However, it has been found in this project that few government agencies or advocates for reform really anticipated the complexity of both the regulatory and practice changes which followed their reforms. By the late 1990s it became evident that most authorities had underestimated the impact of the

change from institutional to community care on individuals, families, communities and local services (AIHW, 2001, pp. 322-363; Green, 2003).

At the same time as Australian governments were embracing community care, a number of significantly different but related changes were in train which had major implications for community services and the management of risk. In the context of the 'reinvention of government' in advanced capitalist societies (Alford and O'Neill, 1994; Osborne and Gaebler, 1992), the roles, organisation, responsibilities and governance of community services were required to undergo extensive change. Five particular transitions have been of significance:

- a radical program of contracting former public health and welfare services to local public, private and non-government agencies
- the implementation of complex tendering and contracting business systems to manage these changes
- the consequent requirements of service providers to reform their governance arrangements in the interests of accountability, service standards, efficiency and effectiveness
- the introduction of a range of quality assurance programs and accreditation requirements for service providers.; and
- formal requirements through contracts and standards processes to manage risks

This powerful set of changes, often referred to as 'new public management', represented a new regulatory regime for a wide range of businesses and services, all directed not only towards the goals of improving efficiency, quality, and performance, but also toward the management of the risks arising from contracting out (Alford and O'Neill, 1994; Braithwaite, 1999; Hood, 1991,1995; Webb, 2006).

However, these changes also led to what these authors identified as contractual modes of regulation. Contracts have always been central to liberalism and have represented the freedom of businesses and organisations, and also individuals, to participate in the marketplace and exercise choice, including decisions about risks. Contracts also open up the service relationship with clients to a process of negotiated transactions about the allocation of benefits and risks, which in turn allows the service user to participate in both the process and the relationship and to grow and develop through it. It is not surprising therefore that in recent years there has been a growing endorsement of 'individualised services', based on what Yeatman (2009, p. 27) recently identified as the need for the new services 'to shape what they have to offer in relation to what is of subjective significance to the client'.

All these changes have implications for the management of risks in community care.

THE RESEARCH DESIGN AND METHODOLOGY

Literature and relevant research

The project commenced with a systematic review of the literature informing contemporary theories of risk; the recent history of risk management and risk regulation, particularly in the United Kingdom and Australia; and the more specific literature regarding risk, human services and community care. The investigators and industry partners met regularly in an informal reading group during the first six months of the project. These readings and discussions have contributed to the way we analysed and explained our principal findings.

Design

The project involved a qualitative study of 24 Victorian community services and six carer support and advocacy organisations across three sectors – mental health, aged care and disability. In total, 138 interviews were conducted with 166 participants, comprising 52 senior executives (including chief executive officers), 19 program managers and team leaders, 40 frontline workers, 34 clients and patients, and 21 family carers.

The project was conducted in two stages. The first involved intensive interviews with the 24 chief executive officers (CEOs) or senior executive managers; after this data was analysed

we proceeded to the second, which involved interviews with program managers, frontline staff and clients from 19 of the 24 participating organisations.

The 24 organisations were all public or not-for-profit agencies. Nineteen were located in the metropolitan region and five in provincial cities. Fourteen of the 24 were community service organisations (i.e. non-government organisations) and ten were public agencies, including one local government council, two regional offices and a specialist service of a government department, and six public health agencies.

In early 2008, the design of the project was amended. A new category of research participants was added to those already involved in the project, namely a sample of chief executive officers and/or senior managers and family carers/members from six advocacy and carer support organisations. These included three mental health organisations, one disability organisation, one multi-sector organisation with a disability focus, and one aged care organisation.

Ethical standards

Ethics approval was obtained from the Human Ethics Committee of La Trobe University and the Human Research Ethics Committee of the Victorian Department of Human Services.

A BRIEF OVERVIEW OF THE LITERATURE AND RESEARCH INFORMING THIS PROJECT

The development of risk management in Australia since the 1980s

While according to Bernstein (1998) and Hacking (1993) attempts to control uncertainty and risk commenced with the Enlightenment, and certain forms of risk management have always been implicit in business, it is only in the last two to three decades that Australia has seen the emergence of significant government-driven policies and strategies to manage risks (Victorian Auditor General's Office, 2003). The imperatives that drove Australian governments and those of all advanced capitalist societies to change their management of risks were major environmental disasters such as Bhopal and Exxon Valdez, and more significantly the increasing numbers of collapses and scandals in the globalised banking and financial markets.

These catastrophic events gave rise to a wide range of regulatory responses. Initially they focused on greater regulation of the credit industry, through such interventions as the Basel Accords I and II. This history is well reported elsewhere, and is not the focus of this study. Its relevance, however, is that these events led not only to increased risk regulation in the financial world, but in almost all the operations of government and business. In this regard the Victorian Auditor General (2003, p. 15) reported that 'as the use of risk management has increased, it has broadened its scope'. Studies, such as the Cadbury Report (Committee on the Financial Aspects of Corporate Governance, UK, 1992) and the Committee of Sponsoring Organizations Report (COSO, USA, 1992), identified the need for organisational control frameworks and strong governance systems, and emphasised the benefit of a robust and formal knowledge of an organisation's risks as a prerequisite for effective control and governance (Victorian Auditor General, 2003).

When risk management exploded into prominence as an imperative for both government and business, it led not only to external regulation, but also to the requirement that agencies, departments and businesses build their own capacity for improved governance and self-regulation (Power, 2004, 2007). By the middle of the 1990s, risk management was given high priority on the agendas of governments and their agencies in the UK, USA, NZ, Canada and Australia (Braithwaite, 1999; Lupton, 1999; Power, 2004; Victorian Auditor General, 2003).

In addition to the pressures created by corporate disasters, CPA Australia (2002) reported that by the mid-1990s risk management in Australia was also being driven by major changes to the way governments of all persuasions conducted their business. These changes included, in particular:

- public sector reforms requiring shifts away from centralised governments and greater devolution of control to individual agencies
- the introduction of a national competition policy which is in turn driving contestability and much greater contracting out of public services
- an increased focus on quality services and customer focus, leading to more individualised services in functions such as health and welfare
- increased reliance on contactors to deliver services, leading in turn to the need to manage risks and standards
- declining financial resources and the requirement to increase efficiency and performance within existing or reduced budgets
- ongoing accountability and increasing public scrutiny of performance and errors (CPA Australia, 2002, p. 10)

Throughout this period both the Australian and the Victorian Governments were much influenced by developments in the United Kingdom, where it was accepted that given the diversity of government functions and responsibilities, risk in the public sector needed to be defined very broadly. The UK National Audit Office, in a report entitled *Supporting Innovation: Managing Risk in Government Departments* (2000), defined risks as:

- anything that poses a threat to the achievement of a department's objectives, programs or to service delivery for citizens
- anything that could damage the reputation of a department and undermine the public's confidence in it
- failure to guard against impropriety, malpractice, waste or poor value for money
- failure to comply with requirements such as those covering health and safety and the environment
- an inability to respond to or manage changed circumstances in a way that prevents or minimises adverse effects on delivery of public services (UK National Audit Office, 2000, p.1)

Central to the rationale for risk management, as developed in Australia, New Zealand, Canada and the United Kingdom, is the importance of improving service delivery, enhancing innovation, and effectively managing change.

These broad and sweeping agendas for risk management in the public sector suggest its role is much wider than the traditional function of controlling specified primary and operational risks. Rather, risk management was increasingly identified as integral to general efficiency and effectiveness of reforms and change management strategies.

The rise of risk management and the adoption of business models and practices for the regulation of public and community services in Australia

As noted above, during the last two decades of the twentieth century, Australian governments, led initially by Victoria, embarked upon an extensive program of reforms to 'modernise' government services, government contracting and public sector regulation. Hood (1991, pp. 4-5) identified seven original doctrinal drivers of these reforms, which included 'explicit standards and measurement of performance', 'greater discipline and parsimony in resource use', 'hands-on professional management' and the value of 'private sector styles of management practice'. Achieving these changes, according to Hutter (2005, p. 2), was seen to be dependent 'upon adopting private sector styles of management and an almost unthinking acceptance that private sector practice was the benchmark against which to assess public sector activities'. In the late 1990s, the Blair government's 'new public management' program, which has had so much influence in Australia, consolidated the adoption and application of enterprise-based models of management and regulation to the public sector (Hutter, 2005).

Thus, by the end of the twentieth century, there was little doubt in the minds of reforming governments in most Western democracies that business practices pointed the way to improved efficiency, innovation and responsible governance. In a short period of time business practices became 'the benchmark against which to assess public sector activities' (Hutter, 2005, p. 2), including the management of risk. As a consequence it was largely corporate and business risk management practices that shaped the state's regulation of itself, the introduction of regimes of enforced self-regulation for corporations, and similar measures

for public agencies and their contracted service providers (Braithwaite, 1999; Hood, 1991; Hutter, 2005; Power, 2007).

In order to understand the relevance of these changes to this project, as will now be evident, we have drawn in particular on the work of the United Kingdom's foremost authorities on public administration and regulation, authors such as Christopher Hood, Henry Rothstein and Mike Power, their colleagues at the *Centre for Analysis of Risk Regulation* (CARR) at the London School of Economics, as well as other academic research and numerous UK government policy papers on regulation and risk management. In addition, the work of Professor John Braithwaite at the Australian National University has been central to our understanding of the broader contexts explaining the rise of risk and risk regulation in Australian public agencies.

In some human services, particularly health services, the scientific and technological basis of some risk technologies meant they were readily accepted as objective tools which complemented the call for evidence-based practice, quality assurance and improved internal auditing (Webb, 2006). As Scott (2004, p. 157) explains, the central objective of the so-called responsive regulation is to stimulate regulatory approaches which foster and support the 'regulatory capacities which already exist' within organisations and businesses, and even individual citizens. In this sense the responsive approach to regulation aligned comfortably with contracting and commissioning processes, allowing contracting departments to package and transfer risks into their performance agreements with service providers.

In the context of the demands for increasing efficiency, greater accountability, reducing costly government interventions and improving public sector governance, few voices questioned the reassuring logic of 'new public management'. It was not until the end of the century that some authoritative voices were heard which drew attention to the significant difference between the needs of business and the needs of government in the management of risk.

Problems arising from the adoption of business risk management models by public agencies and community services

Hood and Rothstein, in their contribution to the major UK National Audit Office (2000) report on *Supporting Innovation: Managing Risk in Government Departments*, argued that there are distinctive regulatory issues and problems in the public sector. They acknowledge that while corporate models of risk management may have been well suited to some functions of government, the question arises whether they meet the needs of the complex risk sharing relationships and the mutual management of *systemic* risks relevant to the responsibilities of government today. These issues are further discussed by Hood, Rothstein and Baldwin (2004).

Hood and Rothstein (2000) argued that in the public sector risk is usually systemic, and is allocated across numerous public agencies and at multiple levels in government. Unlike business, therefore, the management of risk is complex and must be integrated and possibly shared across autonomous organisations. Effective management of risk requires public organisations to work together and develop 'cross-organisational trust and management craftsmanship of a high order' (Bardach, 1999, cited by Hood and Rothstein, 2000, p. 26). We would argue that exactly the same requirements apply to community services, where the collaborative and shared work also includes subtle risk sharing relationships with service users, families and other providers.

From the literature and the evidence of this project we have identified five issues which we consider important in setting the context for this project.

First, business risk management approaches are driven by the institutional imperatives of avoiding blame and litigation

Hood et al. (2004, p. 176), and Hood and Rothstein (2000), drew attention to the critical difference between the responsibilities of public agencies in managing risk in the public interest, and the essentially self-protective interests of corporations. Consequently, they concluded that 'bringing business risk management to public services could easily augment the "blame prevention re-engineering" that is already too well established in public sector organisations generally and risk regulation in particular' (Hood et al., 2004, p. 177). They go on to observe that '(s)ystems that put too much stress on limiting downside business risk at

organisational level can trigger risk-displacement processes among different organisations that create nil (or negative) “public value” (Hood and Rothstein, 2000, p. 26).

Second, the problem of who takes responsibility for systemic risks

Preoccupation with blame avoidance and organisational risk, that is the reputation and liability risks of the agency, diverts attention from systemic risks, the primary risks that constitute the ‘real’ problem for the public and the government (Hood et al., 2004, p. 178). Earlier, Hood and Rothstein (2000, pp. 26-7) had argued that this internal focus may lead to policy inactivity and the use of risk management as a ‘fig leaf’ to hide the failure to address systemic risks.

While traditionally health and welfare providers have been focused on systemic risks and client risks, and have not seen institutional risks as their dominant concern, the findings of this project suggest that such perceptions are changing with the adoption of corporate approaches to risk management and the dominance of the blame culture in public agencies and services.

Third, corporate risk management impacts on trust between agencies

The corporate thrust of public sector reform in general, and risk management in particular, does not encourage high levels of mutual trust across different agencies. If anything, as Hood et al. (2004, p. 178) claim, it ‘was designed to make public organisations go in exactly the opposite direction’.

Hood and Rothstein (2000) also found risk management, accountability measures, and the regulation of standards can negatively impact on the readiness of services to innovate and collaborate with other providers to improve outcomes.

Fourth, risk management and the law governing liability

The culture of blame, and the incentive to transfer risk, arises, in part, from the legal, regulatory and administrative systems that manage both risk and accountability.

The law of negligence and professional malpractice always focuses responsibility on individuals and/or specific organisations. In a useful analysis of the regulatory and legal barriers to collaboration and inter-professional public practice in Canada, Lahey and Currie (2005) demonstrate how the law individualises accountability and creates uncertainty in the minds of professionals engaging in complex and integrated practice in the interests of their patients and clients. They conclude that ‘there is a widespread consensus that structures for professional regulation, especially legislatively defined arenas of practice, are a barrier to a more integrated health care system in general and to interprofessional practice in particular’ (Lahey and Currie, 2005, p. 200). While this analysis is focused largely on the practice of medicine, it is instructive for the way regulation and risk management constructs social care.

Fifth, the problem of ‘acceptable’ risk

Finally, in community services and many other public services, risk management has to work in the absence of agreed understandings of what constitutes the limits of acceptable risk. While there is general agreement about duty of care and what constitutes negligence, there is great reluctance on the part of many parties to confront and agree on the levels of risk we can accept in community care. Acceptable risk, therefore, is defined by the media, public inquiries into adverse incidents and the courts. In the meantime services walk what some called a ‘knife-edge’ in making judgments about acceptable risk.

An underlying problem here is that much of what government does cannot be fully defined by technical rationality. Kemshall (2010) discusses this issue in the context of two different risk rationalities. Business risk management models see the decision maker as a rational actor ‘rooted in economic theory that sees risk choices as located in an economic rationality of cost and benefit’ (Kemshall, 2010, p. 1248). The second rationality is that of the social actor, who is ‘seen as an adaptable actor, mediating social and personal constraints on their choices, and acting prudently within a situated rationality in which options to act otherwise can be severely limited by structural constraints and lack of power to act otherwise’ (Kemshall, 2010, p. 1249). The community care professional bridges both these rationalities. Face to face with their client they must confront both the technical and economic rationality of formal risk management procedures and the situated reality of their client. In this territory there is often no agreement about what is acceptable risk. Some of the participants in this project articulated this dilemma.

THE FINDINGS

What did the participants in this study say about risk and risk management—what were the major themes?

Four main sets of findings emerged from the analysis of the interviews conducted for this project; each is summarised below.

1 PERCEPTIONS OF RISK VARIED ACCORDING TO PARTICIPANTS' ROLES AND RESPONSIBILITIES AND THE PARTICULAR CONTEXTS THAT SHAPED THEIR DAY-TO-DAY WORK AND LIVES.

Generally, CEOs and senior managers were most concerned about risks at the organisational level, especially those associated with:

- funding, itself increasingly volatile in the context of short term contracts and changes in government policy
- financial management
- governance and accountability systems
- relationships with other agencies, including sub-contracting
- reputation
- recruitment and retention of staff

Two particular aspects of this evidence are worth noting here.

Firstly, risks associated with governance and accountability systems were emphasised by CEOs and senior managers from community service organisations (non-government services). Participants from public agencies reported that they had well-established infrastructure and systems in place for quality assurance, auditing and reviews, along with specific-purpose software to record, track and follow-up risks, access to lawyers for legal advice, and other resources. Participants from community service organisations highlighted constraints in implementing reliable governance systems as a direct result of 'infrastructure problems', mainly due to limited finances or a lack of dedicated funding set aside for the emerging systems requirements necessary for effective governance. To illustrate, the CEO of a specialist disability service claimed that implementing risk management systems was costly, particularly in terms of administration, citing that 20 per cent of the budget was needed for administration whereas their funding department had suggested that 12 per cent was adequate. These uneven pressures on agencies and their differential capacities for risk management depending on size and government or non-government status was a major finding of our study.

Secondly, risk to reputation was the most consistently identified organisational risk across all the participating services. The work of public agencies was seen as especially vulnerable to criticism or complaints in the media. To illustrate, the manager of a public disability service cited what he referred to as the 'Herald Sun test' in terms of protecting his service's public image:

At the end of the day what's this going to look like if it hits the front page of the Herald Sun and that is always in the back of your mind in terms of media interest and risk of exposure of negative publicity for the Department and the Minister... The driving focus or force that keeps us doing everything, the work that we do - that's around getting good outcomes for our clients and actually making a difference, but we have to be mindful that at the other end of that there's the sort of other political imperative around the services that we provide. (Manager, public disability service)

Program managers focused on risks to clients and workers in the field, along with a range of risks involved in the actual running of their programs, including:

- recruiting and retaining staff
- supporting workers in what was often described as 'very demanding' work
- complying with OH&S standards
- operating within budgets

- managing time pressures and increased workloads, especially increased administration
- working with other agencies
- managing the increasing complexity of client presentations

For example, noting that the 'administrative requirements' of case management created 'a volume of paperwork', a program manager from a service supporting aged clients, and adults and children with a range of disabilities, commented:

People go into case management because they want to help people have a good life... And what they find is - they have this much time [gesturing] actually interfacing with the participant... And 80 percent of their day is negotiating stuff [with other agencies, funding bodies etc]. (Program manager, non-government case management agency supporting aged clients, and adults and children with a range of disabilities)

And a case manager from the same service noted that the demands of paperwork took her away from direct client work:

You can't fit it all in... sometimes I feel like we're doing more admin than anything... so you try to balance wherever you can, but sometimes it's like - well, do you want me to see this person or do you want me to do that a bit of paperwork? (Case-manager, non-government case management agency supporting aged clients, and adults and children with a range of disabilities)

Across all sectors, most program managers and frontline workers commented on the increased complexity of clients, especially drug-induced presentations, behavioural problems and mental health problems. For example, the program manager of a psychiatric disability rehabilitation outreach/support agency (PDRS) explained that the increased incidence of illicit drug use meant that services were now dealing with clients who were more complex:

The clients that we're getting referred... really have much more complex issues than I think was apparent when I first started in the field [some fifteen years ago]... There's a lot more clients now that have a dual diagnosis so a mental illness and substance abuse issues. It's highly prevalent now in our client group and really that dual diagnosis work is very much the work that we do. (Program manager, PDRS outreach/support agency)

Frontline workers tended to focus on potential risks that could occur during home visits, and on a range of issues faced by clients, most notably:

- the unregulated nature of the home environment
- unpredictability in terms of what could eventuate during a home visit
- verbal and physical aggression from clients (and their families or associates)
- a range of vulnerabilities and predicaments experienced by clients (e.g. financial stress, social isolation)

All frontline workers and most program managers identified the potentially unpredictable behaviours of clients and others in the home as a major, though infrequently experienced, risk. The first meeting with a client could be especially unpredictable as this community nurse explained:

Even though you've had that communication on the telephone, quite often you've got no idea what you're going to be coming up against. It could be a relative that they have not mentioned who has schizophrenia, who is unstable... you can go and do a risk assessment on a house and things can change either whilst you're there or twenty-four hours later. You can go back the next day and you can be confronted with something that was never picked up at your first visit [and] has been brought in either by a relative who's come to stay and they've brought their over-hungry Newfoundland or whatever. (Community nurse, home-based nursing agency)

For the clients we interviewed, concerns about agencies' risk management policies did not occupy a significant place in discussions of their experiences as service users, but rather:

- for the majority, 'risk' was interpreted in terms of personal vulnerabilities and potential dangers arising in the context of dealing with disability and illness

- for most, relationships with respective case managers and direct care workers were central to their experiences as service users, and several clients were especially concerned about the frequent turnover of frontline staff in the services they used

To illustrate the first of these points, one client, who uses a wheelchair and attends a disability service, worried from time to time about negotiating streets and rail crossings, especially when street works were underway:

If they're doing work like on the footpath like construction work, then there are parts where it's unsteady, I try and find another way to get to the shops because I don't feel safe and also I've had to have my front tyres changed because I was getting stuck on the railway tracks. (Client, day program for adults with physical disabilities)

On relationships with workers, another client commented that he found his case worker 'very encouraging' in discussing various strategies to deal with 'the voices' but, like several other clients we interviewed, he found the frequent turnover of staff quite difficult:

I only wish that they didn't have such a turnover in people... I've got very close to workers that worked with me and it's very hard to see them go and then have someone else come along and it takes awhile before you get to know them. (Client, PDRS outreach/support agency)

In contrast, family carers expressed a range of concerns about risk management policies, and four main themes emerged from these interviews:

- Concern over the very circumscribed roles of support workers as a consequence of risk management procedures, particularly in respite settings and accommodation facilities; this sometimes meant that the needs of clients were not attended to adequately, and that the quality and comprehensiveness of care warranted much improvement.
- The considerable emotional stress experienced in the role of carer, including the 'work' of negotiating very complex service systems, was identified as a 'risk' (which created further risks for carers, including poor physical health).
- Carers often felt that they were not 'being heard' or respected by services on the basis of their intimate and expert knowledge of family members, nor utilised as a resource in situations where their input could make a difference.
- Some carers were concerned that the strong emphasis on duty of care (the need to protect against risks) was at odds with the public policy emphasis on person-centred care and social inclusion more generally - and that this limited clients' involvement in a range of community-based activities.

To illustrate the third theme, the daughter of a man who has dementia reflected on the experience of accompanying her father to an Emergency Department of a general hospital:

An acute hospital isn't geared to cope with relatives. And they don't see that the relatives could give helpful suggestions and advice and be of assistance to them - they just see you as being in the road and want you out of the way. And then you feel frustrated because you know that if you were listened to you can make the situation so much easier both for the person with dementia and for the hospital staff that are caring for them... In my experience it was at its worst in an acute hospital situation when they're hospitalized for a medical condition that's got nothing to do with their dementia and the hospital doesn't seem to be able to care for the two conditions together. They will treat them as a heart patient whatever, but the fact that they've got dementia is irrelevant or we've had students, residents, whatever doing a mini-memory test and turning around and saying, 'Oh he's scored fine - he hasn't got dementia'. You think, 'Well yeah you haven't lived with him'. (Family carer, aged care advocacy/support agency)

There were also differences between the three sectors - aged care, disability, and mental health - in how risk was constructed, and the particular risks that were emphasised. Distinctions in the nature of the risks encountered across the different sectors were closely tied to the ethical, legal, public policy and professional frameworks underlying service provision in each sector: clinical/medical frameworks in mental health, normalisation theory in disability and 'ageing in place' in aged care. These differences are elaborated in the full report.

2 PROGRAM MANAGERS AND FRONTLINE WORKERS DEVELOPED THEIR OWN WAYS OF THINKING ABOUT AND NEGOTIATING 'RISK' AND THE RISK MANAGEMENT POLICIES AND PROCEDURES OF THE WORK PLACE.

We referred to these complex reasoning processes as 'risk rationalities' and found three broad types which we classified as 'positive', 'critical' and 'compliant'.

The concept of 'risk rationality' encapsulates the way in which participants interpreted and responded to risk management policies and procedures in their everyday practices and how they felt about them. That is, did they feel that these policies and procedures facilitated their day-to-day work, or did they feel constrained by them? Did they feel that these policies and procedures had any effect on clients' needs, desires and aspirations, and on service outcomes?

Our study demonstrates that professional workers actively work at incorporating risk management policies and procedures into their professional practices. Specifically, they must develop an 'argument' about the way in which formal risk management procedures fit into their professional roles and identities. This demands the work of reasoning and analysis. To this end, some workers emphasised the positive aspects of risk management policies and procedures (designated by the positive rationality), whereas others focused on the negative or problematic aspects (designated by the critical rationality). The compliant rationality, which was expressed exclusively by non-professional workers, was not characterised by such analytical work.

The **positive rationality** was expressed by both professionals and non-professionals and generally these participants:

- perceived risk management policies and procedures as ensuring safety for both workers and clients
- perceived these policies and procedures as fulfilling quality and accountability requirements for the respective organisation
- were not troubled by the need to comply with these policies and procedures and did not resist them
- argued that these policies and procedures actually strengthened their practice, made them more reflective and creative, and more responsible and accountable to their clients

As a consequence, these participants tended to see the obligation to carry out risk management policies and procedures as compatible with their professional values and ethics. From this perspective, risk management activities were *integrated* into their professional practice and professional identities.

Example of a positive rationality: *The very fact that I have to fill out a risk sticker it forces me to bring into my thinking elements of risk because if you get to know a client and you get to know them well and you feel very comfortable, then sometimes you can miss the cues because you're used to the conversation. Like I've got a fellow who says, 'oh I just want to die, I feel like jumping off a bridge' - but he says that every single time and he has for the last eighteen months and then in the next breath he'll say, 'oh yeah and what are we doing next week, are we going out for coffee? ... But another person might say, 'oh I just feel really lousy' - and for them to say that when they haven't said it for six months means that they are really at risk, and having this framework that's in the back of your mind it does I think sort of raise a level of consciousness towards risk issues... I do need to take into account risk probably more than I would if I didn't have that as a constant reminder. Now...I've got to tick those boxes - and hang on a minute... just because so and so said this every home visit for the last six months, should I just ignore it - I still need to think through and so I do think that the requirement to manage risk does shape the way I practice. And my experience in the organisation is that it's been largely positive and not constrictive. (Case manager/social worker, Area Mental Health Service).*

The **critical rationality** was expressed exclusively by professional workers; generally, these participants:

- Perceived risk management policies and procedures as constraining their practice and disadvantaging their clients, particularly in terms of disrupting their capacity to develop trust and rapport with the client

- Often expressed antagonism towards specific risk management requirements, arguing that the upholding of such policies was adverse to clients' needs and could produce a range of new risks associated with reduced quality of service
- Several participants with strong critical convictions admitted that they had breached organisational policy in order to provide clients with a more therapeutic and needs-based intervention than that allowed within the confines of agency policy

As a consequence, these participants saw some risk management policies and procedures as incompatible with their professional values and ethics. From this perspective, risk management activities were experienced as *external* to professional practice and professional identities. However, it did not follow that participants with a critical rationality eschewed risk management as such. They had their own very individual and carefully considered perceptions of what risk meant and how best to manage it within a given situation. They were still actively involved with risk, often conformed to formal requirements, but their sense of professionalism and commitment to clients was strengthened by their critical and more independent approach to risk.

Example of a critical rationality: *Going into a house and finding that the light globe has blown, the little old lady or gentleman... don't have any family and they're saying but I can't see what I'm doing in the evenings, and so you sort of think well it's not rocket science to change a light globe. But if you look at the risk assessments there you don't know what the wiring is like... whether you're potentially going to electrocute yourself. So we are not allowed to do that... In the meantime they could get up at night time... and trip over something and break a hip and they're in hospital, so for me personally - and I do not condone it in any way - I would change a light globe... So again, it's a non-nursing duty, but it was something that I was able to help out with and was a five minute job, but again outside the realm of my role and responsibility. But you know if we can't help a fellow human being and I see it as a low, extremely low risk, then I'm prepared to take that option. (Community nurse, home-based nursing agency)*

The **compliant rationality** was expressed exclusively by non-professional workers ('direct care' workers or 'community care' workers). These participants conveyed a largely unreflective, rule-bound stance towards risk management policies and procedures which, in the context of their day-to-day work, primarily involved occupational health and safety rules and regulations. Most expressed a strong habit of obedience to their employing organisation. They argued that risk management rules and regulations ensured high standards of safety for workers and also for the clients and carers for whom they provided home-based support. Some workers specifically mentioned that OH&S policies and procedures were crucially important in safeguarding workers against back injuries, noting that many workers had developed longstanding 'bad backs' in the past without this protection.

Example of a compliant rationality: *A [family] carer got cranky with me – [his] mother had slipped out of her chair and he wanted me to lift her into the chair and I said 'Well I can't, I'll have to ring up ... someone will have to come out with a lifting machine.' And he was really cross and he did it himself in the end, he wouldn't let me ring. But he expected me to, and I get that from carers... 'Oh I am glad you came and not so and so', and I will say 'Why?' and they will say 'Oh because she is only a skinny little thing.' And I will say 'Well what has that got to do with it?' 'Because if Mum fell you would be able to lift her', and I said 'No I can't - I am not allowed to.' And they get a bit cross about that, they think we should be able to just lift or whatever. And it doesn't matter whether you are big or little, you are not allowed to lift and that is all there is to it. (Direct care worker, home-based nursing agency)*

What is most significant about our findings concerning risk rationalities is the strength of workers' professional and non-professional identities and values and their strong focus on clients' needs (rather than a primary concern with bureaucratic and managerial procedures) – a finding that is in contrast to some of the recent research from the UK which reports that frontline staff in public agencies are generally demoralised and stressed, and feel that they cannot express their 'real' professional values and practices because of the crisis-driven and highly administrative nature of their work (for example see Carey 2007).

3. FOR SERVICES IN THIS STUDY THE IDEA OF 'SHARING' RISK WITH OTHER PROVIDER ORGANISATIONS IN THE CONTEXT OF THEIR WORKING RELATIONSHIPS AS PARTNERS AND COLLABORATORS WAS PROBLEMATIC

While most of the participating organisations worked closely with other providers sharing risks was an unfamiliar concept to frontline workers and most program managers, since risks were generally framed within the individual operations of each organisation.

The major themes emerging from discussions about 'risk sharing' were as follows:

- Most participants felt that risks were 'shared' or 'divided' amongst agencies that were involved in the care of the same client in very specific ways; e.g. that the degree of an agency's risk responsibility was related to its particular role or function in the delivery of community care.
- Discussions with community mental health workers stood out from other workers' discussions because of their focus on clinical risks; all participants were unequivocal in noting that serious clinical risks were to be transferred to the relevant public mental health agency.
- Case managers were seen as having a focal role in taking a lead in managing risks where several agencies were involved in a client's care, largely because of their 'linking role'.
- Several participants identified specific tensions and inherent difficulties in the nature of sharing risk and risk information with other agencies, including the need to uphold client confidentiality.

Illustrating the first of these themes, this program manager from the aged care sector commented about the very specific ways in which risk responsibilities are apportioned:

It's divided amongst the agencies, so the risk attributed to your agency for the care that you're providing is yours to own and nobody else's and each agency would assume that sort of risk. If the service is brokered out to us from another agency, so they're the fund holder, but we're the service provider then all the risk around service provisions, so Occupational Health and Safety and you know Work Cover and all those sorts of things, are ours and we wear that. Things like I guess public liability, that's actually the client's risk, so when you're in their home, that's theirs. The financial risks and so forth are the fund holders', so it's sort of portioned up depending on what you're doing and what you've assumed responsibility for. (Program manager/nurse, service providing support and home care to the aged)

Amongst all the interviews with program managers and frontline workers, there was only one discussion of a formal risk sharing arrangement at the organisational (management) level. In this particular discussion, a program manager of a home-based nursing agency argued that risk sharing was 'problematic' without formal risk agreements between organisations:

I shouldn't mention X Council but we have a really good working relationship with them. We actually have set up a Shared Care Committee, so... we're going to work through those issues, so that we believe we've managed our risks to the point where we can't do any better. What we are asking the Council to do is to share that with us and we already use the same risk forms... We are going to do similar training, so that when we all go in we're saying the same things, so one service going in to do home care is not saying, 'Oh it's okay - I'm not afraid of you', and another service going in will say, 'Hang on, we're not coming in because you've got a Rottweiler' or something, so we're trying to get shared agreement on processes. (Program manager, home-based nursing agency)

Other discussions of risk sharing arrangements across agencies focused largely on the practice of case conferences. These were generally ad hoc arrangements that were made as the need arose, according to the circumstances of individual clients, rather than formal structures and processes for inter-agency collaboration and problem-solving. The evidence of the project confirms the overall absence of clearly defined protocols or guidelines for negotiating and sharing risks *with* other agencies, and a general reliance on ad hoc measures implemented on a case by case basis to resolve differences.

4. EFFECTIVE MANAGEMENT OF RISK AND ORGANISATION RISK 'CULTURES'

The extent to which organisations successfully balanced their service goals and clients' needs alongside responsibly managing risk depended not on the systems and procedures adopted, but on the organisation's risk culture and the degree to which the organisation and its workers were able to approach the management of risk as part of, and integrated with, their service goals.

Organisations with a positive risk culture were characterised by an open dialogue about risk and service values and goals, and this dialogue appeared more likely to occur in non-government and smaller organisations.

Although we had not set out specifically to study the risk cultures of our participating organisations, several themes concerning the way in which issues of risk and risk management were framed at the organisational level clearly emerged through our interviews, including:

- Many participants' identified differences among collaborating organisations in their approaches to risk management.
- The need to integrate risk management practices into the practices of case management and clinical care.
- There were differences in the degree to which workers could 'openly' discuss issues of risk.
- Tensions that arose in the context of protecting the organisation were seen in many instances to 'bureaucratize' the relationship between worker and client.

These tentative findings concerning risk management cultures demonstrate:

- The significance of openness and trust amongst frontline workers themselves and between frontline workers and managers across different levels of the organisational hierarchy.
- The importance of providing opportunities in the workplace for reflection on organisational processes of managing risk, including questions about the impacts of risk management procedures on clients and also on workers.
- Recognising the importance of integrating risk management into the roles, functions and values of workers.

To illustrate efforts to develop a positive risk culture, this senior program manager from a case management agency explained how her agency had attempted to integrate risk management requirements into the actual practice of case management, including an emphasis on involving clients in their own risk management processes where possible:

So I say to case managers, you need to externalize the OH&S issues... put them on the table... we are obliged to take them into account, let's think how we can respond in a way that meets the requirements, the legislative requirements but gets your needs met as well... So I'm always encouraging staff... to actually explain that process and you can do it in a professional way that doesn't bag the government, you know... just say look every organization has OH&S requirements and sometimes unfortunately they don't take into account individual blah, blah, blah [situations], so... we need to get around them and some... of the ways that you get around them quite legitimately.

FOUR IMPLICATIONS OF THESE FINDINGS FOR VICTORIAN COMMUNITY SERVICES

1. IS THERE A NEED FOR A COMMON FRAMEWORK FOR CARE PLANNING, SUPPORTED DECISION MAKING AND RISK MANAGEMENT IN COMMUNITY CARE?

The Issue

This project has demonstrated a significant lack of shared approaches to community care with respect not only to risk assessment and risk management but also to the goals and processes of community care, notably individualisation and participation of service users in decision making.

These findings are significant in the context of the following assumptions about the future of community care:

- Community care will continue to be the preferred service direction in all the service sectors participating in this project as public policy favours even high risk community care alongside high cost hospital and residential alternatives.
- Public policy, the professions and consumer advocacy organisations will continue to support more individualised service models for community care. Public policy will also support the rights of service consumers to participate in the planning of their services, their ongoing role in the delivery and efficacy of these services, and their options to make (some) decisions about risks.
- The increasing complexity of community care will demand more integrated and interdependent care arrangements between formal services in a range of sectors; between formal services and their clients and patients; and between formal services and informal carers, family members and friends.
- Notwithstanding these trends most service providers have adopted risk policies and procedures which are based on different assumptions, namely those about the primacy of protecting their organisation, clients and staff. Although reasonable, these assumptions may not adequately address the broader realities of today's focus on human rights, individualised care, partnerships, collaboration and the role of service consumers in their own care.
- The complexity of care and the range of risks involved will inevitably increase in these contexts. The findings of this project would support consideration of a common framework for service providers in their approach to care planning and decision making with clients and their representatives.

A framework for decision making in community care

We have drawn heavily on the work undertaken by the UK Department of Health arising from extensive Green Paper and White Paper processes in 2005 and 2006 which supported greater involvement of people in their own health and care, while addressing the importance of risks. The outcomes of this work, in terms of managing risks, came together in a national framework entitled *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making*, UK Department of Health (2007).

Objectives of a common framework for care planning and decision making (adapted from *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making*, (UK Department of Health, 2007)):

- To provide a common approach to risk decision making in community care as the basis for working practices, and encourage practitioners and organisations to adopt this common framework in their policies, their agreements with other agencies, and their own cultures and working practices.
- To effect the development of a common set of principles for organisations to use as the basis for supporting people in making decisions about their own lives and managing, in terms of their capacities, any risks in relation to those choices.

- To support the principles of individualising community services and empowering service users through managing choice and risk transparently, and enabling a fair appraisal of the decision process, if required.
- To develop common approaches to balancing necessary levels of protection and preserving reasonable levels of choice and control, in order to help people achieve their potential without compromising their safety, or the safety of others.

Key elements of a framework

The framework would establish a common language, definitions and tools. It would spell out the legal context within which the framework operates. It would also set operational guidelines for defining the key tasks of assessment and care planning; the roles and responsibilities of service users, case managers and direct service providers; and the nature of risk agreements with service users, carers and family members. Finally, it would spell out the documentation and recording required of participating services.

The findings of this study suggest that approaches to community care that reduce the difference between services in care planning and the management of risk would facilitate more effective collaboration and less conflict in the process of service delivery. A common framework would be one possible approach.

2. CAN “RISK MANAGEMENT” ADDRESS THE COMPLEX, SYSTEMIC AND SHARED NATURE OF RISKS IN COMMUNITY CARE?

The Issue

Essentially the risk management models and systems used by most agencies and services are based on business models which fail to address systemic or whole of industry risks, reinforce risk shifting to weaker parties, and reduce incentives for collaborative and integrated service provision.

The evidence from this project would suggest that while some local organisations work together informally to develop common approaches to risk in order to achieve better coordination and integration, formal agreements on risk management are rare. At the completion of this project only one *formal* risk sharing strategy was reported by the ninety chief executive officers, program managers and frontline workers interviewed. For most workers in community services the assumption that risk management is an individual organisation responsibility is so strongly entrenched that alternative approaches are not contemplated, except in longstanding high trust relationships between local workers and managers. Formal common frameworks were virtually non-existent.

Yet the future arrangements of community services will be characterised by increasing complexity and the consequent interdependence of providers and increasing significance of risk agreements between services and clients.

Why are trusting and risk sharing relationships so difficult to achieve?

The recognition of these issues and problems is not restricted to human services. CPA Australia (2002) acknowledges that given the significance of collaborative and cooperative problem solving and policy development now essential across government departments there appear to be major impediments to the shared development of risk management strategies.

These impediments include:

- difficulties in defining and presumably separating roles and responsibilities
- differing cultures
- privacy considerations
- probity considerations
- sensitive Commonwealth-State relations
- resourcing

(CPA Australia, 2002)

Kurunmaki and Miller (2004), working out of the Centre for Analysis of Risk and Regulation at the London School of Economics, identified many risk management problems with the processes of modernising the relationships and partnerships between health and social care services in the United Kingdom. These findings are consistent with our evidence.

Strategies for risk management across coordinated and integrated services in community care

What would have to happen to solve these problems? Again, we would draw on the United Kingdom experience to inform the answers to this question.

Funding departments support collaborative risk sharing arrangements in their contracting practices

Such a shift in contracting practice would involve the following:

- clear procedures and protocols for joint working, a clear understanding of each organisation's accountability and obligations to the other services
- agreed procedures for delivering the service package to which everyone contributes, including responses in crisis
- agreed documentation for the needs assessment process, care planning, risk assessment/monitoring and review/recording
- information sharing policies with partner agencies
- timely processes for resolving complex funding issues or disagreements
- precautionary processes for managing complex high risk situations and cases and processes for conflict resolution

(Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making, UK Department of Health, May, 2007, p. 41)

Collaborations and partnerships identify and formalise the need to share risks in the development of their collaborative working agreements

This most difficult of tasks would involve collaborating organisations identifying and acknowledging each participant's risks, including their understanding of the risks arising from the collaboration or partnership. Where feasible these risks are assessed in terms of the impact, probability and costs, and participating organisations would undertake to work with and mitigate these shared risks across the service agreement or partnership. As a consequence a shared risk management plan is developed.

In addition, where possible, agreement is reached for apportioning financial impact if adverse outcomes occurred; and again, where feasible, agreement is reached on the management of the consequences of adverse outcomes, for clients and patients, community, media and regulatory bodies.

Over time develop legal processes which support shared responsibility between providers, and between providers and service users

Drawing on Lahey and Currie's (2005) work, a number of useful implications for community services can be defined.

First risk sharing practice in community care must recognise and operate within the requirements of negligence law.

Second in this context professionals and service providers would be advised to support the gradual building of standards and guidelines for sound risk sharing practices.

Third Lahey and Currie (2005, p. 215) suggest, with reservations, that legislative reform could advance resolution of the uncertainty that exists around risk sharing practice and partnerships. Legislating for standards in partnership or team based risk sharing work would have this effect, although it is difficult to achieve when practice changes so rapidly (particularly with respect to advances in knowledge and the emergence of new ways of working in complex community care), and there may be considerable disagreement between different professions and service sectors (Lahey and Currie, 2005, p. 215).

Without doubt these steps present difficulties. Nonetheless while governments systematically call on community health and welfare providers to work in partnerships to address policy change, it is reasonable to expect that public agencies and their regulatory bodies would find

ways, such as clear guidelines, standards and common expectations, even legislation, in order to more actively support policies which require a higher level of client-centred practice and risk sharing.

3. WHAT HAS TO HAPPEN TO MAKE RISK MANAGEMENT INTEGRAL TO AND COMPATIBLE WITH PROFESSIONAL PRACTICE?

ARE THE HELPING PROFESSIONS INTEGRATING RISK MANAGEMENT INTO THEIR KNOWLEDGE AND PRACTICE?

The Issue

While risk management is now seen as an integral part of the day to day professional work of engineers, surgeons, scientists and other professions, many professionals interviewed for this project saw risk management as a set of legal and administrative requirements which had adverse consequences on their working relationships with their clients, restricted their clients' choices and their own professional agency.

The interviews with program managers and frontline workers in this study (59 participants) demonstrated that most of the professionals interviewed for this project were seeking professional and ethical frameworks for their approach to risk. In effect, they largely did this 'on their own', finding little help in the professional literature and from the professional development activities available to them. As we have reported, they developed their own risk 'rationalities'—ways of making sense of the conflicting situations they faced, not just in exceptional circumstances but in the day to day decisions necessary in community care. These workers had a strong sense of their professional identity and risk management was an integral part of their professional practice, not just an externally imposed set of administrative procedures and restrictions on their practice.

For reasons we outline below we consider that risk management should be informed by professional as well as corporate strategies.

Many researchers also argue that risk management, together with other elements of 'new public management', has significantly diminished the capacities of individual professionals to exercise judgement and take risks, greatly increased administrative monitoring and supervision, and re-shaped professional identities around managerial rather than therapeutic skills (McDonald, 2006; McDonald et al., 2008; Munro, 2004, 2010; Webb, 2006).

However, while risk assessment tools and risk management procedures are considered useful by most professional workers, individual judgment in unique and unforeseen contexts continues to be a central part of the practice of most of these workers. And these judgments will not always be informed by evidence alone, but also by understanding based on experience, reflection, intuition and complex analysis of unique situations.

The changing contexts of professional practice

Traditionally, the helping professions operated in controlled environments - hospitals, clinics, institutions, community service centres and prisons. These settings were characterised by strong disciplinary hierarchies and rules, and also by interdisciplinary systems and rules. These systems, the structure and routines of the institution, and occupational health and safety procedures established safe and controlled working environments for these workers and their clients and patients.

Of course the situation today is very different. While hospitals remain central to the health system, more and more of the action is being transferred to the community. Deinstitutionalisation, non-institutionalisation, hospital in the home, early discharge, day procedures, new policies promoting the rights and choices of people with disability, ageing in place and many others have transformed the Victorian human services system from the mid 1980s and will continue to do so for the foreseeable future.

These changes have major impacts on frontline helping professionals, including:

- loss of institutionalised structures to protect professional practice
- loss of a professional career range and loss of senior professionals
- reporting to generic, sometimes non-professional, managers
- working with administrative titles such as 'case manager' and more generic administrative roles, rather than discipline-specific titles such as 'social worker'
- new accountability requirements and increased documentation and defensive record keeping

As well as these changes, which are seen negatively from a traditional professional perspective, the new contexts also mean:

- high levels of devolution of services to local and community levels
- significant increases in the diversity and richness of community service organisations and commercial businesses involved in services
- increased support for innovation, especially in the interests of efficiency
- greater focus on early intervention and prevention
- new roles for professionals, and greater diversity of functions and skills
- greater sense of responsibility for workers working alone and in small teams
- opportunities for workers to develop more holistic, organic and local service responses to need
- the development of new flexible inter-agency and inter-disciplinary working arrangements through networks and partnerships

Implications for the way the helping professions identify and locate risk management in professional education and postgraduate training

These findings suggest that risk management should be a much more significant part of the professional training and professional development of today's human service workers whose practice contexts and service delivery demands are very different from twenty years ago. The corporate and managerial approach to risk, which has dominated human services in Victoria and Australia, has been very successful in changing organisation perspectives and awareness of risk, but this approach has often been at the expense of the integration of risk management into professional practice. Unlike child protection in Victoria, which has given prominence to risk management in practice, the dominance of administrative approaches in other sectors may have even de-skilled workers.

The radical changes in the demands on human service professionals in community care suggest that professional education and training now needs to address the implications of these changes, such as:

- preparing professionals to manage risk in complex and volatile contexts without the protections of traditional institutional infrastructures
- equipping professionals for the regulatory and administrative demands of community-based practice, while at the same time fostering confidence in their capacity to manage idiosyncratic and fluid situations for which there are no established procedures
- equipping them to work collaboratively and in partnership with a wide range of other stakeholders in the management of risk, not only other professionals but clients, family members, carers, community interests and substitute decision makers
- preparing them to manage risks in contexts where there is significant *disagreement* about what constitutes 'acceptable' risk

To this point the key bodies governing the professional training of human service workers have shown little recognition of the need to integrate risk management into their undergraduate curriculum and post-graduate qualifications. However, the future of community services will be one increasingly dominated by complexity and risk, and professionals will have to adapt to this risk in their practice, and are already doing so, as is demonstrated by this project.

4. WHY ARE RISK CULTURES IN HUMAN SERVICE ORGANISATIONS IMPORTANT AND HOW DO THEY DEVELOP POSITIVE RISK CULTURES?

The issue

As has already been reported, most participating organisations identified differences between their approach to risk management and that of other service providers with whom they had a working relationship as partners, collaborators or members of interdependent service teams. They would not necessarily define these as ‘cultural’ differences, but they did see differences in risk aversion, risk taking, readiness to solve problems about risk (especially for clients), and differences in rigidity or flexibility of procedures. While only a small number of the participating organisations articulated a distinctive risk culture, almost all of the participants recognised there were different approaches to managing risk in community care.

On the few occasions that executives, program managers and frontline workers referred explicitly to the ‘culture’ of corporate risk management, it was often seen as antithetical to professional and organisational culture, especially in community services organisations. As a result some CEOs set out to build their own distinctive organisational risk culture. Also in the discussion of the different risk rationalities of the workers it was clear that many workers, particularly professional workers, developed their own ‘risk cultures’ in order to deal with this perceived problem.

At the VMIA’s inaugural State Risk Conference in October 2009 it was significant that a number of speakers addressed the issue of risk cultures in organisations, identifying both the apparent detachment of risk management from practice and the impact of negative risk cultures on innovation and effectiveness. It appeared that some of the problems identified by Hood and Rothstein (2000) a decade ago were emerging here not only in public agencies, but also in community and commercial organisations.

It is for these reasons that a number of regulatory bodies in the public sectors of the UK (e.g. UK National Audit Office, 2000), Canada (e.g. Treasury Board of Canada Secretariat, 1999, 2000) and Australia (e.g. Victorian Auditor General, 2003, 2004) have worked hard to try and distinguish the distinctive issues confronting public sector services in the successful management of risk. As originally identified by Hood and Rothstein (2000), public agencies and regulatory bodies have become increasingly concerned that ‘the managing of risk in the public service often became synonymous with avoiding risk, which also implied avoiding innovation’ (Treasury Board of Canada Secretariat, 1999, also 2000). We would conclude that addressing this problem requires, among other things, the development of risk cultures which reconcile the tensions arising from the management of risk in public services such as community care.

Factors that influence an organisation’s risk culture

An organisation’s risk culture will be influenced by many factors, but amongst the most important are the following:

- The vision and values of the organisation are central to its explicit or implicit risk culture and set the stage for the entity’s tolerance for risk, what the risk experts call the ‘risk appetite’.
- The degree to which management and workers see risk as integral to their practice at all levels determines whether or not the risk culture is relevant to their roles and functions or alien to their roles and functions.
- The external environment of the organisation, especially in terms of relationships with funding bodies or government departments, regulatory bodies, and community interests, will also be central to the risk culture. A hostile or distrustful working relationship with funding or regulatory bodies will significantly impact on a service provider’s risk culture.
- In addition, the external environment defined by the public and political ‘understanding’ of acceptable risk, the reactions to adverse incidents, the degree of tolerance for ‘mistakes’, and the readiness to blame and punish, all have a strong capacity to shape risk cultures.
- In the context of all these kinds of defining issues, leadership, trust, shared vision and sense of security of staff at all levels are all keys to the risk culture.

Developing a positive risk culture*

On the basis of the evidence from this project, the research literature and the public documents addressing this issue, we make the following observations:

First risk management needs to be developed as part of the operations at all levels of an organisation --- boards, strategic planning, business planning, program development, training and service delivery. This was seldom the case for the participating organisations in this project, most of which had risk management systems at governance levels, and then at some operational levels, but not in the context of a coherent risk culture. Most organisations seemed to be constructing their risk management as a response to externally imposed compliance requirements, rather than as something they developed as integral to their mission, strategic objectives, effective operations and their own practice guidelines.

Second articulating risk as central to creativity, innovation, and effectiveness as well as safety, prevention of hazards, risk avoidance and managing adverse events are all essential to a positive risk culture. At the VMIA Risk Conference mentioned above continual reference was made to the importance of 'embedding' risk management as both a positive and negative issue at all levels. We find the uses of the term 'embedding' both misleading and unhelpful. The term perpetuates the concept of risk management as belonging to and controlled by management, and it negates the fostering of more worker-owned and context-specific practices of risk management, especially in frontline community care. It makes more sense to build on existing practice and consciousness of risk, as well as introducing new understandings and knowledge.

Third some risk consultants are now suggesting that introducing risk management into job descriptions and duty statements is a significant way of reinforcing risk management as an integral part of operational roles and practice.

Fourth a positive risk culture is enhanced if in the processes of debriefing, case reviews, and auditing reviews, the impacts of both positive and adverse risks are analysed and discussed. Positive risk management as part of review at planning levels, program development and practice levels reinforces a strong and legitimate risk culture.

Fifth portraying risk as a dynamic factor in the organisation's capacity to respond to change, learn from positive and negative events, and apply new knowledge, all reinforces the significance of creating a strong and visible risk culture. Risk management is part of achievement and positive performance as well as the necessary protection from dangers and hazards.

(*Note: Many of these points were discussed at the VMIA Risk Conference, 2009.)

CONCLUDING NOTE TO READERS

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