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Soapbox: Technical, relational and relational-collaborative approaches to risk management

Percy Aggett and Philip Messent
East London NHS Foundation Trust, UK

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In the run-up toChristmas 2017, I (P.A.) returned home to a home full of blazing coloured lights festooned in every room, placed there by my partner. The thought occurred to me to check each power supply unit as they had been reused from a previous year. One of the units was very hot to touch and was emitting a strong smell of burning, and following a conversation, my partner and I removed it.

In a large Child and Adolescent Mental Health (CAMH) service open-plan team room, housing approximately 40 clinicians and support staff, I (P.A.) noticed that staff were continuously talking about risk and seeking advice in similar ways, in what were often, short but effective consultations with seniors or one another. I began to notice that these consultations involved several key domain areas for discussion and that these were enthusiastic, generative, safe and collegiate conversations, in contrast to the tense and stilted nature of many more formal discussions about risk management in multidisciplinary team meetings.

A very able staff member complains that she is hesitant about speaking at such multidisciplinary team meetings because every time she speaks, 'someone knows better'. She becomes anxious when this happens and reports that she therefore does not disclose what she really thinks and feels. She says that she doesn't feel safe.

Introduction: three approaches to clinical risk

In this article, we develop further the arguments made in a previous paper in this journal (Aggett, Messent, & Staines, 2013), proposing a model of risk management that moves away from an overemphasis on 'technical' approaches to ensuring that this is balanced by organisations supporting 'relational' approaches and further, 'relational-collaborative' approaches.

We contend that events such as those described above occur all the time in the organisations in which we work, but we hardly notice them. And we think that they tell us a lot about what kind of organisations provide a secure environment for practitioners which will enable the sort of conversations that enhance clinical risk management (Vetere & Stratton, 2016).

Corresponding author:
Percy Aggett, 3, Ossian Road, London N4 4DX, UK.
Email: Percy.Aggett@Lineone.net

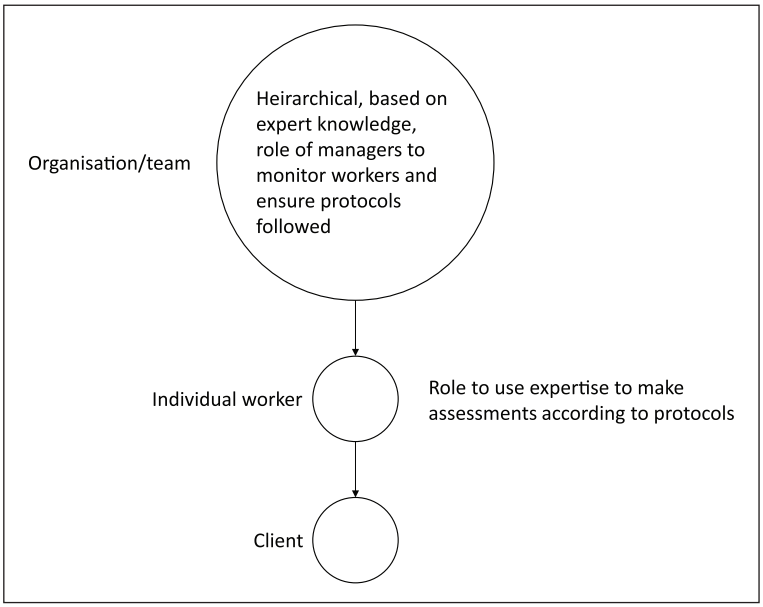

Figure 1. A technical model.

Clinical risk and its management have had an increasing influence upon how clinicians and their managers think about their work over the past 15 years in CAMHS and other public services. In National Health Service (NHS) CAMHS clinics, cases seen by clinicians in recent years have all received a risk-rating (sometimes without any discussion about this with clients), with plans for assessing and managing perceived risks having to be drawn up and filled in on approved forms, in what we might term as a formal or technical approach to 'risk management'. Risk is largely assessed by clinicians as if it is within their domain of expertise to measure it with certainty and to know how best to respond to it with clarity, supervised and monitored by senior staff and managers. This way of thinking about risk and its management, largely borrowed from other domains of risk analysis, and illustrated in Figure 1, has dominated risk discourses in a number of fields for many years and one can discern the reasons why; it arises cumulatively from the necessary and mandated post hoc analysis of critical incidents, has value in giving clarity to clinician thinking, particularly in emergencies and crises, and enables accountability in clinical decision-making. Focusing the busy clinician on the analysis of the nature of the risk, who or what might cause the risk, who or what might be affected by the risk and what factors might limit the risk, is clearly invaluable. It is easy to see why this approach has had such currency, but as outlined in our previous article (Aggett et al., 2013) we think that it may lull leaders, clinicians and teams into a false sense of security, unless complemented by other, more interactive, and conversational approaches. Indeed, this has been borne out by the findings of systematic enquiries into critical incidents, in the United Kingdom and internationally, where organisational culture and not necessarily or solely the absence of protocol created a context for harm and injury (HM Govt, 2013; NASA, 1986).

In CAMHS, we see clinicians as struggling on a moment-to-moment basis with three challenging tensions: (a) trying to be effective/facilitate change, (b) trying to construct helpful relationships/alliances with clients/families and (c) at the same time managing clinical risk (King's Fund, 2008). These are continual and complex tensions across all sectors of healthcare and may be related

to different individual cognitive sets and feeling states, and situational contexts. Clinicians in our experience often report continual uncertainty, fear and an experience of critical scrutiny as they find ways to manage these tensions. Our organisations in the main appear to prioritise the technical (i.e. protocol-driven) management of risk over everything else.

Pressures on CAMH organisations

In addition, the pressures on CAMH services have increased tremendously in the past couple of years amidst cuts to services, service re-structuring, increasing amounts of self-harm and emergency presentations (Frith, 2016), and multiple nationally driven quality improvement initiatives. As community services contract, specialist services experience greater referral rates, creating a vicious circle. There may be limits to service improvement plans so that despite efficiency improvements, cuts to resources will have a deleterious effect on good risk management. But clinicians struggle on an hourly basis with clinical risk management throughout such changes. These pressures demand generative, thoughtful and benevolent supervision, leadership, management and organisational practices.

National quality discourses have had a lot to say about therapy effectiveness and alliances, and service improvements (CYP-IAPT, 2018), but with the exception of the Munro report (Munro, 2011), the Thrive typology (Anna Freud Centre, 2018) and therapy methodologies working in the safeguarding domain (Bevington, Fuggle, Fonagy, Target, & Asen, 2013; Goodman & Trowler, 2011; Henggeler & Schaeffer, 2016; Jakob, 2018; Turnell & Edwards, 1999), there has been little that acknowledges the ongoing stresses faced by CAMHS clinicians in the domain of risk or offers generative ways of managing it (Vetere & Stratton, 2016).

A second discourse: the relational approach

In an earlier paper in this journal (Aggett et al, op. cit.), we argued that there are two discernible discourses about clinical risk management, that *both are important* but that one had been privileged to the detriment of the other. One, what might be called the *technical* approach, concerns itself with the post hoc analysis of incidents and creates protocols, following 'single causal point' analysis to prevent such events occurring again; in this description the clinician is viewed as a lone actor 'assessing risk' and acting on it, with varying degrees of collaboration with the client and his or her organisation. Along with protocol development, large structural changes in organisations are often seen as solutions to what is considered poor risk management. The other, which we termed the *relational* approach (as illustrated in Figure 2), locates risk management in the micro-interaction and conversations that occur between colleagues and with client families, in the self-talk that clinicians engage in when assessing risk and in the kind of open conversations taking place within multidisciplinary teams.

We showed that there had been a concern in high-risk industries like aviation, fuel and investment finance to the same effect, and that there were worldwide moves across industry and commerce to re-balance the two discourses by finding ways, in leadership programmes, management strategies and service organisations to capture and work with the messy complexity of practice in predictive rather than retrospective ways (Schon, 1983). We see our services as lagging behind such change in a way that is to the detriment of both our staff and our clients.

Protocols and structures

We are mindful that one of the core complaints of busy health and social care staff is the amount of form-filling, a lot of it online, which now has to be completed before, after and often during

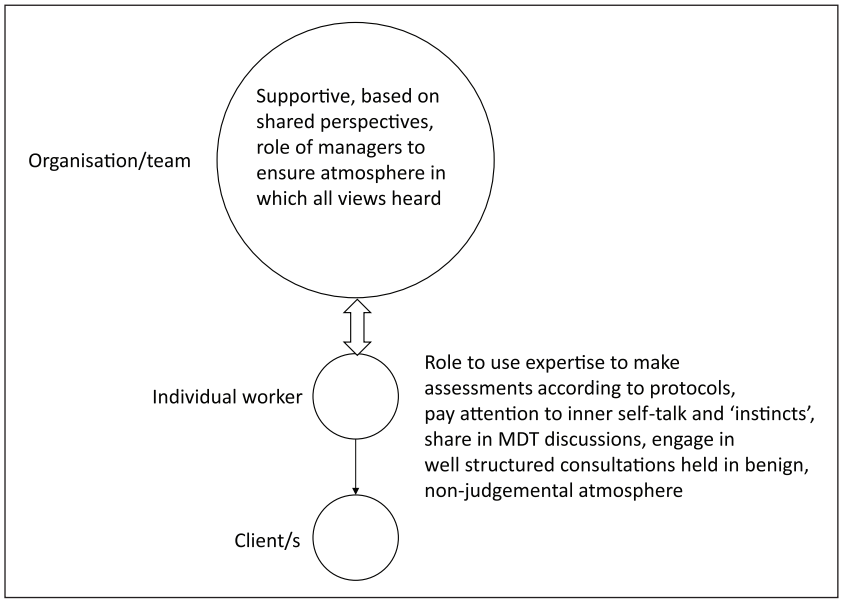

Figure 2. Relational model.

conversations with clients. We argued that this focus on form-filling follows upon this overemphasis upon a technical approach, relegating the actual, daily, relational approach to risk to the sidelines. Ironically, this contrasts with a key finding from over 40 years of scrutiny reports in child and adult safeguarding and mental health that a key contributor to poor risk management is poor team and multi-agency communication. Solutions to poor team communication are often located in service reorganisation rather than equipping practitioners and leaders in ways to talk effectively and collegiately about risk. Training for leaders in CAMHS, (assuming they receive training at all) is likely to be in the former approach, not the latter.

And the relational approach *is* messy. What actually was going on inside my (P.A.'s) mind when I decided to bend down and check the power sockets? I would argue that a number of different things were happening. I had read somewhere about house fires being caused by faulty LED light sockets; I was aware that all the lights were being used again and may be paired with incompatible sockets; I have a cognitive set that assumes that the worst may happen; I am a little bit anxious generally; I could speak about it to my partner; had one of my senses, outside of my present awareness, picked up that something was not quite right?

Are line managers, clinical team leaders and supervisors in CAMHS trained or given support in focusing on this kind of self-talk about risk? What are the conversational ethics in the sort of rapid informal consultations described above? How can successful relational risk models be modelled and taught? How do clinical team leaders chair meetings in a way which bring forth the best conversations about risk, in which different positions and views can be heard respectfully allowing a way forward to emerge? How can multidisciplinary team meetings be chaired in a way which enables clinicians to disclose self-talk, hesitation, errors, mistakes and so on? And how can we create ongoing learning contexts within organisations to discuss regularly how risk has been managed well, as well as drawing from times when things have gone wrong? (Aggett et al, op.cit).

In psychiatry, psychology and nursing clinical decision-making and risk management models have only in the last 20 years crept into training programmes, and in some therapy discipline such

trainings are currently sparse (Magnavita, 2016). One of the complaints of psychiatrists in busy CAMH teams is that they commonly become the holders of the 'risk agenda' and can feel 'dumped on' by other colleagues in matters of risk. *One way forward would be to develop a core relational and technical risk management training skill set for all CAMHS clinicians and insist that all therapy tutors on courses are equipped to teach it.*

Arguably, our emphasis here on the centrality of clinician experience is harking back to what seems like lost knowledge – the early work of Tom Main and colleagues in underlining the importance of understanding clinician stress and the inner world of the busy clinician in mental health services (Main, 1957). Technical approaches to mental health, though very important, tend not to capture the messy daily interaction between clients, therapists and teams. 'Reflective practice' or 'self-reflexivity' should be seen as major resources in modern risk management, not just as ways of improving alliances or facilitating more client change.

Recent research

Research in experimental psychology on attribution bias and on the cognitive and emotional complexity involved in risk appraisal may be helpful here (Kahneman, 2011; Loewenstein, Weber, Hsee, & Welch, 2001; Slovic, Finucane, Peters, & MacGregor, 2004). This work might explain that 'hunches', 'intuitions', so often not captured in the technical paradigm, are actually very rapid environmental appraisals outside the clinician's current awareness that clinicians and managers can be trained to be aware of and act upon. How often have we heard clinicians who have just had to undergo a scrutiny enquiry say, 'I knew something was wrong but wasn't sure, wasn't sure what to say. I wish I had talked to someone'. We contend that this is a key attribute of the relational approach – to pay attention to the direct, often intense self-talk going on inside clinicians, and to create an organisational climate in which clinicians can feel safe to give 'voice' to these in brief consultations, supervisions and multidisciplinary team meetings. I (P.M.) have written elsewhere (Messent, 2016) about some of the ways in which managers and teams can together foster such a collegiate atmosphere. It demands advanced skill sets in leadership and communication, generative and positive organisational values, and is not well supported by current technical models.

Going beyond the organisation: relational-collaborative approaches

The belief that risk can be well managed from within CAMHS multidisciplinary teams is itself based on a dangerous fallacy that, within the context of their often brief contact with client families, CAMHS clinicians are the *sole* evaluators of risk and its management. This fallacy leaves clinicians burdened with an unrealistic sense of their own ability to assess and manage risk. Client families are themselves managing these risks on a daily, hourly, minute-by-minute basis and will themselves have ideas about levels of risk and how best to manage it. Except in exceptional cases the most effective way of reducing risk involves holding collaborative conversations with families in which family members feel that their own anxieties are being heard and recognised, and in which they can feel supported to make plans for reducing risk, rather than by clinicians taking a disengaged stance and trying to direct family members on how to behave (though there is of course a place for offering expertise in the course of such conversations). In such conversations, it is likely that resources in the extended family and community will be identified, which would not have come to light in the more hierarchical, expert-led technical approach to risk management (see Figure 3). The vital skill set of creating a context for such conversations would be a core component of the risk-management training we are advocating.

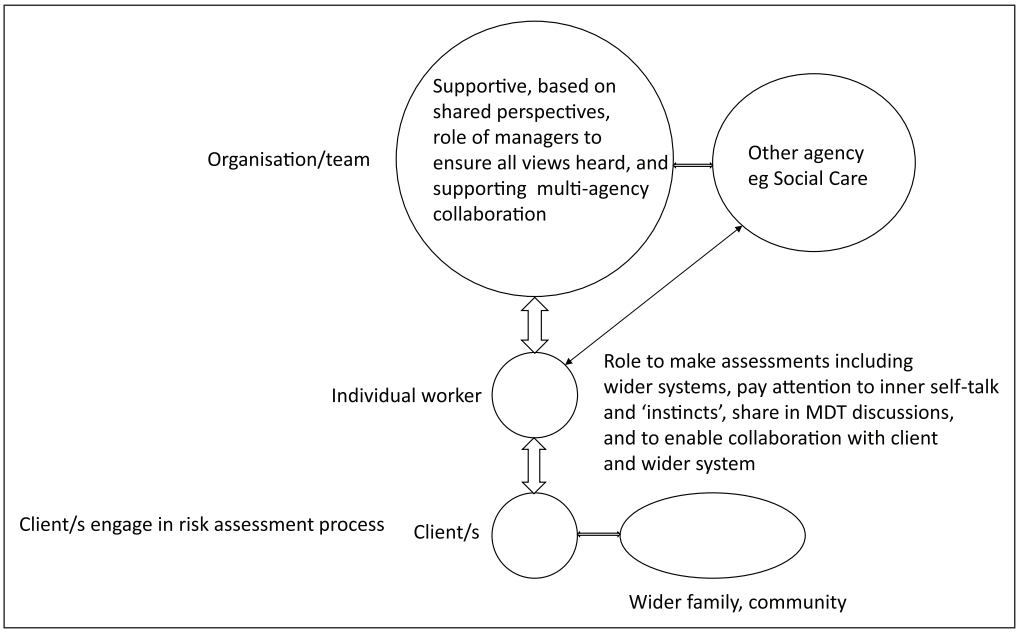

Figure 3. Relational-collaborative model.

Another focus for such training would be in collaborating effectively with colleagues from other agencies. Many of the findings of serious case reviews (Reder, Duncan, & Gray, 1983) have noted poor inter-agency communication. Yet risk assessments are conducted by individual agencies and rarely in our experience shared between agencies; it is as though each agency is conducting its own risk assessment to show that it has performed its duties properly, without giving thought to the way that agencies will manage such risks more effectively if they do so in collaboration with each other. Again, it is easy to see why this approach has continuing influence, with individual agencies likely to be held legally culpable for any shortcomings in the services it provides. One practitioner had an experience when his words and actions featured prominently in a risk assessment completed by another agency involving a young person who was at considerable risk, effectively described as performing a central role in that agency's action plan for reducing risk, yet without this ever being communicated to him! It was only when something went seriously wrong for this young person that this record was shared as part of a case review. How could things be done differently? Why not share multi-agency risk assessments and risk management plans for families where there are several agencies involved, in the same way that multi-agency plans are agreed in Child Protection reviews? This would take a reconceptualisation of risk as a shared responsibility, rather than belonging to one clinician or agency. Such a shift would also mean a reduction in the (unrealistic) burden of responsibility for individual clinicians and teams. The 'Signs of Safety' approach to child protection (Turnell and Edwards, op.cit.) describes one methodology for a more transparent and collaborative way of assessing risk, with each agency completing the same 'Risk and Well-Being' scaling tool for a joint meeting with the client parents, then setting safety and well-being goals, agreeing on 'what needs to happen' and steps towards these goals. Stanley, Keenan, Roberts, and Moore (2017) have described one multi-agency initiative in Birmingham, England, where this approach has been adopted to shape the 'early help' services across the city, replacing in the process over 80 pre-exiting assessment tools in use by separate agencies.

Creating bridges between risk approaches

We are arguing here, therefore, that we should develop models that act as useful bridges between technical and relational/collaborative approaches. For example while checklists are used extensively in aviation, fuel industry and surgical teams, it is the *dialogue between team members* focused on the checklist that reduces risks considerably (Gawande, 2010). One anecdotal example in our experience is how non-medical junior CAMH service clinicians are trained to perform self-harm assessments in acute hospital settings. Checklists help busy clinicians to remember to ask very significant questions such as – *has the patient had previous A&E attendances for self-harm? In the opinion of the medical team, is the patient medically fit for discharge? How was the patient's mood in the weeks leading up to the overdose?* However, relational skills are needed in creating a context for exploring the meaning of what has occurred with clients and their families, communicating with the ward staff and other agencies, knowing when to take advice from psychiatric colleagues and in bringing relevant members of the network together in a crisis situation to collaborate in creating a safety plan. Junior staff will need training as much in these skills as in following more technical checklists.

Summary: creating safe and generative organisational cultures

The current emphasis on designing services from the bottom-up, co-produced with clients and taking seriously the complaints, concerns and ideas they have about service improvement, complemented by a culture of shared decision-making is to be welcomed at all levels, but could also be extended to how risks can be best assessed and managed; one can't create a service ethos based on privileging service-user feedback without paying attention also to feedback from practitioners. This feedback from practitioners is only called forth and can only be utilised effectively in *safe* organisations, where fear is kept to a minimum, where practitioners feel respected when they speak, where meetings are conducted in an atmosphere of safety, and where technical approaches are complemented by relational approaches. Going back to the threefold tensions we described earlier – the task of clinicians, alongside managing clinical risk, is to develop close enough relationships and alliances with clients to produce change; to do this clinicians need to tune into/*really* listen to the client. To enable clinicians to do this effectively, over long time cycles and without the risk of burnout, clinicians need to be treated in a likewise manner by the organisation. Our contention is that in such organisations clinical risk will be better managed, clinicians better protected from burnout and outcomes for clients improved.

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Author biographies

Percy Aggett is a systemic psychotherapist who engages in teaching, supervision, and consultancy. He is interested in creating safe and imaginative organisations where workers feel supported,and effective, despite stresses.

Philip Messent is a systemic psychotherapist who engages in writing, teaching, supervision and consultancy. He is particularly interested in working with services to put into practice systemic approaches to clinical risk management.