Social Inclusion and Individualised Service Provision in High Risk Community Care: Balancing Regulation, Judgment and Discretion

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Since the late twentieth century, health and welfare policy in Australia and the UK has focused on enhancing the freedom, life choices and participation of service users. Public policy, based on the construct of social inclusion, requires greater individualisation of services, active engagement with service users, and innovative partnerships between different providers. At the same time, however, the management of risk through a range of compliance procedures can discourage the exercise of discretion by workers, limit the participation of their clients and reduce incentives for innovative cooperation between services. Drawing on in-depth interviews with community care professionals and their managers engaged in high risk social care in Australia, this article gives particular attention to the relevance of risk to social inclusion and individualised service provision.

Keywords: Community care, social inclusion, risk management, individualised care, Australia.

Introduction

In Australia, the United Kingdom and other Western democracies, advancing the autonomy, life choices and responsibilities of citizens through the life course have become important foundational elements of public policy. As a consequence, strategies based on the construct of social inclusion and operationalised as consumer participation in the planning of personalised or individualised services packages have transformed programs for adults needing continuing health care, personal care and support.

Burchardt *et al.* (2002) argue that the realisation of social inclusion objectives requires that peoples engagements with services are meaningful and respected, and that they participate in decision-making about their own lives and their communities. Rose (1999: 10) pointed out over a decade ago that these changes demonstrate that individual freedom, rather than equality, has emerged as the marker of our progress, and 'ideas of freedom have come to define the ground of our ethical systems, our practice of politics and our habits of criticism'.

However, at the same time as social inclusion gained prominence in policy debates in Australia, the demands on service organisations and bureaucracies were increasingly framed by the need to control, manage and distribute risks (Ayres and Braithwaite, 1992; Braithwaite, 1999; Power, 2007). If individuals were to exercise greater autonomy and

control of their lives, they would need safe and predictable environments in which to enjoy this freedom, and people around them would need to be safe (Rose, 1999).These contemporary imperatives bring into even sharper focus the problem of reconciling the exercise of high levels of discretion and judgment by service providers 'on the street' (Lipsky, 1980) and political and regulatory requirements for compliance, accountability and certainty.

Common policy developments in the United Kingdom and Australia

By the last decade of the twentieth century, health and welfare policies were clearly focused on the rights, participation and empowerment of service users. The United Kingdom White Paper *Caring for People* (Department of Health, 1989) required professionals to involve vulnerable people in assessment processes as a means of assisting them to increase their control over their lives. Health policy espoused the view that 'personalised health care can be used to empower patients to take control of their own health, particularly in relation to chronic illnesses' (Redfern *et al.*, 2006: 124). In a paper entitled *Choosing Health: Making Healthier Choices Easier* (Department of Health, 2004), patient choice 'moved to the centre of UK government's programme of health system reform' (Calnan and Rowe, 2005: 10).

These developments were followed by a Green Paper on social care entitled *Independence, Well-being and Choice* (Department of Health, 2005), which argued for new approaches to the delivery and organisation of services in order to foster improved social inclusion and social participation. Significantly, the Green Paper also opened up the problem of managing risk in this process when it stated:

> We want to move to a system where adults are able to take greater control of their lives. We want to encourage a debate about risk management and the right balance between protecting individuals and enabling them to manage their own risks. (Department of Health, 2005: 28)

The subsequent White Paper, *Our Health, Our Care, Our Say* (Department of Health, 2006), acknowledged that risk management and social inclusion processes are unavoidably intertwined, with tensions to be resolved in delivering freedom and choice, alongside controlling risk, safety and protection. These high level developments in health and social care acknowledged, but did not address, their consequences for increased worker discretion, judgment and accountability, particularly at street level. Significantly, however, the Department of Health conducted extensive consultations on these practice issues, and out of this process developed a national practice framework entitled *Independence, Choice and Risk: A Guide to Best Practice in Supported Decision Making* (Department of Health, 2007).

In Australia, a similar but less ambitious commitment to social inclusion for dependent and vulnerable adults commenced in 1985 when the Commonwealth Government enthusiastically endorsed a national programme of home and community care. Initially, these changes were promoted in the name of human rights, access to a normal life and autonomy (Howe *et al.*, 1990). From that point, public policy at national and state levels set out to build a range of responses to the care and

support needs of dependent people, responses which were appropriate to both their age and stage in the life course, and which negated the need for high cost institutional care.

However, unlike the United Kingdom, Australia's transition from institutional to individualised and inclusive community care did not directly confront the related problems of increased worker and client exposure to uncertainty and risk. Corporate risk management models and practices quickly filled this gap, but the helping professions in Australia largely failed to recognise the significance of these changes to the construction of an ethical and inclusive professional practice and the implications for judgment and discretion. There was a marked failure to address the relationship of risk to individualised care. As a consequence, a number of problems identified in the UK literature have emerged.

First, as Munro (2004, 2010) in relation to child protection, and Evans and Harris (2004) to community care, so lucidly demonstrate, risk management means that workers come to rely on routinised procedures to protect themselves in the context of complex and idiosyncratic practice problems, instead of their experience and judgment. Risk management, when detached from socially inclusive practice and the exercise of judgment, erodes professional confidence and deskills workers for complex decision-making. These forces can only be balanced by developing practice standards and by the refinement of skilled professional judgement.

Second, the management of risk in contemporary community care demands a very different approach to risk management than the conventional corporate models designed to protect service providers and their workers from error and blame. Managing risk in the interest of social inclusion and autonomy requires a negotiated approach to managing risk between the provider and their client, and in the context of complex care it also means sharing risks between different service providers. However, as Hood *et al.* (2004) pointed out, risk management inevitably encourages the development of a blame culture, which in turn encourages organisations to adopt practices which are 'defensible' instead of practices which are 'right' (Taylor, 2006: 1424). Procedures for sharing risks with clients and partners are seldom found in corporate risk manuals. Rather, these procedures are designed to protect each specific organisation and their professionals from the consequences of adverse events. So powerful are these effects that practice can be explicitly defined by the need to defend and protect the organisation, rather than fulfil the objectives of social inclusion.

Third, contemporary approaches to risk management give special significance to critical and adverse incidents. Their dominance means they come to define in retrospect what constitutes an 'acceptable' or 'unacceptable' practice. One of the perverse effects is that poor judgment and practice can be considered appropriate, by default, if *nothing* goes wrong; but reasoned and informed decisions about risk are perceived as error and poor practice if *something* does go wrong (Taylor and Donnelly, 2006: 247–53). Increasingly, high dependency and high risk community care requires some commonly accepted benchmarks for what constitutes 'good' practice and acceptable risks. There is a need for a broader range of stakeholders to confront this problem of defining what is a good and acceptable risk practice, rather than retrospectively making judgments about practice in inquiries and courts of review examining so-called adverse incidents and 'errors' (Robertson and Collinson, 2011: 159–60).

An Australian study of risk and community care

In order to study these issues in an Australian community context, the Australian Research Council approved an extensive study of frontline practice, focusing on service providers, frontline workers and service users' experiences of individualised care, the management of risk and adaptations to these changes. The thematic stories discussed here are drawn from interviews undertaken as part of this qualitative study of twenty-four Victorian community services across three sectors: disability, aged care and mental health. Initially, twenty-four interviews were conducted with Chief Executive Officers and senior-level managers, after which 103 in-depth interviews were conducted with service managers, frontline workers, clients and family carers.

This article draws specifically on the interviews with the nineteen service managers and forty frontline workers who participated in the study. Interviewees were asked about their interpretations and experiences of reconciling risk and social inclusion objectives in the context of occupational health and safety rules and organisational responses to adverse incidents, and the impacts of risk management policies on their work with service users more generally. With the exception of only two managers, all fifty-nine participants had previously worked on the frontline and were very well acquainted with the minutiae and demands of frontline work.

We explore the world of high risk community care through the evolving practice of frontline professionals and service managers as they engage with their clients and other key participants in the realisation of greater autonomy, individualisation and choice, while meeting increasing accountability and risk management requirements. These stories illustrate the complex ways in which the relationship between social inclusion, risk management and discretion is negotiated, processed and resolved by frontline workers.

Reconciling social inclusion and risk at the frontline of community care

Policies of social inclusion require the re-shaping of care at the level of interpersonal relationships. As Fine (2005: 257) so aptly defines it, care is 'the outcome of a relationship between the different parties in which mutual respect, and the fostering of the capabilities and autonomy of the recipient are foremost'. The client is therefore 'entitled to have his or her sense of self or subjective experience taken seriously by those with whom s/he interacts' and this means that 'both the "what" and the "how" of the service need to be oriented to the individual considered as a unique centre of subjective experience' (Yeatman, 2009: 16). It follows then that the process of balancing the client's freedom to choose how to live and the worker's 'duty of care' to protect him/her from risk is built on rational negotiation between two parties in the context of an open, trusting and mutually respectful relationship. Here risk management is integrated with socially inclusive practice.

We can see how the management of risk is integrated with socially inclusive practice and the exercise of professional discretion in a story told by Sandra, a manager from an aged care/disability service, about a client with muscular dystrophy. She shows how such open negotiation in arriving at a clear risk agreement is empowering for both worker and client. Described as 'very intelligent' and 'very capable', this woman,

'whose body is failing her miserably', wished emphatically to remain living alone at home:

> She says, 'Look at the end of the day, my choice is to live at home – if I have to lie on the floor for two hours in the middle of the night if I've fallen out of bed . . . that's the risk I want to take, because I do not want to go to a nursing home at fifty'. So look, we'll do all the checks that we can, but she put it very nicely: 'That's my choice, if I have an accident in bed . . . if I have to wait till the carer comes at seven in the morning, I'll wait . . . there are emergency services but if people can't come, that's the choice I make – not to live in a place where there's a nurse down the hall'. So it's about agreeing on risk, and getting permission to put certain things in place to manage the risk.

Here Sandra expresses respect for her client's needs and individuality and has considered her point of view by creating space for her to speak openly about her concerns. The relationship between worker and client is based on mutual respect; Sandra facilitates the client's decision-making and autonomy, which is empowering for both worker and client. In this example, 'risk' is seen as integral to the practice of community care, and is also constructed both positively and negatively. The client is seen as having the right to risk-taking, independence and choice; she makes a decision to lie on the floor and wait for assistance should she get into difficulty over night, rather than enter residential care 'where there's a nurse down the hall'. In addition, however, workers must ensure that 'certain things' are organised to reduce potential risks, thus upholding their 'duty of care' according to professional ethics and organisational policy. The client is conceptualised as a partner in the care she receives; this is demonstrated through the active negotiations over how risks are to be managed. Her opinions are sought and discussed openly; 'it's about agreeing on risk' and 'getting permission' to manage it in specific ways.

Many organisational risk management regimes construct duty of care in negative, defensive frames, aimed at protecting the service and their workers from error and blame. Risk is to be avoided at all costs. In such situations, risk management is detached from socially inclusive practice. This means assessing for the risk of harmful consequences by focusing on a person's deficits rather than his/her strengths and needs. Kate, a manager of a mental health service, felt troubled that risk-averse policies could deny some clients 'a full opportunity at times to do what they need to do' in order to deal with traumatic experiences. In a similar vein to Robertson and Collinson's (2011: 156) participants, who 'talked of how they had a duty to enable risks to be taken by service-users for [future] positive outcomes', she discussed having taken a very carefully calculated risk with a suicidal client. This caused alarm amongst other agencies, but she felt that it was important to respect his individual needs and, in one particular matter, allow his expression of grief, rather than simply admitting him involuntarily to hospital. This client had a recent history of self-harm and frequently talked about harming himself:

> He was a very isolated individual and his dog was very important. His dog was dying . . . and the vet recommended putting the dog down and he asked if he could have time alone with the dog and I thought, 'This is one of those times where it's a judgment call' and I felt confident enough to say 'I'm going to take the risk'. Because he had been talking about . . . if the dog had to die that he was going to die with the dog and I made the judgment call, but I could see that was really important for him and I drove him home to have time with the dog. I picked the dog up from the vet with him and gave him a period of time . . . and he brings up regularly that we

did that together and he knew not many staff would have trusted him and would have given him the opportunity.

This excerpt points to the underlying tensions between risk management guidelines that focus exclusively on ensuring safety and avoiding critical incidents, and client autonomy and choice. There is often 'evidence', in the form of the client's history, that informs duty of care decisions and the need for restrictions on client choice. With heightened sensitivities over reputation, many services emphasise such restrictions, 'increasingly concerned with protecting themselves *against* vulnerable clients, carers and families' (Carey, 2007: 99).

However, workers may be confronted with a situation where a client's capacity to exercise some control and decision-making may be more important than the risks arising from denying this control. The professional who knows the client well will recognise the significance of the exercise of autonomy and decision-making in fostering the individual's capabilities and 'needs as a self' (Yeatman, 2009: 10). The fostering of these capabilities heightens the client's independence and social participation, and thus his experience of social inclusion. Borrowing the words of another manager in the study, this particular example illustrates the worker's 'appreciation of being able to sit with those discomforts [of not having control over the situation] . . . for a better outcome over time'.

Many experienced professional workers have developed their own risk management strategies over the years, which may not be compatible with current more stringently applied occupational health and safety requirements. Several workers claimed that these regulations often seemed oriented to protecting workers and the organisation rather than clients and could, in some instances, hinder relationship building with clients.

Like other community nurses in our sample, David, who works in a home-based nursing agency, admitted to going beyond the realm of his clearly defined nursing duties to help a client who was aged and frail. In this passage, he explains how he weighs up the occupational health and safety risks involved in changing a light globe, a 'non-nursing duty' that he is 'not allowed to do':

> 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 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 . . . I would change a light globe . . . it was something that I was able to help out with and was a five minute job, but outside the realm of my role and responsibility. But 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.

David sees this 'five minute job' as an act of compassion, but he also sees it as risk-reducing in itself. The story illustrates this worker's resourcefulness and independence as a professional operating alone and exercising discretion. He calculates his options by undertaking his own 'risk assessment', leading to a decision to breach the policy based on both the probability of an adverse outcome and his own professional assessment of other issues involved. He approaches 'risk' in terms of the well-being of a frail, aged client,

focusing specifically on maintaining her safety and quality of life at home, and responds accordingly. Thus, his actions in changing the light globe demonstrate an individualised response to her particular needs, which fosters her independence and ultimately her social participation.

Standardised rules and procedures can create competing goods, between the official, objective 'good' and the 'good' embedded in the subjective world of actual practice with individuals. In this situation, however, the worker used his own resources, experience and judgment, that is he exercised 'agency' in weighing up the likelihood of an adverse outcome, and acted accordingly in the interests of the client.

Interviewees from aged care services spoke at length about the complex range of risks involved in providing community care for the growing population of people with dementia. The public policy imperative to support clients to live at home for as long as possible often meant balancing risks in terms of distinct alternatives, a 'normal' life with increasing but familiar risks as against a 'restricted' life with unfamiliar risks. For a person with dementia, living at home is inherently risky, but the familiarity of the home environment and neighbourhood provides a degree of security, autonomy and continuity, along with possibilities for social inclusion. On the other hand, transferring to the 'safety' of residential or hospital care, as several interviewees argued, could mean a range of new risks in an unfamiliar environment: sleep disturbances, infections, increased disorientation and increased risk of falls and, ultimately, reduced physical and mental well-being and reduced quality of life. Although a person with dementia living at home is 'exposed to risk', as Michael, a frontline worker/team leader, explained, one has to weigh up the course of 'greatest benefit and least harm'.

The process of navigating these tensions is clearly illustrated in a story he told about a client with 'moderate dementia', who lived alone at home and 'had a routine of occasionally taking herself down to the McDonalds in the morning':

> She was getting daily nursing visits to provide her medication, and periodically the nurse would ring me and say, 'Look I can't find the client' and I'd say, 'Just go down to McDonalds'. By all accounts she was probably physically exposed to risk, but what was working was that it was a routine that she knew, she could get there and back, she didn't have to cross a road which was the main thing, but yeah . . . she could have fallen and been out of range of support – but my view with that client was that if we had tried to circumvent that, she would have tried to circumvent our efforts, so working with the strength, working with the person's capacity – it's something she enjoys, so you're not going to take it away – the nurse would go down there and give her the medication in McDonalds.

This excerpt shows the very careful reasoning processes in which this worker has engaged to mount an argument for supporting his client at home. In recognising her particular 'strength' and 'capacity' and the activities 'she enjoys', he demonstrated an individualised approach to her care where her safety and security, her social participation and experience of autonomy were given centre-stage. At the same time, he was patently aware that, should an adverse event occur, the service could be seen as 'holding' the client 'too long' at home. Like several other interviewees, this worker was concerned that there were no common community or political understandings regarding what constitutes 'acceptable' or 'unacceptable risk' in the home-based care of older people. He felt that 'a working agreement about risk in the community' was needed at a political level to

'validate what is occurring in terms of risk management and why it's occurring'. Robertson and Collinson (2011: 160) also recognise the importance of educating the public about the way in which services support their clients, including the possibilities of 'positive risk taking occasionally failing'.

Herein lies the trip wire of a potentially adverse event which will usually be judged, after the fact, to have been caused by error. In the contemporary climate of increased community expectations that professionals and services should be able to control an ever-expanding array of risks and therefore media coverage based on the assumption of failure, the effectiveness of a service's risk management tends to be assessed in terms of the *outcome*, rather than the *decision-making processes* involved (see Munro, 2004, 2010). Hence, every adverse incident is a potential threat to an organisation's reputation, depending on the way it is constructed and reported and who is seen to be at fault. This means that the worker internalises the 'potential' or 'what if' scenario of a future adverse event in his/her problem-solving and risk analysis (Rose, 1998: 185), together with the imperatives of policy objectives and professional ethics.

Conclusion

We conclude this analysis with the contention that risk management and social inclusion in community care, generally presented as representing different paradigms of contemporary practice, are inextricably interrelated and interdependent. Evans and Harris (2004), drawing on Lipsky's (1980) classic analysis of street-level bureaucrats, argue that professional agency, creativity and discretion are essential in community care. Our findings support this position. The innate complexity and unpredictability of street level community care, together with the need to reconcile apparently competing policy imperatives, requires practices and decisions based on risk-taking, risk avoidance and contextually specific judgments. Even the most risk-averse and procedurally bound services cannot regulate for all events and, more significantly, they cannot anticipate those informal risk 'agreements' which are based on the relationship between the service user and worker (Robertson and Collinson, 2011).

When the nurse 'unlawfully' changes the light globe, a severely disabled woman elects to face the night alone at home, a dementing client is supported to wander restlessly in her neighbourhood every day, both clients and workers are exercising considerable discretion, 'reinterpreting' standard procedure on the basis of a normative view of professional commitments and the significance of a relationship which supports some degree of risk-taking based on judgment and trust. Socially inclusive and personalised community care requires a complex risk-taking and risk-managing street level practice.

However, neither the lofty policy objectives of social inclusion nor the meticulously prescribed procedures to manage risks confront this praxis. Frontline workers and their clients, in contrast, do so in both the small decisions they make every day and sometimes in major decisions which significantly impact on their lives and work. This article has set out to recognise and respect this reality and its centrality to twenty-first century community care (Taylor, 2006: 1425).

While community care has made many advances in response to the policy objectives of social inclusion and individualised service provision, risk management has continued to be driven by regulatory measures framed by procedures, check lists and the continuing further restriction of professional discretion and judgment. Governments are reluctant

to open up consideration of what constitutes acceptable risk in community care, and there has been little progress in the formulation of standards which would guide not only discretionary decision-making but how different service providers might be able to share risks with their clients and with each other in complex community care. We explore these areas of development for risk management in our report of the Australian Research Council project which has informed this project (Green *et al.*, 2010).

Acknowledgements

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