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Health risk escalators and the rehabilitation of offenders with learning disabilities

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Abstract

This paper presents a study of risk management in a hospital within the UK. National Health Service which attempts to rehabilitate offenders with learning disabilities. Analysis is based on the metaphor of a 'risk escalator'. Health and social care systems can be characterised as risk escalators if they possess three attributes. Firstly, risk managers should agree the rough ordering of the severity of a set of related risks. Secondly, a repertoire of responses which provide different trade-offs between autonomy and safety, and which can be calibrated against risk severity, should be available. Thirdly, the potential for positive and/or negative feedback, which give risk escalators their dynamic character, should be identified. Risk escalators may be deliberately designed, or may, like the hospital regime discussed in this paper, coalesce from pre-existing sub-systems offering different autonomy/safety balances. They may carry service users upwards towards greater safety if needed, as in health screening systems, or downward towards greater autonomy if justified, for instance in rehabilitation systems. Their therapeutic status is contestable. Upward risk escalators can be accused of generating positive feedback, with iatrogenic effect. Downward risk escalators may be criticised for pushing service users too strongly towards less intense interventions, causing neglect. The present case study brings out emergent properties of a downward risk escalator, including: organisational disruption to system functioning; preferencing of safety over autonomy; active and reflexive system management by clients; multiple, organisational risk rationalities; and the reification of riskiness as a generic attribute of individuals. © 2002 Elsevier Science Ltd. All rights reserved.

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> What then is the role of the psychiatrist in penal matters? He is not an expert in responsibility but an adviser on punishment; it is up to him to say whether the subject is 'dangerous', in what way one should be protected from him, how one should intervene to alter him, whether it would be better to try to force him into submission, or to treat him. (Foucault, 1977, p. 22)

Introduction

This paper will, firstly, discuss the concept of risk escalator (Heyman & Henriksen, 1998, pp. 95–103). It will then illustrate the applicability of the concept to the analysis of health care systems through an illustrative case study of a hospital concerned with the rehabilitation of offenders with learning disabilities. Hospital staff confronted the dilemma of balancing patient safety against autonomy. They were required, on the one hand, to ensure that released patients would not pose an unacceptable risk to the public, but, on the other, to ensure that patients were not institutionalised for longer than was necessary. The concept of risk escalator provides a way of understanding how human service providers attempt to deal with the autonomy/safety dilemma within complex care systems.

In April 2000, the transfer of Dutch footballer Ruud Van Nistelrooy broke down when doctors working for the purchasing club, Manchester United, asked him to undergo keyhole surgery so that possible long-term knee

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damage could be investigated. The footballer declined on the grounds that his injury was minor, and that investigative surgery would actually impede his recovery. Shortly after the deal fell through, Van Nistelrooy suffered a training accident to his knee. Dutch commentators suggested that the accident had occurred because he had been playing exceptionally hard in order to prove Manchester United wrong. According to this account, a preventative endeavour had increased risk. The concept of risk escalator brings out such feedback dynamics.

The concept of risk

Discussion of risk escalators must be predicated on an interpretation of the concept of risk. Only a sketch of a position can be offered in this paper. Risk has been defined as '*the* ***probability*** *that a certain particular* ***adverse event*** *occurs during a stated period of* ***time***' (The Royal Society, 1992, p. 2, present authors' emphasis). This definition treats risks as natural events which can be objectively assessed. However, alternative epistemologies have been proposed. For example, Lupton (2000, p. 29) has argued that the governmentality approach of Foucault generates a relativistic, 'strong' social constructionist analysis of risk reasoning. This approach treats the capacity to selectively highlight unacceptable risks as an underpinning of social power and control in science-based societies. The cultural theory approach of Douglas offers a weaker form of social constructionism, emphasising the relationship between selective attention to particular dangers and wider cultural concerns.

If risk is regarded as a composite, complex concept, built up from the four elements (probability, events, adversity, time) highlighted in the Royal Society definition, different epistemologies may be required for each (Heyman & Henriksen, 1998). 'Adverse events' can be reframed as negatively valued categories. Events may be categorised and grouped in many ways, although some classification methods will make more pragmatic sense than others. Event classes can be valued differently even though the common human condition guarantees some degree of universality. Time periods reference subjective but culturally mediated processes of future management rather than externally stated, arbitrary time limits. Finally, empirically based probabilities can be best understood in Bayesian fashion as referencing degrees of uncertainty derived inductively from observations of past frequencies of event sub-categories (Suppes, 1994, p. 18). Many, but not any, probabilities of the same event can reasonably be derived inductively from available evidence. Wynne (1996, p. 57) conceptualises risks as '*intellectual constructs which artificially reduce larger uncertainties to ostensibly calculable probabilities of specific harm. The tacit social assumptions which create such 'natural' frames are rarely expressed or recognised*'.

Health risk escalators

To operate as a risk escalator, a preventative system needs to be seen to possess three properties, discussed briefly below. It should be possible, firstly, to differentiate degrees of risk severity; and, secondly, to match these differences against responses which provide different balances between autonomy and safety. Thirdly, it should be possible for individuals to be propelled up or down a risk escalator by positive or negative feedback. These assumptions only reference shared perceptions. We do not propose, for example, that risk severity can be objectively measured, only that the operation of a risk management system is predicated on a presumed consensus about these three attributes.

The first requisite for the operation of a risk escalator is that risk managers must presume a consensus about degrees of risk severity. The term 'risk manager' refers, in this paper, to any persons who see themselves as engaging with a risk. In relation to the study discussed in this paper, it references, primarily, health professionals who attempted to balance rehabilitation against the risk that patients might re-offend. However, some concerns expressed by patients, and discussed below, for example that compliant offenders might be released too quickly, can readily be translated into the terms of risk discourse.

Calibration of risk severity itself entails a complex, value-dependent process of judgement. For example, hospital staff were required to concern themselves about the risks of patients re-offending in diverse ways. Index categories such as violence or sexual offending encompassed a variety of problems the severity of which might be homogenised or assessed differently. The consensual operation of a social system of risk management requires the backgrounding and taking for granted of such complex judgmental processes.

The second requirement for a care system to take the form of a risk escalator is the availability of a range of preventative responses, each striking a different balance between autonomy denying intervention intensity and risk-reducing efficacy. For example, vulnerable older people may receive home help, move into sheltered housing or be institutionalised in residences which provide varying levels of support. Children judged at risk of abuse by family members may be protected through social work visits, care/protection orders of increasing intensity, or removal from the family home. Our hospital research site provided a range of regimes which differed in staffing level, degree of surveillance, patient autonomy and separation from the external world. In these and many other cases, risk managers are faced with the same dilemma. The presumably increased preventative efficacy of more intense interventions has to

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