

Assessing risk within primary care: Logics, contingencies, histories

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A thesis submitted for the degree of doctorate in clinical psychology

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2016

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Acknowledgements

I would like to thank my supervisors, Ewen Speed and Susan McPherson, for their close reading of this work, pointing out areas of inconsistency and developing my thinking and thus the overall thesis. I would like to express my gratitude to the service who took part in this research. In a busy working environment, they gave me their valuable time and support. I would also like to thank the practitioners and clients who took part in this project. It goes without saying, but it goes better with saying, that this research would not have been possible without them. I would also like to thank all of the staff involved in the clinical psychology doctorate programme at the University of Essex. I have really valued the experiences and opportunities I have had throughout training, and the integrative approach taken on the course. This encourages an openness towards interdisciplinary work and thought, which has been crucial for the ideas I have tried to develop in this thesis. In particular, outside of the School of Health and Human Sciences, teaching and seminars run by the Centre for Psychoanalytic Studies and the Department of Government have enriched my thinking and so the ideas presented here. Finally, I would like to thank my cohort who I have enjoyed sharing ideas and experiences with over the past three years.

Summary

There has been an explosion of discourse about risk and risk assessment beginning in the 1980s, growing during the 1990s and continuing to accelerate. This has extended to the arena of mental health care where there is an expectation for services to assess and manage risks, and high quality clinical assessment has been re-described to incorporate risk assessment. This expectation obscures certain problems with risk assessment such as its accuracy, the selective nature of the risks prioritised, and the potential for it to enhance stigma and encourage defensive practice. It also obscures how risk assessment emerged out of a particular social and historical context, and was linked to high profile homicides, the introduction of community care, and a cultural emphasis on accountability and litigation. This thesis reconceptualises risk assessment as a hegemonic discourse within mental health care through an engagement with the theoretical concepts of the logics approach, rooted in poststructuralist discourse theory. It turns towards the actual clinical practice of completing risk assessments through analysing assessments completed within an Improving Access to Psychological Therapies service. An articulation of the social, political and fantasmatic logics influencing these risk assessments is offered. These assessments are characterised as functioning according to the social logics of *well-oiled administration* and *preservation* where bureaucratic process is prioritised, contingency ironed out and managing potential risks to the service predominates. These social logics become comprehensible within a competitive commissioning context with political logics of difference preventing an equivalence between practitioners and clients. Fantasmatic logics generated an investment in the process of completing risk assessments with a well-documented assessment offering protection to practitioners and the service from the obstacles that clients could become. Implications are discussed and *clinical perceptions of risks* offered as an alternative social practice that recognises the radical contingency of the social world.

Chapter 1: Introduction and Problematisation

1.1 Chapter Overview

This chapter introduces the empirical context and theoretical orientation of the research. It discusses its location within the literature and the initial moments of puzzlement that led to the development of this project. From here, the thesis turns to the social practice of risk assessment within therapeutic settings and considers its context, some problems with it and some of its consequences as part of an archaeological investigation. The chapter then moves in a genealogical direction and considers the ignoble beginnings of risk assessment within mental health following the killing of Jonathan Zito by Christopher Clunis. It ends by formalising the research questions being studied.

1.2 Introduction

This thesis took as its object the assessment of risk within primary care. The focus was not on one particular type of risk, such as the risk an individual posed to him or herself, rather, the focus was on the multiple ways risk surfaced and the way in which it was understood and responded to. This did therefore include the risk someone posed to him or herself, but also the risk posed to others, to services and to the wider social order. Risk can manifest in various ways; it can be explicitly stated by the actors involved, it can lurk beneath the surface, being talked around without being directly mentioned, or it can inform the structure of an encounter itself. All such manifestations of risk were relevant here.

1.2.1 Empirical context and material.

The particular context studied was duty screening assessments completed within an Improving Access to Psychological Therapies service (IAPT) in primary care. IAPT is a relatively recent phenomenon. It was launched as a government initiative in 2008 and involved the creation of new psychological therapy services across England to treat depression and anxiety disorders (Department of Health, 2008). This was a substantial development which involved an additional investment in the National Health Service (NHS)

of £173 million per annum, and by spring 2011, the majority of England had an IAPT service, 3,660 new cognitive behavioural therapy workers had been trained and over 600,000 people had begun treatment (Clark et al., 2009; IAPT, n.d.). These services were, and still are, seen as an important part of the overall implementation of the National Institute for Clinical Excellence (NICE) guidelines for depression and anxiety disorders.¹ In the current range of guidelines for depression and anxiety, NICE (2009, 2011) recommend a range of psychological and pharmacological treatments, and also specify a framework for the provision of services which is referred to as a stepped-care model.

IAPT slots into this system of stepped care and provides interventions at the primary care level (steps 2 and 3), with services at the secondary care level consisting of specialist mental health services (step 4). The stepped-care model is described as one where people receive the “most effective yet least burdensome treatment...and which has a self-correcting mechanism built in (that is, if a person does not benefit from an initial intervention they are ‘stepped up’ to a more complex intervention)” (NICE, 2009, p. 122). The duty screening assessments that formed the primary empirical material for this research are used to assess people’s suitability for the interventions IAPT offer, which include, at step two, guided self-help based upon cognitive behavioural therapy (CBT), group-based CBT and computerised CBT, and at step three, individual CBT.² Alternatively, they are used to inform a referral to specialist services. These assessments explicitly include an assessment of the risk an individual poses to him or herself, or to or from others, which is considered a key component of all mental health assessments and the stepped-care approach: people who present a “considerable immediate risk to themselves or others” are to be referred “urgently to specialist mental health services” (NICE, 2009, p. 18).

This thesis investigated the way in which risk was assessed within an IAPT service. This was done through analysing audio recordings of the duty screening assessments. Additional empirical material consisted of discourse about risk from a range of texts: policy documents, NICE guidelines, newspapers, mental health textbooks as well as theoretical and empirical studies.

1.2.2 Theoretical stance and strategy.

As with all research, the empirical material was considered from a particular theoretical orientation. The research was informed by the view that meaning and the social world can never be fully, or permanently, fixed. This ontological stance was informed by the approach to discourse theory elaborated by Laclau and Mouffe (2014). Following Laclau and Mouffe, this did not mean the social world was seen as a free-for-all where anything goes as some crude characterisations of social constructionist approaches contend. Rather, the view was that discourses can attain a hegemonic position that may be conceptualised as a partial fixation or stabilisation of meaning.³ These hegemonic discourses can be powerful, hard to challenge, and appear, crucially, as taken for granted facts or practices structuring the social. However, such discourses, despite attempts made to cover up their contingency, can never achieve complete sedimentation and so remain vulnerable to resistance and re-articulation.

There is therefore a radical contingency about the elements, linguistic and material, that constitute the social world, leaving a structural incompleteness in any system and a fundamental lack in the identity of subjects. Applying this to risk assessments, they become a social practice consisting of contingent elements located within a wider system of meaning. There can never be a full or complete risk assessment and contingency can be seen in various ways such as the risks being prioritised, who is at risk, how something is understood as a risk and what risks are excluded. Rather than being an essential and necessary component of mental health assessments, risk assessment becomes one way of doing things with a particular history and is linked to the projects of certain social actors.

This approach was applied in relation to the risk assessments studied here. More specifically, the thesis employed Glynos and Howarth's (2007) logics approach to discourse, which has grown out of the work of Laclau and Mouffe. The logics approach provides a framework for empirical, interpretative and critical research within the social sciences. It is a problem-driven approach to research which begins by confronting puzzling issues in the present. Then, through a process of reflection and engagement, a problem, or problematisation, can be constituted. In this case, Foucault's archaeological and genealogical

work, supplemented by the concept of hegemony (Howarth, 2002), informs the process of problematisation. This involves “a movement of critical analysis in which one tries to see how the different solutions to a problem have been constructed; but also how these different solutions result from a specific form of problematization” (Foucault & Rabinow, 1984, p. 389).

Following an archaeological and genealogical problematisation of risk assessment, a more detailed outline of the theoretical concepts and ontological presuppositions of the logics approach will be provided in the research strategy chapter. The three logics that constitute this approach are social, political and fantasmatic logics (Glynos & Howarth, 2007). Social logics refer to patterned social practices and can be thought of as the rules or grammar of a practice; political logics show the institution of a particular practice or regime; and fantasmatic logics refer to the grip a particular practice has over us. In short, these logics enable a characterisation of what practices are (social logics), how they came into being and remain so (political) and why (fantasmatic).

The analysis of the audio recorded risk assessments will then be presented. This will involve a characterisation of the empirical material using the logics framework. The argument constructed over the course of the thesis should be thought of as a critical explanation made through a process of articulation. The thesis will conclude by considering the extent to which this research offers a plausible account of its research object. This will involve a discussion of the research process and consideration will be given to what this can tell us about both risk assessment and a logics approach. This follows Howarth’s (2000) pragmatic view for evaluating research using a discourse approach “by the degree to which it makes possible new and meaningful interpretations of the social and political phenomena it investigates” (p. 130).

1.2.3 Place of research.

Within the academic literature, there has been an explosion of discourse about risk and risk assessment beginning in the 1980s, growing during the 1990s and continuing to

accelerate. As one example, *Risk Analysis: An International Journal*, first released in 1981, is a journal published by the Society for Risk Analysis and covers issues relating to the social sciences and mathematics (Wiley Online Library, n.d.). In the 1990s, this journal published 523 articles and between 2000 and 2009 this rose to 2,379 articles. In the last ten years it has doubled its number of pages and impact factor, and has gone from having four issues per year in the 1980s, to six in the 1990s, to twelve by 2009.

Within healthcare, *Risk Management and Healthcare Policy* was first published in 2008 and in 2014-15 published fifty three articles compared with fifteen in the first two years (Dovepress, n.d.). This increasing appetite for risk can also be seen when searching academic databases. Searching CINAHL Complete, MEDLINE with full text and PsycARTICLES in February 2015 using the term risk produced 2,109,852 articles, of which 1,973,962 (93.6%) were published since 1990. A slightly more refined search strategy of: (1) risk assess* OR risk manag*, (2) therap* and (3) mental health OR mental illness returned 341, 535 results, of which 331,290 (97%) were published since 1990.

Within this broad area of therapeutic risk assessment or management within mental health care, the published research varies in scope and intention. Broadly speaking, there is a body of work discussing methods of risk assessment (Buchanan, 1999), risk assessment instruments (Phull, 2012), different theoretical approaches to risk assessment (Doctor, 2004; Holloway, 2004; Witteman, 2004), and assessment of different kinds of risk, such as risk of violence (Langan, 2010) and risk of suicide (Cutcliffe & Barker, 2004). There is also work that has explored the practice of risk assessment from the perspective of those involved (Aflague & Ferszt, 2010; Godin, 2004; Moerman, 2012), and approaches using poststructuralist ideas to engage with risk (Crowe & Carlyle, 2003; Rose, 1998).

This thesis falls within the latter camp but offers an alternative way of engaging with risk assessment practices through the use of the logics framework and the distinct ontological position this offers. This involves an open engagement with work coming from alternative ontological and epistemological positions, but an attempt to understand such work from the ontological position of radical contingency. The thesis is also unique in engaging with actual

clinical practice as the source of empirical data, which is informed by the view of there being an overreliance on interviews within qualitative research (Potter & Hepburn, 2005), and a desire to place clinical practice centre stage. The logics approach is a relatively recent framework for empirical research and has typically been utilised to engage with issues of policy (Clarke, 2012; Glynos, Klimecki, & Willmott, 2012; Glynos, Speed, & West, 2015; Hawkins, 2015) and so the empirical context being studied here is also novel for this approach, although the logics frame has been used to study interview data relating to business education (Andersson & Öhman, 2015) and business board room interactions (Thompson & Willmott, 2015).

1.2.4 Puzzling issues.

The puzzling issues began from my own experience working within an IAPT service as a Psychological Wellbeing Practitioner, although not the service involved in this research, where I provided NICE recommended interventions and completed risk assessments. A range of questions arose from this experience. The training materials for the psychological wellbeing practitioner role describe risk assessment as essential and provide a recommended format for assessing risk: firstly assess suicidal intent, then specific action plans; following this, there is guidance on how to assess current or past actions, access to means, and then preventative factors; finally, risk to others, and risk of neglect should be assessed (Richards & Whyte, 2011). This recommended format is accompanied by “empathy dots”, and these are supposed to remind workers to “use statements of empathy at regular times in the interview”, although no examples of empathy statements are provided (Richards & Whyte, 2011, pp. 13–14). For subsequent interviews, an example of how to introduce a risk assessment is provided:

Last time we talked, I mentioned that sometimes when people are depressed they can feel so despondent that they feel like taking their own lives. You said that [insert summary of last risk assessment]. Can you tell me if there has been any change in this? (Richards & Whyte, 2011, p. 16)

The way in which people responded to the risk assessment had an impact on the services they received and these questions were asked in the context of a therapeutic assessment typically completed by telephone. My experience of this work raised a number of questions for me such as: *does asking standardised questions in this way influence the responses given? Can this information actually be obtained in such a straightforward way? How does the way in which the questions are asked inform the responses given? How does the context of the therapeutic assessment influence the responses? Would people respond differently if they knew how it may affect the service they receive?*

1.2.5 Tentative questions.

Completing these risk assessments was seen as the single most important aspect of an encounter. When there was a concern about someone's level of risk which led to a referral to specialist services, the information would be documented and passed onto the relevant service. This could often be a process which evoked considerable anxiety about documenting information and completing paperwork as well as about the actual issue itself. Once a referral had been accepted, there would be no further involvement. This raised wider questions about risk assessments which this research will grapple with: *why have risk assessments come to be seen as so important? Why are they carried out in the way they are? Are there alternatives? What influenced the development of risk assessments? What risks do they engage with and what risks do they neglect? What consequences do they have, generally, as well as in relation to views of services, patients, therapists? How do they connect to service organisation?*

These questions describe the initial moment of puzzlement, and are used to inform the next stage of the research process, which is the development of the specific processes of problematisation. This is accomplished through an archaeological and genealogical consideration of risk assessment.

1.3 Problematising Risk Assessments – An Archaeological Contribution

1.3.1 Risk assessment – some context.

Risk has become a familiar concept and frequently encountered term in twenty-first century life. We meet risk in many areas of life including the classroom, the clinic and the law court. Risk pervades both public and private organisations. It is, as Power (2004) puts it, “all around us” (p. 9). Consequently, it can appear as a taken-for-granted concept which does not require defining. However, as a signifier, it is used in multiple ways; it refers to the possibility of an unwelcome consequence; the possibility of harm or loss, such as financial loss; the possibility of an error; a person or thing likely to produce a good or bad outcome in some respect; and so the list goes on (Risk, n.d.). The standard approach taken within the arena of mental health is to see risk as a combined measure of the subjective probability of an event and the events likely impact (Undrill, 2007).

In *The Risk Management of Everything*, Power (2004) describes how since the 1990s it has become increasingly important for companies to have a “broad and formal risk management programme” in order to be considered effective (p. 11). Consistent with the surge of academic literature focusing on risk mentioned above, he describes an explosion of discourse about risk management which emerged not from government sources initially, although they have adopted risk management thinking, but from private sector companies who opportunistically used risk to redefine their own strategic utility. The contemporary emphasis on organisational governance and corporate responsibility, as well as new information systems and certain crises, has created an environment where risk can be deployed in this way. Power (2004) calls risk an *organising concept* which has created a “new style of organisational discipline and accountability” (p. 9).

1.3.1.1 IAPTs emergence.

It is helpful therefore to conceptualise risk and risk assessment as a historically situated discourse linked to specific projects and goals of particular social actors. Within the field of mental health, there are a range of professional groups: psychiatry, clinical psychology, psychotherapy, social work, mental health nursing being just a few; and different epistemological approaches towards mental health such as biological, psychoanalytic,

systemic, cognitive, behavioural and so forth.⁴ The risk assessments studied here were located within an IAPT service, a new project which emerged from this recent historical context. This project grew out of the liberal, utilitarian approach espoused by Layard (2003) in his work looking at unemployment, welfare and more recent work seeking to measure and maximise happiness. The development of IAPT is said to be a consequence of the increasing significance of NICE as well as particular economic and clinical arguments (Clark et al., 2009). The depression report was a key document involved in establishing IAPT.

The depression report.

This report drew upon a range of elements to make the case for new psychological therapy services in the form of IAPT. The report begins with an affective appeal: “crippling depression and chronic anxiety are the biggest causes of misery in Britain today. They are the great submerged problem, which shame keeps out of sight” (Layard et al., 2006, p. 1). The argument presented for new psychological therapy services describes depression and anxiety as illnesses that affect one in three families in Britain. The strategic success of the report can be helpfully understood through considering Laclau and Mouffe’s (2014) description of a logic of equivalence. A logic of equivalence works by simplifying social space into opposing camps, creating a chain of equivalential identity between social actors in opposition to a common enemy. Here, IAPT, NICE, families and people with these ‘illnesses’ are aligned with ‘evidence-based psychological therapies’, CBT in particular. This favouring of CBT is better understood through reconceptualising it as currently achieving hegemonic status within the world of psychological therapy rather than being ‘better’ per se than other therapies (Pilgrim, 2011). No less significant, there is also an equivalence with economic arguments in favour of reducing state expenditure on incapacity benefits and increasing productivity and tax revenues. This chain of equivalence sets itself in opposition to unspecified “endless or backward-looking treatments” as well as political actors not willing to support IAPT: “everyone who wants something to be done should write to their MP calling for action” (Layard et al., 2006, pp. 1–2).

Clinical governance.

NICE came into being in 1999 as part of the government at the time desiring evidence based clinical practice and cost-effectiveness within the NHS. NICE was established to appraise research and provide recommendations for treatment, which would then be audited through a process of clinical governance as set out in *A First Class Service* (Department of Health, 1998).⁵ This was said to reduce confusion for clinicians and patients about expected care. Clinical governance was seen as a way of making services accountable for providing recommended treatments and for improving service quality, with audit, regulation and patient involvement being key components (McPherson, Richardson, & Leroux, 2003). This made the chief executives of NHS Trusts accountable for quality of service provision as well as financial responsibilities, and incorporated an obligation to have clear policies specifying risk practices including systematic risk assessment and risk reduction programmes. This was seen as a way of overcoming the failings of a market based system which prioritised finances and activity, not clinical quality (McSherry, Pearce, & Tingle, 2011).

Clinical governance grew out of the model of corporate governance in business which had been introduced by companies to safeguard investments and assets, and minimise company risks (McSherry et al., 2011). Corporate governance was seen as having value in the public sector and so was introduced into the NHS with the focus being on accountability, transparency and integrity. As corporate governance focused on financial and operational success, clinical aspects of healthcare provision were not accounted for and it was here that clinical governance was seen as a way of ensuring overall, total governance.

If clinical governance was seen as a way of addressing some market failings, key elements of a market-based system, in particular choice and competition, have been extended in recent NHS reforms (Glynos et al., 2015). This has also included a reduced role for the government in daily management of the NHS and a competitive commissioning process whereby *any qualified provider* can bid to provide services with the view that this will create

innovation and improvements.⁶ This competitive context, and cultural embracement of risk thinking, intensifies the need for organisations to have an effective risk assessment and reduction programme in order to win service provision contracts.

1.3.1.2 Juridical and political context.

Recent government policy also makes clear the expectation that services should be assessing all types of risk, and managing and reducing risks. Risk assessment is described as “an intrinsic aspect of all high-quality clinical assessment and not a separate activity” (Department of Health, 2011, p. 77). Services are not expected to prevent all incidents of violence but there are too many cases where more could and should have been done and inquiries often highlight the same problems. Good risk management is said to involve: good record-keeping, access to information about a person’s history and risks; addressing a person’s needs; effective communication with other agencies; appropriate information sharing; effective risk assessment and management which incorporates risk posed to self, to others, from others and safeguarding issues; a consideration of risk and protective factors; clarity about objectives and responsibilities; and effective use of the Mental Health Act.⁷

The political importance given to managing risk was underscored by the publication of the *Best Practice in Managing Risk* document which emphasised the dual objectives of patient autonomy and public safety (Department of Health, 2007). A good therapeutic relationship was re-described to include an “objective assessment of risk” as well as “sympathetic support” (Department of Health, 2007, p. 3). The aim of this document was to embed risk management in daily clinical practice as part of the Care Programme Approach. This document also announced the planned introduction of supervised community treatment; “a new power...to ensure that high-risk and vulnerable patients receive the treatment that they need after hospital discharge” (p. 3). Sixteen best practice points were outlined followed by a discussion of various standardised ‘risk tools’ for assessing multiple risks, risk of violence or sexual violence, risk of antisocial or offending behaviour, and risk of suicide or self-harm. The document has since been updated stressing its continued importance and

providing additional guidance on implementation within services (Department of Health, 2009).

The contemporary emphasis on accountability and litigation intensifies the role the legal system plays in relation to risk. The legal view of risk is concerned with obligation or responsibility for loss, harm or damage. Mental health professionals are said to have a duty of care towards patients which includes an adequate knowledge of mental illnesses and treatments, and an application of such knowledge in the best interests of a patient (Harrison, 1997). Professionals can face legal action and be judged on this which involves considering recommendations of relevant professional bodies such as the Royal College of Psychiatry, or the Health and Care Professions Council, and government guidelines which specify standards of care. The legal system therefore complements the political emphasis upon risk and becomes the arbiter for the implementation of government policy. The juridical and political may not always align however, and the link between the political, juridical and clinical is best seen as one in constant flux. One example is the recent emphasis on protecting the civil liberties of patients being used to challenge restrictive political and clinical perspectives (as illustrated in the genealogy section below). Although this may have changed little in practice as patients' credibility during legal proceedings is typically questioned from the outset (Rogers & Pilgrim, 2014).

This context elevates juridical and political processes over clinical ones and makes the possibility of facing legal action the risk people strive to avoid, and so constructs patients as a source of threat to professionals. It also makes visible the additional role of the mental health practitioner; not only should practitioners be prioritising their patients' best interests from a clinical perspective, they should firstly be ensuring they follow legal and political guidance. This shows the social role granted to psychiatry and related professions, which Rose (1996) describes as being a "technician of social order" (p. 6). Put more plainly, there is a responsibility "for the welfare not only of...patients or clients, but more broadly for the public at large" and an expectation that individual practitioners "should be able to assess risk and take appropriate action" (Duggan, 1997, p. 1).

The administrative task of assessing and managing risk has therefore become a part of everyday, routine practice within mental health, as well as a legal obligation. Additionally, risk assessment within IAPT is considered important as the treatments they provide are not appropriate for those with “significant risk” (Clark et al., 2009, p. 912). It becomes important then to identify those with significant risk not only because of the *actual risk* but because of an additional risk of treatment not being appropriate. As the service is not designed for people with significant risk, this creates an additional risk in terms of clinical governance as the service could be held accountable should there be a risk incident. Like in *The Depression Report*, this creates an equivalence with juridical and political processes, which given the context outlined above, has an important strategic value in the ability to provide mental health services.

IAPT has therefore neatly slotted into this legal, political and organisational framework and their risk assessments follow these recommendations. In doing this, a number of tensions between clinical and juridical thought are smoothed over and clinical conceptions are subordinated to legal-political ones. This is done by incorporating legal-political conceptions into clinical discourse, such as prioritising the responsibility to protect the public from someone who may become violent as opposed to prioritising treatment for that person’s mental health. However, there may be times when these conflict and it is not clear if, once established, clinical services remain subordinate to juridical and political processes in terms of their daily operations. The reality may not be so straightforward and this chain of equivalence, or subordination, may, at times, dissolve. After all, there has been longstanding conflict, tension and conceptual disagreement between medical and juridical approaches to disorder (Rogers & Pilgrim, 2014). What is clear is that these developments neglect a number of debates that have taken place in relation to risk assessment and have not gone unchallenged.

1.3.2 Risk assessment – some problems.

This legal-political discourse takes for granted that risk is necessarily a bad thing that should be minimised which the focus then shifts towards. However, focusing on risk itself has produced the view that any definition of risk is a political act which is inherently controversial due to the way the chosen definition “can affect the outcome of policy debates, the allocation of resources among safety measures, and the distribution of political power in society” (Fischhoff, Watson, & Hope, 1984, p. 124). Defining risk therefore involves making value judgements. As Ewald (1991) puts it: “nothing is a risk in itself; there is no risk in reality. But on the other hand, anything can be a risk; it all depends on how one analyses the danger, considers the event” (p. 199). One value judgement is the importance given to potential undesirable consequences in a given situation. The legal-political stance also portrays the assessment and management of risk as necessary and straightforward. However, within risk assessment literature this view has been problematised.

1.3.2.1 Accuracy of assessment.

Despite this embracing of risk assessment, it has not been shown to be effective in accurately assessing, predicting or reducing the risk of suicide or violence. A review of the effectiveness of risk assessments concluded that “there is little evidence that this approach is effective in reducing risk of harm to self or others” (Wand, 2012, p. 6). In relation to violence, the Royal College of Psychiatry (2008) describe an absence of evidence around risk assessment tools reducing or preventing violent incidents and state that “accurate prediction is never possible for individual patients...the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person’s behaviour” (p. 10). Similarly, with suicide, accurate prediction of individual suicides has been described as impossible, even when knowing information about an individual that is connected with suicidal intent (Harriss & Hawton, 2005).

1.3.2.2 Methods of risk assessment.

The difficulty of assessing risk accurately can be seen in the debate over methods of risk assessment which have focused on the ability of risk assessments to accurately predict risk rather than reduce risk. Historically, the two dominant approaches to risk assessment have been the unstructured, clinical approach and the statistical, actuarial approach (Lamont & Brunero, 2009). Clinical approaches are based on the judgement of a professional following an assessment. In contrast, actuarial approaches involve using risk assessment tools to identify static or historical factors associated with an increased risk, referred to as risk factors.

Different theoretical approaches also influence the way risk assessment is understood and carried out. Writing within the psychodynamic tradition, and against actuarial approaches, Doctor (2004) describes the importance of entering a patient's inner world and object relationships, and confronting the feelings which emerge within the transference and countertransference. From this view, actuarial approaches become "a defence against real contact with violent patients" (p. 267). Assessment of risk is said to require an ability to tolerate unbearable psychic pain and an awareness of the extent to which we try to avoid reality. Elsewhere, risk assessment has been described as a directive activity which conflicts with particular schools of thought such as person-centred counselling where an assessment may be viewed as an experiential, holistic process rather than a scientific endeavour (Moerman, 2012).

The actuarial approach to risk assessment was adopted in response to the shortcomings of the traditional clinical approach which was seen as anecdotal and critiqued for being subjective, unreliable and based on insufficient information. The accuracy of this method was described as being no better than chance, and clinicians were not felt to possess particular expertise in relation to predicting risk, with knowledge of past violence seen as more accurate (Langan, 2010; Monahan, 1981). The actuarial approach, however, is not without problems.

1.3.2.3 Base rate problems.

One problem with the actuarial approach relates to what is known as the base rate problem, which highlights the difficulty of predicting a behaviour that occurs rarely within a population being studied, such as violent behaviour in the general population. Risk assessment tools are considered in terms of sensitivity, the ability to correctly identify those at risk, and specificity, the ability to correctly identify those not at risk (Duggan, 1997). Tests have four possibilities: correctly identifying those at risk (true positive), correctly identifying those not at risk (true negative), incorrectly identifying those at risk as not being at risk (false negative), or incorrectly identifying those not at risk as being at risk (false positive). A ratio is derived from these possibilities to produce sensitivity (true positives/true positives and false negatives) and specificity (true negatives/true negatives and false positives) values. A test with low sensitivity will have a high number of false negatives and a test with low specificity will have a high number of false positives. Positive and negative predictive values are calculated from these tests. Positive predictive values are the proportion of individuals correctly predicted by a test to be at risk and negative predictive values, the proportion of individuals correctly predicted to not be at risk. These values are influenced by the prevalence of the risk behaviour being studied. Using Duggan's (1997) hypothetical example, in a population of 100 people, where 10 are violent, a test with 90% sensitivity and 95% specificity would give a positive predictive value of 64% and a negative predictive value of 99%.⁸ This would mean 64% (9 people) of those the test identifies as being violent would actually be violent, and 36% (5 people) identified as being violent would be false positives. This test would correctly identify 99% (85 people) of non-violent people and 1% (1 person) would be false negatives. Figure 1 represents this.

Figure 1. Test results

		TRULY VIOLENT	
		Yes	No
TEST	Positive	9	5
	Negative	1	85

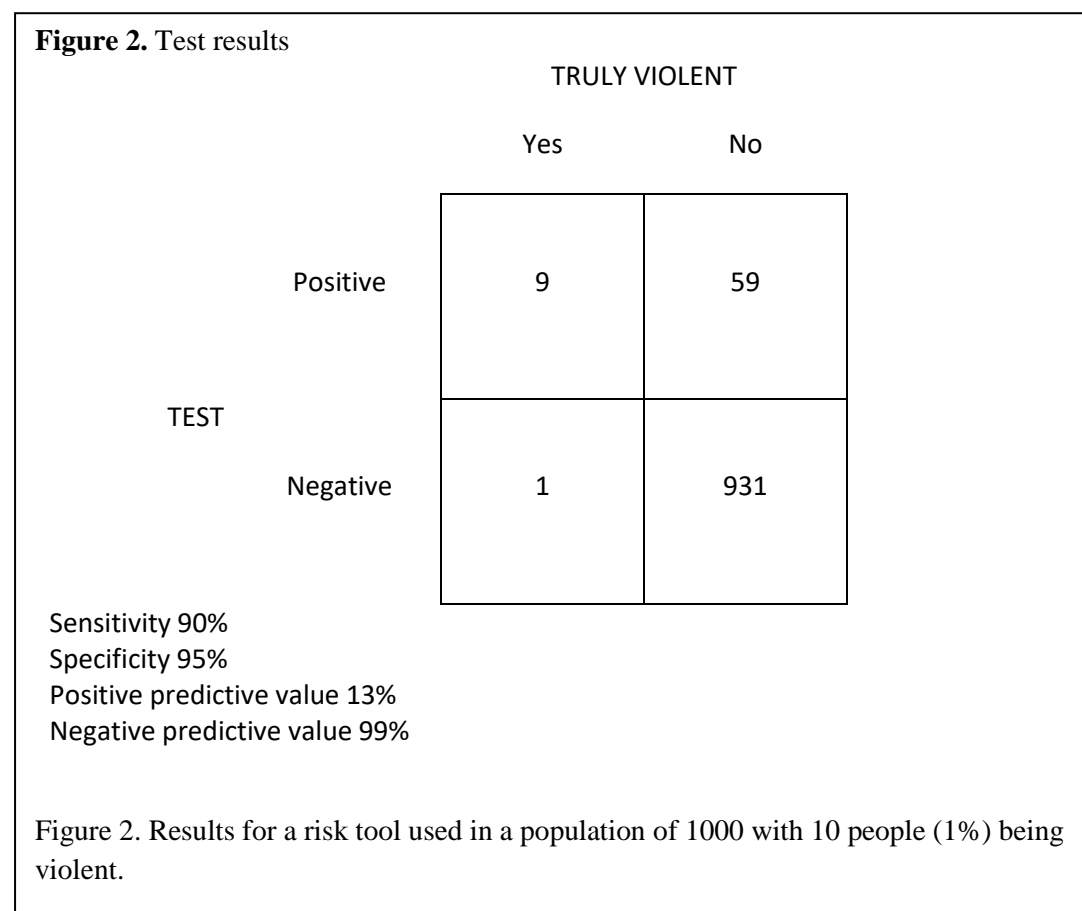
Sensitivity 90%
 Specificity 95%
 Positive predictive value 64%
 Negative predictive value 99%

Figure 1. Results for a risk tool used in a population of 100 with 10 people (10%) being violent.

Note. Adapted from “Introduction” by C. Duggan, 1997, *British Journal of Psychiatry*, 170 (suppl. 32), p. 2. Copyright 1997 by The Royal College of Psychiatrists.

When the prevalence rate changes to 10 in 1000 people (1%), the same test would maintain a high negative predictive value of 99% but the positive predictive value reduces to 13%. As shown in figure 2, this means the test would incorrectly identify 59 people as violent who are not, and, as before, incorrectly identify one violent individual as non-violent. In this case, the majority (86.8%) of those the test identifies as violent would not actually be violent. This clearly shows a problem with the application of such tests in cases where the behaviour being studied is rare within the population like violence and suicide. As Szumukler (2001) puts it: “even a test with an impossible 0.9 accuracy for both true positives and true negatives will be wrong more than nine times out of ten at a base rate of 1%” (p. 85). Even when classifying patients into high or low risk categories, an empirically derived hypothetical example, with an optimal risk assessment, showed that to prevent one homicide by patients with schizophrenia, 35,000 successful individual risk management programmes would be required

(Large, Ryan, Singh, Paton, & Nielssen, 2011). This has led to the suggestion of a need to discuss acceptable levels of false positives, described as a moral issue (Buchanan & Leese, 2001; Szmukler, 2003). Discussing the base rate problem elsewhere, Szmukler and Rose (2013) conclude that the events we are most concerned with preventing “because of their infrequency are not statistically predictable in a clinically useful way when it comes to an individual patient” (p. 129).⁹



Note. Adapted from “Introduction” by C. Duggan, 1997, *British Journal of Psychiatry*, 170 (suppl. 32), p. 2. Copyright 1997 by The Royal College of Psychiatrists.

1.3.2.4 Causal explanations.

Actuarial approaches, then, involve converting risk into a numerical problem and are based upon information about groups which may not be relevant to a given individual. The problems with prediction has led to calls for them to be used with great caution or abandoned

(Hart, Michie, & Cooke, 2007), and for their use to be restricted to people with clear risk factors (Swanson, 2008). In Buchanan's (1999) critique of actuarial approaches, he describes how mathematical models only use one type of probability, probability based on chance. Drawing on the philosophy of Hume, he claims there is an alternative type of probability based on causes and describes how the probability of an aircraft crashing could be based on how many aircrafts crash on the relevant route or on an inspection of the state of the aircraft. Buchanan concludes that it is not appropriate to rely purely on mathematical approaches to assessing risk, although he claims the future of these approaches is not in doubt, and there must be a consideration of causes or explanations of risk behaviour which requires a clinical approach.

While Buchanan points to the limits of prediction and thus rejects the idea of simple causal laws, prioritising causes or explanations of risk behaviour relies upon the idea that this can be achieved through identifying a causal pattern across situations. The strength of this approach is that it rejects the false choice between universal, causal laws lacking in context and particular, case-specific descriptions lacking in applicability. However, as Glynn and Howarth (2007) describe in their critique of causal mechanisms, the idea of causal patterns remains tied to a causal law *ideal* based on a mechanistic understanding of causality which cannot be realised in understanding social phenomena.

Causal patterns themselves require an explanation, which relies upon contextualisation, and, in relation to the social sciences, such patterns require subjects to maintain them. As they can be modified, through knowledge of them for example, a causal view falls apart. An alternative would be to explain risk behaviour purely through referring to an individual's inner states. This would be equally problematic for neglecting social practices which constitute such inner states. An ontology of lack offers a way of avoiding such individualism without returning purely to a privileging of social structures. More will be said about this in the strategy section below.

1.3.2.5 Structured professional judgement.

Nevertheless, a combination of the clinical and actuarial approach has been described as the preferred method of risk assessment (Lamont & Brunero, 2009). This has been called a structured professional judgement or structured clinical judgement and makes use of empirically validated risk factors, clinical experience and knowledge about the individual being assessed. The argument for this has been forcefully made by Maden (2005) who says “the evidence is clear” and that attempts by psychiatrists to distance themselves from violence damages the “profession’s public image” (p. 121). He cites the overrepresentation of ethnic minorities among detained patients as a reason to be sceptical about an unstructured approach to risk assessment, although doesn’t clarify the relationship between the two other than to describe the unstructured approach as one based on “gut feelings, instincts, intuitions and rules of thumb” (p. 121). He argues that standardised measures could lead to more scientific study and describes how both public and governmental confidence in the psychiatric profession is low:

the lesson for general psychiatry is that, once the public and politicians have made violence a major issue, services need to be seen to be taking it seriously. Structured risk assessment is not the whole answer, but it sends the right message. (Maden, 2005, p. 121)

Maden concludes his account by saying that whilst clinicians were arguing about whether or not to assess risk, the managers “got on with it...it is time for clinicians to take back the initiative and to take the lead in introducing scientifically based, clinically meaningful risk assessment” (p. 122).

This opposition of clinicians to managers, the public and politicians shows a potential antagonism in social space which Maden attempts to appease by *sending the right message* while also creating an important role for clinicians by drawing upon scientific discourse in completing risk assessments. While this incorporates the concerns of the public and politicians into clinical thought, it also works to elevate the clinical approach through its scientific expertise. Through constructing managers as a threat to clinicians, the legitimacy

and content of the debate over whether to assess risk or not is obscured and the reputation of the psychiatric profession prioritised. The integration of clinical and actuarial approaches does not necessarily make them more accurate though, and leaves a number of other issues unresolved including the difficulty of multiple interacting risk factors, difficulties in acquiring accurate and comprehensive information, how best to incorporate actuarial information and how to prevent or minimise risk (Langan, 2010).

1.3.2.6 Risks assessed.

A further problem with current risk assessment practice is that some risks command much greater attention than others. Mainly, this consists of the risks posed by the mentally ill to themselves or others, with the latter given special significance. This is linked to an assumption that people with mental illnesses pose more of a risk than the general population. There is a large body of research exploring this with variation in findings, methodological approaches and quality of research (Langan, 2010; The Royal College of Psychiatrists, 2008). Within an epidemiological frame and associated positivist epistemology, a small association between psychosis and violence has been described but the consensus is that “acts of harm to others perpetrated by people with a mental illness are not primarily related to their mental illness once substance misuse is taken into account” (Wand, 2012, p. 4).¹⁰ This leads to the view that substance misuse is riskier than mental illness as 9% of homicides are estimated to be by people in recent contact with mental health services, whereas 61% are linked to alcohol and drug misuse (Swinson et al., 2007). There is a related estimate with suicide too; of the 4,500 – 5,000 people who complete suicide each year, only around 25% have had contact with mental health services in the year preceding their death. Most suicides will occur in low risk groups simply because these groups are larger than high risk groups (Wand, 2012). While these views usefully show problems with the current approach to risk assessment in mental health, they also present the social world as one which is relatively static, simplistic and fully knowable. This is at odds with the approach taken here as it loses sight of the radical contingency and historicity that constitutes the social world.

Nevertheless, this approach suggests that the extensive focus on the risk posed by people with mental illness is disproportionate. Pilgrim and Rogers (2011) highlight the arbitrary nature of this in their critique of separate legislation existing for people with mental health problems. They cite the actuarial knowledge of the risk of violence posed by intoxicated young men every weekend but the lack of legislation for this particular group. Focusing on these elements of risk also serves to obscure other marginalised risks. For example, there may be a risk from coming into contact with mental health services. Some possible risks include loss of liberty, forced treatment (typically pharmacological) or being treated by someone incompetent or abusive (Vassilev & Pilgrim, 2007). There is also the risk that treatment is ineffective, unhelpful or makes things worse, such as the side effects of medication or the stigma received from a diagnosis. There may also be less straightforward risks as seen in the work of Hacking (2007). He describes how the human sciences bring into being new types of people, which he calls 'making up people'. This is a process which involves a classification system, people being classified, institutional involvement, knowledge production and relevant experts. Hacking describes a 'looping effect' where classifications interact with the people classified and so alter the classifications. What his work shows is that receiving support for a particular mental illness, or, more relevant here, being classified as a risk, may constitute a new identity with unclear consequences for the person so identified.

In an interview study with community mental health nurses, Godin (2004) documents how the current emphasis on risk assessment and management, along with the potential for blame, encourages attention to be turned away from the risks faced by people with mental illness, inadequate accommodation for example, towards the risks they pose. This potentially prevents clinicians from understanding the victimisation people may have experienced. An additional concept of risk is that of positive risk taking, or therapeutic risk taking. Here, professionals purposefully take risks which they anticipate may be therapeutically beneficial to see if someone responds well, such as someone being given an opportunity to live independently. Maybe there are risks involved in not taking risks. Parsons (2008) describes

the dignity of risk to illustrate the double standard whereby people with mental illness are denied the right to make risky or self-defeating decisions and to then learn from these mistakes contra to how everyone else is able to do this.

There are also social or systemic risks which fade into the distance. For example, criminalising drug use creates an illicit drug market which produces violence from the state in attempting to police it and from those associated with organised crime (Pilgrim & Rogers, 2011). This systemic violence is far greater than the violence which comes from the effects of using such substances. Additionally, particular communities with higher levels of poverty, unemployment and substance abuse could be seen as posing a risk to the individuals within those communities, with the communities then, instead of individuals, being targeted for intervention (Wand, 2012).

1.3.3 Risk assessment – some consequences.

1.3.3.1 Inaccuracy and coercion.

A number of consequences of this extensive focus on risk assessment have been pointed to. Firstly, risk assessment remains inaccurate. The move to integrating clinical and actuarial approaches provides a space for advocates from both camps, but it does not necessarily improve accuracy. After all, actuarial tools were seen as a way of overcoming the limitations of clinical judgement but have not been successful in this and so it is unclear how combining the two will improve accuracy. For some, the use of actuarial tools will lead to the mistaken prediction that they are at risk which, if supported by clinical judgement, could lead to the provision of unnecessary interventions. Due to the actuarial base rate problem, this is likely to involve greater numbers when used in general settings like primary care than in more specialist settings where incidences are higher. For those correctly seen as not at risk, the process of assessment may have been disruptive, could exacerbate stigma, and may lead to them receiving less care or resources (Large et al., 2011). It may also be the case that despite correctly identifying someone at risk, and providing an intervention, the risk event still takes place; and, conversely, if risk is used to determine treatment, those incorrectly

identified as not being a risk may not receive treatment that may have been desired or beneficial.

The nature of the provided interventions then become important in ways which may involve people being detained in hospital and treated without their consent prior to any violent act (or other risk) being committed, as legislated for in the Mental Health Act (2007). This process illogically assumes no difference between voluntary and forced treatment for mental illness (Rogers & Pilgrim, 2014). Many researchers have called this separate legislation for mental illness discriminatory and called for its abolition or considerable revision (Large, Ryan, Nielssen, & Hayes, 2008; Wand, 2012). Ultimately, it remains unclear whether the interventions will be successful in preventing the events they set out to.

1.3.3.2 Secondary risk management.

When the cultural emphasis on accountability and litigation is considered, the emphasis on risk assessment encourages defensive practice. Patients become a source of threat. This leads to what Power (2004) describes as secondary risk management where professionals become preoccupied with managing their own risks rather than the primary task for which they are employed. A consequence of risk assessment then is that it diverts attention away from the primary task of providing treatments for the mentally ill and creates a new kind of expert, one skilled at managing the risks posed to one's reputation through defensive practices. This can be thought of as substituting expertise for what is administratively accountable. As Power (2004) puts it: "In such a cultural environment, with institutions which tend to amplify blame and the logic of compensation, it is rational for organisations and the agents within them to invest in management systems with a strong secondary risk flavour" (p. 41).

Anxiety about future uncertainty, that risk assessment is a response to, may be tamed on one level, but this may involve it being displaced onto the assessor. Following Power, Undrill (2007) describes the generation of anxiety in the assessor as the most important effect of risk assessment, it creates a situation where:

a patient may be detained because not detaining them produces intolerable anxiety in the staff involved in the assessment. Who in the field of mental health has not asked themselves ‘How would this decision play in court (or in the newspapers) if it went wrong?’ This is secondary risk management in action. (Undrill, 2007, p. 295)

Risk assessment then becomes a form of insurance for professionals who may make decisions “from the perspective of the need to defend it in some public tribunal in the future” (Rose, 1998, p. 186). This may explain why risk assessment pro formas used by mental health services tend to just focus on risks for which professionals may be held accountable, at the expense of other risks like socio-economic risks (Hawley et al., 2006).

1.3.3.3 Stigma and trust.

The selection of some risks over others and the attention given to this brings into view moral and political dimensions to risk assessment. Douglas (1992) uses this to describe risk as a secular form of sin and as fulfilling a similar function to that of practices of confinement within Victorian asylums. Risk becomes an acceptable form of stigma whereby a high-risk individual in the community is a legitimate moral concern due to posing an unacceptable danger. This bypasses the accusation of discriminating against the mentally ill, discrimination which is illegal as legislated for in the Equality Act, but ultimately serves to maintain the association between mental illness and danger, and thus reinforces stigma and authoritarian practices. In addition, “the assumption that mental disorder causes violence in adults distracts attention from the need to address the deleterious material, social and economic conditions experienced by many mentally disordered people...[which] encourages processes of social exclusion and ‘otherness’” (Langan, 2010, p. 89).

When patients become a source of threat, this is likely to have a detrimental effect on the relationship between them and professionals, and the anxiety generated from this may also make it difficult for professionals to more accurately describe the risks posed by people with mental illness (Undrill, 2007). This could serve to increase stigma, and may lead to people not wanting to access services (Szmukler, 2003). Trust in professionals may therefore

be compromised. Szmukler and Rose (2013) discuss the importance of trust in mental health practice and how risk assessment can undermine the necessary context for effective treatment. It can take time away from building a therapeutic relationship and leave patients wondering what professionals' priorities are which may leave patients reluctant to receive treatment.¹¹

1.3.3.4 Uncertainty.

Viewed as an attempt at knowing what is unknowable, risk assessment becomes a paradox (Power, 2004). There is a danger of this unknowable aspect of risk assessment disappearing out of view through translating unknowable risks into information that can be reported to senior staff. This involves a quick move away from uncertainty, it becomes managed in a particular way rather than being acknowledged as the unknowable. This is akin to what Hacking (1990) described as the paradoxical taming of chance where future uncertainty is transformed, brought into the present, made calculable in terms of probability and then used to justify decisions. Translating uncertainty into knowable information, like through actuarial and structured clinical approaches, gives the impression that risk can be accurately assessed and so increases the importance placed on risk assessment at the expense of uncertainty. This could provide a false sense of security and risk assessment may be seen as a stage of treatment rather than risk being understood as something uncertain that fluctuates over time and in different circumstances. Maybe then, a consequence of risk assessment practice is not that we are more aware of the risks we face and able to develop rational responses, but more that we are becoming increasingly anxious and unable to tolerate uncertainty. If so, secondary risk management expands in importance.

The uncertainty involved in risk assessments can be thought of as Knightian uncertainty, which Undrill (2007) describes as the epistemological uncertainty that exists when large numbers of independent observations of an event are not possible, in contrast with true risk which Knight (2013) described as measurable, knowable and manageable.¹² Risk assessments used in mental health, which focus on highly idiosyncratic and unpredictable

events like suicide and homicide, clearly deal with the former of these two. In keeping with the ontological stance, the view here is that there will always remain a degree of uncertainty in social structures and human subjects owing to the radical contingency of the social world. Losing sight of uncertainty and contingency, through risk assessment, may lead to a descent into an ideological mode of functioning where the openness of the social world is concealed. This could play out in a number of ways such as a retreat into a position of certainty, denying any unknowability. Or certain fantasies that promise closure may be pursued, such as a fantasy of a risk-free world which can be achieved through a perfect system of assessment or through fully eliminating obstacles seen to maintain risk.

1.3.3.5 Governmentality.

At a broader level, risk assessment may be part of what Castell (1991) calls the shift from the clinic of the subject to the epidemiological clinic. This shift involved a move away from the focus on the concrete individual, as in previous traditions of medicine, to a focus on a combination of factors of risk linked to a form of governability seen in postmodern societies. Instead of a clinical interview, an examination of a patient becomes an examination of records compiled by various professionals. Key to Castell's argument is what he calls the replacement of dangerousness with risk. This involved a move away from viewing danger as located within an individual, to viewing risk as located within a range of abstract factors. This relied upon making risk calculable which involved an estimation of probability based upon a statistical model of the regularity of events. This leads to new forms of surveillance in order to detect risk factors and relies upon making risk calculable to evaluate its probability. Armstrong (2002) describes this as a "new model of medicine that placed the process of surveillance rather than the identification of the pathological lesion at its core" (p. 109). Risk factors become critical as potential eventualities which need to be managed through correcting aberrations, changing attitudes to health and behaviours. Castel (1991) locates this shift within a "grandiose technocratic rationalising dream of absolute control of the accidental, understood as the irruption of the unpredictable" (p. 289). Two implications are

discussed; firstly, diagnosis and treatment are separated and caring becomes an activity of expertise, and, secondly, technicians or experts become subordinate to administrators or managers.

In one of Rose's (1998) studies of the governing of the modern individual, he describes risk as structuring and shaping the mental health system with risk classifications being "the means by which professionals think, act and justify their actions" (p. 189). For Rose, the current regime of risk does not reflect a risk society, as others have argued (Beck, 1992), but operates heterogeneously across a multiplicity of points (clinical, epidemiological, actuarial, forensic and probabilistic) and creates a circuit of surveillance. Rose articulates three consequences of this inscription of risk thought. First, it allows the mental health profession itself to be governed at a distance under the shadow of the law. The administrative role of mental health professionals involves a series of obligations in relation to risk in order to enhance public safety – the public inquiry has played a key role here. Clinical activity is therefore pierced through with administrative, political duty. Secondly, risk thought provides a misleading sense of objectivity through conversion of risk into numbers. This serves to obscure the process by which the number was arrived at, thus concealing the ethical dimension and minimising contestation. Thirdly, it reflects what Rose (1998) calls a "governing through madness" (p. 190). Here, a new class of monsters lurk within the risk grid, ideally pinned down by it, and the very reason we need it. The fantasy of these monsters threatens the fantasy of their obverse: an idyllic construction of the public, an idealised community living harmoniously.

1.4 Ignoble Beginnings – Problematising Risk through a Genealogical Lens

1.4.1 Risk assessment and community care.

Another way of problematising risk assessment is to turn our attention towards the idiosyncratic social and historical circumstances that led to it achieving the significance it has come to have. Taking a view of the social as open in its essence, describing historical context becomes not a documenting of the truth of a given point in time but a description of

hegemonic discourses, social practices and ideological investments. And as historians of science have shown, this is also linked to the same processes in the present.¹³ Historical context is not seen neutrally then, but through the lens of the present.

Considering psychiatry from this theoretical view, there is not one history of psychiatry but many which are organised in a variety of ways. For example, in the British context, Berrios and Freeman (1991) organise their text around institutions, ideas and people. Elsewhere, Shorter (1997) in his influential social history, *A History of Psychiatry*, describes what he sees as the success of the biological approach to psychiatry while focusing on how culture and psychiatry intertwine. Shorter divides psychiatry's history into an era of asylums, a first biological period, a psychoanalytic period and a second biological period amongst others. It is beyond the scope of this project to offer an in depth consideration of risk in relation to such histories of psychiatry. However, risk has become sedimented within the current era of community care so it is helpful to consider this briefly, and its constitutive outside, variously: the hospital, the institution, the asylum.

In the second half of the twentieth century, there was an increasing desire for a move towards community care, or deinstitutionalisation, and away from the asylum. Overlooking a range of social, institutional and political changes, some have linked this shift to the development of the drug chlorpromazine, used as an antipsychotic, enabling more effective treatment (Eghigian, 2010). However, anti-asylum sentiments existed long before this. In the 1850s, discourses emerged describing confinement as detrimental through rendering temporary excitement or depression into permanent insanity (Bennett, 1991). During this period though, asylums increased in size and were used for people who caused trouble in the community or had no family to care for them.

Out-patient treatment began before the twentieth century and this practice was implemented at the Maudsley Hospital in the 1920s, and thereafter became an important component of treatment in part due to public concerns about asylum conditions (Bennett, 1991). It was thus in opposition to the asylum that community care was articulated. After World War II, there were a series of changes which accelerated the move towards the

community: mental hospitals became increasingly less isolated with many adopting an open-door policy for patients, therapeutic communities were established, and day centres were set up. These changes occurred in the shadow of the wider development of the welfare state which, of course, included the establishment of the NHS. With this, mental hospitals became the responsibility of the NHS rather than local authorities and this led to an increasing emphasis on treatments which do not require admission or which lead to discharge much sooner than had occurred in previous periods.

Planning for community care advanced in the 1960s and there was greater media and political coverage of mental illness (Bennett, 1991). More critical voices existed too; R. D. Laing (1967) famously argued that schizophrenia is not an illness but an arbitrary label and that it is psychiatry and its practices that produce mad behaviour; and Goffman (1991), in an American context, described mental hospitals as total institutions which serve a social function of containing those perceived to be a threat to the community. The 1970s and 80s saw a shift towards psychiatric patients being treated in general hospitals and a governmental focus on reducing expenditure. Rogers and Pilgrim (2014) describe how community care, as a political objective, first appeared in the Mental Treatment Act of 1930 and became a consensus by the 70s. They link community care to a range of elements: the crisis of the asylum, economic determinism, and a shift to focusing on acute problems and primary care. Enoch Powell's (1961) *Water Tower* speech rhetorically exemplifies the political commitment to community care with his description of the need for an "elimination" of the "asylums which our forefathers built with such immense solidity to express the notions of their day" (p. 1).

Perhaps contemporary notions are just as peculiar as those of the past. In 1990 the government introduced the National Health Service and Community Care Act which aimed to reduce costs of hospital and community provision through a range of interventions (Holloway, 1996). These included introducing a purchaser/provider divide by requiring health and social services to distance themselves from care provision, relying on market forces to increase the quality of care, transferring primary responsibility for community care

to social services, diverting funding from the unlimited social security budget to the limited local authority social services budget, and dividing health and social care.

By this time, community care was well underway and involved a variety of activities and services, including the development of community mental health centres, an increase in community psychiatric nurses and the provision of residential and day care facilities (Rogers & Pilgrim, 2014). Community care came with its own challenges though, in part relating to the loss of the multiple functions asylums provided: accommodation, treatment, and, in particular, social control. The importance of social control can clearly be seen in one of the most influential texts on the history of madness, *Madness and Civilisation* (Foucault, 2001a). Here, the way in which madness is understood is linked to particular historical conditions and systems of thought. One thread in this complex work shows how a process of confinement of people seen as socially problematic, the mad, the idle, the poor and so on, preceded any attempt at cure or treatment. With the social and institutional changes of the late eighteenth century, madness became isolated from poverty and idleness which enabled it to become an object of medical categorisation and obscured the social, juridical function being performed. This social, juridical function becomes more clearly visible at certain moments however, and the incident that produced risk assessment's ignoble beginnings is one such moment.

1.4.2 Christopher Clunis: A dangerous victim.

While waiting for a tube at Finsbury Park station in December 1992, Jonathan Zito was attacked and killed at random by a stranger, Christopher Clunis (Waterhouse & Williams, 1993). Zito, a white, recently married Italian man, was on his way to celebrate Christmas with his and his new wife's family. Clunis, a large, black, unemployed man with a diagnosis of schizophrenia, who had been in and out of psychiatric services for the past five years, stabbed Zito in the face several times.¹⁴ Clunis had been reported to the police on a number of occasions in the days preceding this incident and had been discharged from a psychiatric hospital three months earlier. He had failed to attend a number of outpatient appointments and in the past had attempted to stab a police officer, a patient and a roommate.

Following this incident, Virginia Bottomley, Health Secretary at the time, ordered a review of the law surrounding community care received by psychiatric patients following hospital discharge.¹⁵ Bottomley argued that not enough mechanisms existed to supervise “those most at risk” (The Guardian, 1993, p. 1). Initially, press reporting was modest.¹⁶ Two days after the incident, *The Times* (1992) reported in a matter of fact manner that the unemployed Clunis had stabbed Zito to death through the eye and that he was due to appear in court that day. It was not until June 1993 that newspapers became more interested and coverage became more impassioned. *The Daily Mail* (1993) titled an article “Why was he set free to kill my husband? Widow’s question as psychotic knifeman is locked away at last” (p. 15). In the article, Zito’s wife, Jayne, describes her desire for a full public inquiry into the care Clunis received:

There are people walking the streets with serious mental health problems who are frightened about what is happening to them. They have nowhere to go and no-one to care for them and they cannot take responsibility for what they do. I want to know why Christopher Clunis was on that platform that day. You still need long term psychiatric units for people like him. (The Daily Mail, 1993, p. 15)

An investigation was carried out by *The Independent* who similarly focused on the care Clunis received arguing that buck-passing by professionals allowed a very dangerous man to slip “through the net. Why was he not detained in hospital? If he was being treated under the Government’s ‘Care in the Community’ policy, who was supposed to be caring for him?” (Waterhouse & Williams, 1993, p. 17).

Press coverage began to snowball. Clunis was convicted of manslaughter at the end of June and political pressure increased with opposition politicians calling for a suspension of plans to close psychiatric units and a review of community care arrangements and resources (The Times, 1993a). Jayne Zito gave a press conference on the day of Clunis’s conviction calling for a public inquiry and met with Virginia Bottomley and John Bowis, a health minister, a week later where she repeated this request. Bowis described Jayne Zito as “courageous and dignified” but rejected a public inquiry in favour of a private inquiry

conducted by the two regional health authorities most recently involved in Clunis's care (The Independent, 1993a, p. 6). Jayne Zito called Bottomley and Bowis "patronising and full of platitudes. They tried to turn this into my personal tragedy instead of tackling the questions that need to be answered about Care in the Community. They used our meeting as a PR opportunity. Shame on them" (The Independent, 1993a, p. 6).

Jayne Zito was not alone in her criticism. Two mental illness charities, the National Schizophrenia Fellowship (NSF) and Schizophrenia A National Emergency (SANE), used the Clunis incident to argue that community care was becoming a black hole where people disappeared, and potentially negligent, due to being underfunded, with 40 people being killed by people with mental illness in the last two years and over 100 people with mental illness committing suicide (The Independent, 1993b).¹⁷

Supervised discharge emerged as one response to this shifting landscape. The Royal College of Psychiatrists had previously proposed Community Supervision Orders as a solution to the problem of patients refusing treatment, such as medication, in the community after discharge. This would allow them to be rapidly re-detained if they refused to be supervised in the community (Holloway, 1996). These orders were criticised by patient groups and enforcing medication was said to be a violation of people's civil liberties (The Times, 1993b). Supervised discharge, by contrast, would involve individual professionals being given responsibility for patients in the community with the responsibility to assess their suitability to live in the community and the ability to section them under the Mental Health Act if required. This was announced as part of a Ten Point Plan which recommended a review of possible admission when someone refuses to comply rather than an automatic return to hospital as well as an extension from a six month period to a year "during which patients given extended leave...can be recalled to hospital" (Burns, 1994, p. 130). This contrasted with the response desired by a range of social actors including the British Medical Association, Mind and the NSF who argued for additional funding and resources, a minister for community care and an ombudsman (Press Association, 1993a).

In November 1993, Jayne Zito announced she was planning to take legal action alongside Clunis and against the NHS for failing to care (The Evening Standard, 1993). One year after Zito's death, *The Independent* published a two thousand word article by Jayne Zito describing her loss (Press Association, 1993b). She said that when she saw Clunis in court "there was no one there to hate...the man I saw was empty, hollow, a shell of a life" and how she:

wanted the government to do something, to feel something. I wanted the goodness that Jon and I had shared and the value of human life to be recognised...There is also Christopher Clunis, the fear that I have passed him in the street, although I know that he is in Rampton...Mr Clunis and I, and Jon, have in common the need to expose the unhumanity [sic] of the system of community care that has been set up by this government. The system and some professionals working within it failed at critical moments, and it led to the denial of a life. (Press Association, 1993b, p. 20)

In Jayne Zito's actions and this article, mental health campaigners, people with mental illness and people who are victims of crimes committed by people with mental illness are aligned in opposition to the 'system', some professionals within it, and the government who are given ultimate responsibility. This builds upon a specific articulation of Clunis as dangerous, but also as a victim of an inhumane system, afraid, in need of care and not responsible for his actions. In Clunis, then, we see the production of a paradoxical individual, a dangerous victim.

This dangerous victim also existed in the findings of the inquiry into Clunis's care (Ritchie, Dick, & Lingham, 1994). The 'Ritchie report' (1994) describes the Zito family, Christopher Clunis's story, specifically focusing on his involvement with services in London and Jamaica, the incident itself, deficiencies in care, and recommendations. The report describes Jonathan Zito, recently married, as a talented musician, composer and artist with "an unassuming manner, a gentle and sensitive nature and was liked by all who knew him" (p. 99). Clunis, by contrast, is described, using witness statements, as "shabbily dressed", "strange", "a bit crazy", "without any sign of remorse or concern", "slow" and "possibly

educationally subnormal” (pp. 100–101). Later, he is described as an “intelligent and apparently easy going man, articulate and with a good sense of humour”, as someone who needed help but did not know how to ask (p. 103).

So we have a slow, crazy Clunis and a smart, laid back Clunis. This double description, a fear-stigma paradox, produces both an image of a madman we need to fear and a victim of a mental illness requiring care. Through the use of witness statements, it simultaneously constructs a dangerous individual while avoiding the accusation of contributing to the stigma people with mental illness experience. It also relies upon a specific description of Zito to do this. He is likeable, sensitive, recently married, a model citizen, but an ordinary one. Regardless of the actuality of Zito, in this report he signifies the opposite of the dangerous version of Clunis. In this contrast between Zito and Clunis, we can see, drawing upon Lacanian psychoanalysis, a fantasy narrative containing both beatific and horrific aspects. Zito embodies the beatific, which occurs when there is a promise of social salvation, fullness or harmony, Clunis, the horrific, a threatening menace leading to societal decline (Glynos, 2011). Here, Zito personifies such harmony as a model citizen who succumbed to the mad, subnormal obstacle that is Clunis. This narrative then contains elements which can speak to us on an ideological level with an illusory promise of a harmonious society if the threat can be eradicated, or properly contained within a humane system of community care. Race is important here too, although it tended to be unspoken, in allowing ‘otherness’ to be linked with fear. Clunis, being black, implicitly referenced those historical discourses which have intertwined the black male body with threat and danger, as seen in the disproportionately high diagnoses of psychosis and use of sectioning amongst black people (Neal, 1998).

1.4.2.1 The turn to risk.

The Ritchie report made numerous recommendations including more additional funding for patients who need special care, extra psychiatric beds and haven type accommodation for those unable to cope in the community (Ritchie et al., 1994). The report

also recommended the establishment of a register of all patients subject to section 117 of the 1983 Mental Health Act and the allocation of a responsible professional. Section 117 relates to the aftercare arrangements for people who have been detained under the mental health act. This recommendation was not a new idea. The Ten Point Plan had recommended the establishment of special supervision registers for those who are “most at risk” and “need most support”, as well as the powers of supervised discharge discussed above (Burns, 1994, p. 130). These registers were introduced in April 1994, two months after the publication of the Ritchie report (Holloway, 1994).

The Ten Point Plan’s recommendations were formalised in new governmental guidance: the *Introduction of Supervision Registers for Mentally Ill People from 1 April* and *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* (Department of Health, 1994a, 1994b). The risk registers were to identify and provide information on patients who “are, or are liable to be, at risk of committing serious violence or suicide or of serious self neglect” (Department of Health, 1994b, p. 1). The decision to place someone on the register was said to rest with the responsible consultant psychiatrist in liaison with the team and to be based upon detailed evidence. The information required for someone on the register includes: personal information; nature of risk (category of risk, warning indicators and evidence of specific episodes of risk behaviour, including relevant criminal convictions); key worker and relevant professionals; and care programme details.

The discharge guidance describes itself as an application of the Care Programme Approach (CPA) and here risk is “a prime consideration in discharge decisions” (Department of Health, 1994a, p. 3). NHS professionals and service providers are instructed to put the guidance “into immediate practice” (p. 1). The emphasis is on avoiding discharge unless clinicians are satisfied that a patient will not pose a serious risk to him or herself, or others and that this needs to be based on “full and proper consideration of any evidence” (p. 6). Those with a history of aggressive and risk taking behaviour are said to present special problems and require very careful assessment.

1.4.2.2 Dissenting discourses.

If Jayne Zito's discourse creates an equivalence between the government and the system, many professionals did their best to break such a chain of equivalence down in response to the announcement of risk registers. Dissenting discourses abounded which show not just an opposition to the registers but also to risk coming to dominate clinical practice. Fiona Caldicott (1994), then president of the Royal College of Psychiatrists, articulated a number of concerns on behalf of the College in a letter to Virginia Bottomley published in the *Psychiatric Bulletin*. The letter begins with an acknowledgement of the many letters Caldicott had received from members across the country expressing concern about the registers. She states there is a strong view the registers will not help in documenting a minority of people who require close care and supervision, something the College supports in principle.

Twelve specific concerns are raised (Caldicott, 1994). The criteria are said to be over inclusive and would lead to a considerable proportion of patients being on the register. The cost of establishing the registers throughout the country is estimated as £77 million. There is a strong concern about the legal position facing clinicians and services if there is a serious incident involving someone not on the register. Assessing risk is said to be imprecise and risk itself, impossible to be eliminated. It is not clear how people can be removed from the register as the risk factors continue to have an impact in the long term. The registers are also said to create a disincentive for working with patients who are on them because of professional and personal risk if anything were to go wrong. There is a concern that including people with personality disorders would lead to a diversion of much needed resources for this group. The registers are said to be an infringement upon civil liberties and, as such, a major benefit to being on them would need to be demonstrated before they are introduced. The registers are said to be of little clinical use on a daily basis and so liable to become inaccurate and possibly lead to complacency as they give the impression something has been done. The actual process of placing people upon a list is said to be counter therapeutic and could reduce people's desire to enter services. It is also felt that breaches of confidentiality are likely and that the whole process is very time consuming and so would reduce face to face clinical care.

This letter of dissent combines a range of elements to make the case against the adoption of the risk registers and echoes some of the problems with risk assessment described in the archaeology section above. It also shows how the introduction of these risk registers, and an emphasis on risk more generally, was a very particular response to only some of the numerous problems articulated following the Clunis incident, and one which involved shifting responsibility from government to the psychiatric profession. Aware of this, many within the profession objected. The difficulty of being able to predict dangerousness was pointed to, as well as the fear “that the supervision registers will reinforce perceptions of psychiatrists and mental health professionals as agents of social control whose major role is protecting the public from dangerous or deviant behaviour” (Holloway, 1994, p. 594).

Six consultant psychiatrists, three senior registrars and a consultant psychotherapist put their names on an article arguing that there was no clear benefit to patients from being on the registers and that it was unclear how patients should be informed they are on the register and how this might affect them (O’Connor et al., 1994). The lack of consultation and extra resources required was a further concern. The register was seen as harmful by labelling someone as potentially at risk and obscuring the real underlying problems leading to their psychiatric condition. Instead of focusing on good community provision, housing, employment and psychiatric services this was said to be colluding with an “exercise designed to shift accountability and disguises poor psychiatric provision” (O’Connor et al., 1994, p. 1237). The registers were also described as “an invitation to litigation”, especially when there is a serious incident involving someone not included on the register as this would seem negligent (Harrison & Bartlett, 1994, p. 551). The logics affecting the decision to take someone off the register are also questioned: if the best predictor of the future is the past, then many people will remain on the register regardless of improvements as the risk factors will remain in their past.

Others attempted to redirect the conversation so that risk registers were discussed in relation to community care. Mind and the health union, Unison, felt the risk registers were an attempt to distract people from the crisis of community care and its real causes, and that there

was a need for more community services, 24 hour crisis centres and supported accommodation (Press Association, 1993b). Jayne Zito's campaigning continued with her delivering a petition signed by 30,000 people, including the British Medical Association and the Association of Directors of Social Services, to Downing Street in May 1994 (Press Association, 1994). This petition argued for national standards in community care provision, 24 hour services, an end to drugs being prescribed above recommended dosages, less electroconvulsive therapy and more counselling and alternative therapies available through general practitioners. This followed Jayne Zito claiming, three months earlier, that Virginia Bottomley was accountable for the death of her husband which Bottomley had displaced onto police, health staff, a Labour run social services authority and combatted with an extra 10 million pounds for community based mental health services in London (The Observer, 1994).

1.4.2.3 The glue to hold things together.

The contestations were then contested. Virginia Bottomley (1994) replied to Caldicott's letter disputing each of the points raised and downplaying the extent to which risk registers altered clinical practice. Bottomley claimed that they would merely help systematise risk assessment and management processes. Government policy thus ploughed ahead and some leading psychiatrists voiced their support: "To blame government policy for community care is to deny our individual responsibilities as psychiatrists: we discharged the patients, not the Secretary of State" (Tyrer & Kennedy, 1995, p. 193). It is said to be a contradiction to worry about the civil liberties of patients while also supporting institutional care, and psychiatrists are criticised for ignoring the increasing public concern for the rights of those at risk like Jonathan Zito. The profession is looking for "the glue that will hold together all the components of care for those people who cannot hold them together for themselves, and no longer have a mental hospital to do it for them" (Tyrer & Kennedy, 1995, p. 194). The risk register is said to be this glue, but maybe risk as a system of thought became the glue which seeped into the void made visible by the case of Christopher Clunis.

1.4.3 Isabel Schwarz.

Six months after the Clunis incident then, risk was articulated into a coherent discourse. It became a key feature of governmental guidance and risk assessment became a statutory duty for clinicians despite numerous concerns. A few years earlier, in response to a similar incident, risk featured but was not articulated as a solution in quite the same way. In July 1984, Sharon Campbell stabbed her social worker, Isabel Schwarz, to death in Schwarz's office (Sheppard, 2004). There was a relative lack of discourse about this incident in UK newspapers in relation to the Clunis incident. A Nexis search of UK publications returns just 14 articles using the search terms (1) Sharon Campbell and (2) Isabel Schwarz OR Social Worker. This contrasts with 577 articles using the search terms (1) Christopher Clunis and (2) Zito.

The first of the Schwarz articles was published in *The Guardian* nearly a year after the killing (W. Schwarz, 1985). This was written by Walter Schwarz, Isabel's cousin. He describes how one of Schwarz's colleagues found her dead in her office at Bexley Mental Hospital at 8.50pm on a Friday evening. Campbell, a former patient at Bexley, with a diagnosis of schizophrenia, was charged on forensic evidence. The article states that Schwarz's parents did not decide to pursue legal action but Isabel's father, Dr Victor Schwarz, a Reader in Biochemistry at Manchester University, had sent a list of awkward questions to Bexley Social Services. A motive is given in that Campbell was previously discharged from Bexley and transferred to a hostel against her will. Schwarz had offered to drive her to the hostel and on the way Campbell started attacking Schwarz with her handbag who then called the police. Campbell was taken away by the police without charge. She subsequently made threatening phone calls to Schwarz before, ultimately, she killed her. The article describes dangerous situations as inherent in social work and a need for better training, protection and security is stressed. Risk does feature in this discourse but not directly attached to Campbell; Schwarz is said to have taken risks which society is described as indifferent to. Following the incident, Campbell, like Clunis, pleaded guilty to manslaughter and was sent to Broadmoor indefinitely.

While Jayne Zito's reflections on her husband's death were published in *The Independent*, Victor Schwarz's (1985) were published in a social work journal, *Community Care*. Schwarz (1985) describes his hope that Isabel's death will not be "entirely in vain" (p. 22). Schwarz describes how mistakes were made in Campbell's care. It was not that her level of risk was not assessed, but that her *mental state* was not assessed regularly. This shows us that we are in an era before risk assessment had become sedimented, although Schwarz does argue for a log to be kept of anyone who has been violent or threatened to be, and for any violence or threat to be reported so social workers can protect themselves and the public.

An inquiry was called for in February 1986 and promised by the government in June. However, by January 1987 it had still not been established (The Guardian, 1987a). An official public inquiry was eventually set up by the Department of Health and Social Security (now defunct) focusing on the care and aftercare Campbell received and in response to Victor Schwarz's claims that Isabel died as a result of negligence (The Guardian, 1987b). During the inquiry, Stanley Bute, a social worker and expert witness on violence, described how violence is often not reported by social workers as it can be considered unprofessional, limit promotion opportunities and make some professionals feel guilty (The Guardian, 1987). Bute also described the need for a central register of people who had been violent, which would later become a risk register.

The inquiry report was published in 1988 (Spokes, Pare, & Royle, 1988). It concluded that if Campbell had not fallen through the gaps of the local system, the incident could have been avoided. The risks of violence to social workers were discussed but risk assessment and management was not recommended. Instead, there was an emphasis on social workers being trained to recognise and avert violent incidents as well as to report them. The report also recommended that health and local authorities should be provided with a written summary of their statutory duties in relation to aftercare by the Secretary of State, and that good practice guidelines on the same issue should be provided by the Royal College of Psychiatrists.

The Royal College of Psychiatrists' (1991) response was to publish guidance on good practice in the aftercare of psychiatric patients following discharge. This guidance was said to reflect the philosophy of the CPA, recently introduced by the government. This philosophy is said to be to ensure that all mentally ill people are discharged into the community only when they have adequate services to meet their needs. The document is said to be concerned with people who are potentially violent or particularly vulnerable because they present a risk to themselves or others. Risk surfaces in this way on two occasions in the guidance but then retreats with the emphasis returning to violence and vulnerability.

The same can be said of the CPA (Department of Health, 1990) in its initial manifestation.¹⁸ Here, four main components were outlined: the need for systematic assessments of the health and social needs of people accepted into specialist mental health services; the need to devise a care plan to identify the care required from health and social care; the need to appoint a keyworker to stay in touch with the patient, monitor and co-ordinate care; and the need for regular review and update of care plans where required. By the time the CPA was revised (Department of Health, 1999), risk assessment and management was in a position to be articulated as one of the key revisions to this documentation. Table 1 provides an overview of the inscription of risk discourse within government policy and guidance, and select key events from 1988 to 2011.

Table 1

Inscription of risk discourse within Department of Health (DH) policy or guidance

Year	DH Policy or Guidance	Risk discourse	Key Events
1988		Social workers to be trained to recognise, prevent and report violent incidents	Spokes inquiry report into death of Isabel Schwarz published
1990	NHS and Community Care Act The Care Programme Approach		Market based principles introduced into NHS Purchaser/provider split Health and social care divided
1991			Care Programme Approach (CPA) introduced
1992		Health Secretary, Virginia Bottomley, orders review of community care law to supervise those most at risk	Christopher Clunis kills Jonathan Zito Ben Silcock mauled by lion at London Zoo
1993			Ten Point Plan recommends supervised discharge Jayne Zito announces plan to take legal action alongside Clunis and against the NHS
1994	Introduction of Supervision Registers	Supervision registers introduced to identify and provide information on those at risk of committing serious violence or suicide or self-neglect	Ritchie Report (report of Clunis inquiry) recommends supervision registers and allocation of responsible professional
	Guidance on Discharge of Mentally Disordered People	Risk assessment required before a patient is discharged from hospital	
1995	Mental Health (Patients in the Community) Act	Supervision registers and CPA become statutory Supervised Discharge Orders enable compulsory treatment (although not medication) for patients previously detained under the Mental Health Act	
1997	The New NHS: Modern, dependable		New Labour Government Responsibility for commissioning services shifts from Health Authorities and GP fund holders to Primary Care Groups Emphasis on partnership between government, private

Year	DH Policy or Guidance	Risk discourse	Key Events
1998	A First Class Service Modernising Mental Health Services	NHS trusts obliged to have clear risk assessment and management policies Emphasis on the need for public safety from a small but significant minority of patients posing a danger to themselves and others	companies and voluntary organisations NICE launched Clinical Governance introduced
1999	Modernising the CPA National Service Framework for Mental Health	Risk assessment and management a key revision of CPA Guidance removes the need for supervision registers if replaced by a two tier CPA	
2002			Primary Care Trusts replace Primary Care Groups and become responsible for commissioning Health Authorities replaced by smaller number of Strategic Health Authorities
2005	Mental Capacity Act		
2006			The Depression Report makes the case for an increased role for psychological therapies
2007	Best Practice in Managing Risk Mental Health Act amended	Therapeutic relationship re-described to include an objective assessment of risk Risk management embedded in CPA Community Treatment Orders replace Supervised Discharge giving the allocated responsible clinician the powers to return a patient to hospital for forced medication if non-compliant	
2008	IAPT implementation plan Refocusing the CPA	CPA introduced only for high risk patients	IAPT launched
2009	Best Practice in Managing Risk	2007 guidance updated to include implementation advice Collaborative structured clinical approach to risk assessment emphasised	

Year	DH Policy or Guidance	Risk discourse	Key Events
2010			Coalition Government formed between Conservative Party and Liberal Democrat Party
2011	No Health Without Mental Health	Risk assessment described as an intrinsic aspect of clinical assessment	Majority of England has IAPT service 3,660 new CBT practitioners Over 600,000 people treated

1.4.4 From Schwarz to Clunis to risk.

The Schwarz incident clearly did not have the same impact as the Clunis incident, and risk did not feature in the same way, showing its historical contingency. With Schwarz, the focus was on people who have been violent and how to deal with violent incidents, with Clunis, attention shifted to the future, towards predicting and reducing risk. When viewing the social world as one criss-crossed by antagonisms, the Schwarz incident did not have the same dislocatory effects as with Clunis. It was a serious incident within the system of mental health care which had an influence on policy and systems of care. However, it did not lead to the system of care being questioned in the same way, instead the focus was on reforming aspects of practice for social workers with little opposition or alternative projects articulated. This incident had less public visibility than the Clunis incident and we did not see such a range of social actors engaging with the Schwarz incident. Mental health charities and political campaigning were not present to the same degree. The wider context is significant; by the time of the Clunis incident, many mental hospitals had closed and community care was well underway but even in the late 80s, the vast majority of mental illness funding still went to inpatient care (Holloway, 1996). Mental illness itself was less visible than it was soon to become.

This does not mean that risk discourse appeared for the first time following the Clunis incident in a moment of brilliant or necessary discovery. Risk had been germinating for some time before as we can see in the Schwarz incident, and in academic and clinical debates over how best to assess dangerousness which had been present since the 1980s

(Monahan, 1981). This is also evidenced by an article in *The Guardian* (1992) ten months before the Clunis incident. Here, additional homicides by psychiatric patients were discussed with an emphasis on the killings being foreseeable and thus preventable. The article speaks of “two conflicting imperatives: safety for the public, rights for patients” (p. 19). A more rigorous approach to discharging patients is called for such as one expert’s description of a graduated approach of “small, minor-risk taking decisions. ‘If the risk works, take another, but if it doesn’t, go back a step. That way you avoid potential disaster’” (p. 19). Here we see the anticipation of risk as a way of dissolving an antagonism between the public and patients.

One wonders about the fantasmatic aspect of this as community care materialised. The madman, presumed dangerous, is no longer confined but is free to roam the streets. Clunis embodied this and some of the headlines at the time speak to a widespread anxiety about people with mental illness, in particular the *psychotic knifeman*. But at the same time, the madman has also become a victim, a person not responsible for his actions, someone we can identify with. Clunis’s constitutive outside, Zito, becomes merged with him. Anti-stigma campaigns and the extension of civil liberties to the mentally ill, influenced by humanistic discourses, allowed mentally ill people to align with charities and campaigners in opposition to the system of care as it existed at this time. The danger then becomes the system of care and those who administer it, a system which is not effectively run, lacking in bureaucratic efficiency, resources and funding.

The impossible ideal here, of course, is the perfectly efficient system of psychiatric care and, when needed, control. Risk assessment and management allowing for individuals to be distributed appropriately within an elaborate system of psychiatric care with various sites and levels of security (institutional: high, medium and low secure units; and community: secondary care, primary care). Here, we all become equivalent in opposing risk – we are all subject to risk – and so the oppositions we saw between the government and psychiatry; between people with mental illness, political campaigners, unions, the press against the government and system of care slowly fade away and become less visible. So does the fact that risk as we know it relied upon a specific context to be articulated in the way it was: a

privatised system of health care, a liberal economic order, an individualistic philosophy which values blame and responsibility.

As we have seen though, the system of mental health care remains vulnerable to contestation by a range of social actors and will always do so from the perspective of the ontological position taken here, radical contingency.

1.4.5 Hegemony of risk assessment.

In the aftermath of the Christopher Clunis incident, which occurred as care in the community accelerated, a range of discourses were articulated by a variety of social actors. This involved the government's community care policy being critiqued in numerous ways including being inhumane, potentially negligent due to being underfunded, and lacking in appropriate resources and treatments. This line of critique was taken up variously by Jayne Zito, mental illness charities and unions, the media and opposition politicians. The government response was to introduce supervised discharge whereby individual professionals were made responsible for patients in the community with the ability to section them if required, and expected to avoid discharging someone unless they were satisfied the patient would not pose a serious risk to him or herself, or to others. This required systematic risk assessment and risk registers were introduced to provide information on people who were, or who were liable to be, at risk of committing serious violence or suicide.

This move by the government shifted the discourse away from potential problems with community care and risk as a signifier was a key part of this. Prior to this incident risk retained more of its contingent nature. Isabel Schwarz, for example, took risks in her work with Sharon Campbell and rather than being considered a risk, Campbell was seen in terms of her mental state and social work was said to involve dangerous situations. Following Clunis, risk was modified to refer very specifically to the risk posed by people with mental illness to themselves or to others and this risk became linked to individual professionals whose responsibility it was to systematically assess the risk. This anticipated a good therapeutic relationship being re-described to include an objective assessment of risk as seen in

subsequent government documentation and so the hegemonic status of risk assessment practice within mental health. This response can be considered ideological as it provides an illusory promise of closure, a false sense of reassurance. It is as if incidents like those involving Clunis and Schwarz will never occur if risk can be systematically assessed. Or if they can be correctly identified the risk or threat that they pose can be eradicated. It also provides someone to blame if things go wrong – the risk assessor.

The extent to which we should not be reassured by this response is clear when considering the limitations of risk assessment as shown in the archaeological and genealogical problematisation. It is worth rehearsing this to crystallise the problematic aspects of risk assessment practice. Firstly, accurate prediction of risk is not possible and risk assessment is imprecise regardless of the method of assessment. The risk behaviours being focused on, like violence and suicide, are rare within the population which means the majority predicted by an assessment, actuarial or otherwise, to be at risk would actually be false positives. Even when someone is correctly identified as being at risk, it is unclear whether an intervention will actually reduce the risk.

If resources are limited and the allocation of resources is linked to risk assessment, this could have negative consequences. For some, this will involve being considered at risk which could be counter therapeutic and for those who are false positives, this may involve receiving unnecessary interventions. For others, they may not receive care or resources they may find beneficial. Some, for whom risk assessment is unnecessary, may find the process of risk assessment disruptive and it could serve to increase stigma through maintaining an association between mental illness and danger, which could encourage social exclusion. This is particularly the case in primary care settings like IAPT where many people receive risk assessments. There is also a consequence of risk assessment encouraging defensive practice and patients being seen as a source of threat. This may create a disincentive for working with particular patients. It may also lead to an over emphasis on secondary risk management within a culture of litigation whereby clinicians become skilled at managing the risk to their reputation through defensive practices at the expense of developing skills in the primary task

of providing treatment for people with a mental illness. Risk assessment is time consuming too and so takes time away from other tasks, like building a therapeutic relationship. This may reduce trust in mental health services as clinicians become absorbed in their administrative duties, and so leave people reluctant to receive treatment.

The extensive focus on risk assessment may conceal other risks too. It may obscure possible risks from coming into contact with mental health services, like loss of liberty, forced treatment or even poor treatment. It may also obscure more social risks like the risks involved in living in inadequate accommodation or being exposed to victimisation. It may narrow the focus to the individual and so prevent social or systemic risks, like poverty and unemployment, from being considered. At a broader level, perhaps this feeds into a culture unable to tolerate uncertainty and so increasingly susceptible to ideological modes of functioning.

1.5 Research Questions

Turning towards the actual practice of risk assessments, this archaeological and genealogical problematisation leads to a number of questions to be explored within the empirical work:

1. What does the actual practice of risk assessment in an IAPT service entail? How can this be characterised?
2. How is the practice of risk assessment instituted? What alliances between social actors does it create or disavow?
3. What influences people engaging in risk assessment practice in the way that they do? Why do people continue to complete risk assessments despite them being problematic?

The logics framework offers a way of engaging with these questions as it provides a way of understanding social practices through examining social logics; a way of understanding how practices are maintained, challenged or transformed through political

logics; and a way of understanding why practices retain an affective grip through fantasmatic logics. The logics approach and research strategy will now be outlined in more detail.

Chapter 2: Research Strategy

2.1 Chapter Overview

This chapter outlines the strategy developed for this research which utilises a logics approach. It begins by offering some background to the logics approach and contrasting this approach with other approaches used in social science research. It then discusses discourse theory and outlines the specific elements that constitute a logics approach emphasising the ontological position that informs the research. The chapter then considers the empirical context and material that form the object of study. The research process is then outlined as well as the process of analysis and the chapter concludes by describing ethical considerations made in relation to completing the research.

2.2 A Logics Approach

2.2.1 Background considerations.

This thesis is informed by the framework set out in the *Logics of Critical Explanation in Social and Political Theory* (Glynos & Howarth, 2007). This approach sets itself in opposition to those seeking to establish universal, causal laws, those based upon causal mechanisms, as well as hermeneutical approaches which prioritise contextualised understandings of people's own interpretations. Instead, Glynos and Howarth (2007) aim to establish a framework which can integrate empirical, interpretative and critical considerations. This involves deviating from the typical format of social science research and also has key differences from discourse analytic approaches most commonly used in psychology.¹⁹

The typical methods used within social science research are informed by the underlying epistemological assumptions of positivism.²⁰ From this view, knowledge is generated through empirical observation and measurement, and developed for the purposes of prediction and control. The hypothetico-deductive method is the dominant method linked to positivism which involves inducing falsifiable hypotheses from observed phenomena, deducing ways of testing these empirically and then doing so, before confirming or refining

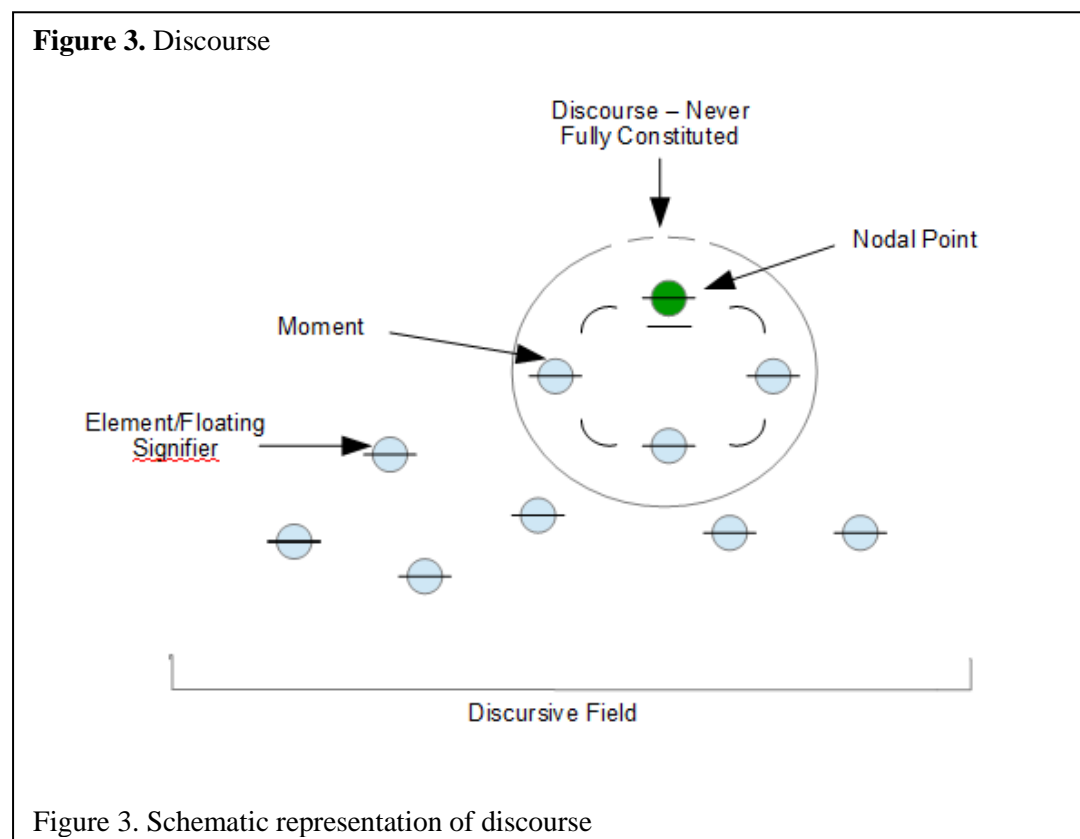
hypotheses based upon the results (Howitt & Cramer, 2011). Positivist approaches have been widely critiqued.²¹ One important element of this critique challenges the idea that scientific knowledge can be neutral, value-free and objective, with both theoretical and empirical work undermining this ideal (Glynos & Howarth, 2007). The role of context is also problematic within positivist approaches, where the tendency would be to view it as an extraneous variable to be controlled which obscures the active role context plays in shaping meaning and understanding.

Approaches which have developed in response to some of these criticisms, including causal mechanism and hermeneutic approaches, are also seen as problematic from the logics perspective. The strength of these approaches is that they take into account, but do not rely solely on, the meaning people attribute to their own actions. However, the idea of causal mechanisms remains influenced by the powerful ideal of causal laws, and hermeneutical accounts become overly localised and so fail to adequately explain and critique social phenomena. The logics approach recasts the influence of a “causal law paradigm” as a hegemonic grip which is inappropriate for engaging with social processes due to a narrow conception of testing and explanation and a neglect of context and ontology (pp. 18-19). It therefore prioritises ontological considerations rooted in poststructuralist discourse theory.

2.2.2 Discourse theory. ²²

The logics approach grew out of Laclau and Mouffe’s (2014) poststructuralist and post-Marxist conception of discourse. Here, everything in the social world can be seen as being discursive as everything is or can become an object of discourse. The meaning of a particular object is therefore what is important and meaning depends upon a socially and historically constructed system of rules and differences. Laclau and Mouffe (2014, pp. 91 – 101) describe how within the *discursive field* that is the social world, individual *elements* exist. These *elements* are differential positions that have not yet been articulated within a discourse and so have a *floating character*. They can be combined by social actors through a process of *articulation* to form a *discourse*, a system of meaningful practices which forms the

identities of subjects and objects. This articulatory practice turns elements into moments through articulating their differential positions. As figure 3 attempts to represent, this involves the inclusion of some elements and the exclusion of others which means that forming a discourse is seen as inherently political as it requires drawing a political frontier between elements inside and outside a discourse. *Nodal points* are a key part of this process as they enable elements to be structured into a meaningful system of moments. This means that nodal points are in essence empty and so can be thought of as *empty signifiers* yet they work by binding a system of meaning. This involves power as it is a structuring of relations between different social agents.



Discourses are therefore seen as contingent and historically constituted but nevertheless capable of achieving a stable status or a knot of definite meaning (Torfing, 1999). Competing discourses can be seen as engaged in a struggle for hegemonic positions and thus stabilisation of the social order (Howarth, 2000). Hegemony is therefore a crucial

theoretical concept within discourse theory, where the major aim of hegemonic projects is to construct and stabilise nodal points by articulating as many available elements as possible, which produces a concrete social order. No discourse though is fully capable of achieving complete sedimentation of a field of discursivity as elements can be re-articulated and discourses can be challenged or disintegrate. In fact, they can never be fully constituted or achieve an objective, full presence and so are marked by a lack of closure. This brings us to the ontological position of lack that characterises the approach used here.

2.2.3 Ontology.

In opposition to approaches which bracket ontology as unknowable or limited to knowledge claims about the nature of being, and then prioritise epistemological considerations, the logics approach places ontology centre stage. Here, ontology is seen as “not only about the different *kinds* of things in the world, but is more importantly about the *being* of these beings” (Glynos & Howarth, 2007, p. 160).

A series of ontological assumptions therefore inform the approach taken in this research and so influence the way in which it engages with the practices being studied. This is true of all research, including positivist social science approaches, even if such presuppositions are not specified. Here, all actions, social practices and regimes, here understood as systems of practices, are seen as discursive in nature to reflect the view that meaning is central to all human practices. Objects acquire a definition or identity through particular discourses or systems of meaning. Howarth (2000) illustrates this by discussing the different meanings a forest can have: a part of an ecosystem, an area of natural beauty, an obstacle for a proposed motorway, a resource to be exploited for economic growth and so forth. We saw this too with Clunis; he was intelligent, dangerous, psychotic, in need of care, not responsible for his actions, a risk and more besides. Crucially, radical contingency structures the entire discursive field and the discourses formed within it meaning that all identities and practices are inherently instable: “radical contingency opposes empirical contingency’s sense of possibility with a sense of *impossibility*; the *constitutive* failure of any

objectivity to attain a full identity” (Glynos & Howarth, 2007, p. 110). What becomes important here then is the “contingency, historicity and precariousness” of objects and subjects rather than their essence and causal influence (p. 11).

The division of social space into four different dimensions is a further ontological presupposition of a logics approach and social practices can be understood in relation to these dimensions which are described along two axes: a political-social axis and an ideological-ethical axis (Glynos & Howarth, 2007, pp. 110-120). The social dimension relates to being absorbed in social practices and so inattentive to radical contingency. This contrasts with the political dimension where radical contingency is brought to the fore and social relations are contested. The ideological dimension refers to those aspects of social relations where subjects engage in practices which conceal radical contingency. Finally, the ethical dimension relates to practices where subjects attend to issues of radical contingency whilst engaging in social practices.

In relation to risk assessment, the social dimension would involve the actual practice of carrying out an assessment or being assessed. The political dimension would involve defending risk assessment practice, or explaining, justifying or contesting it. The ideological dimension would involve being caught within a fantasmatic narrative that views risk assessment as a necessity. The ethical dimension would involve a consideration of risk assessment’s contingent nature and its limitations. This may include an awareness that the fantasies that lead us to desire a perfect system of risk assessment are just that, fantasies.

2.2.4 The subject.

In line with the above ontology, the subject is viewed as “a discursive construct or entity, whose identity depends on its relationship to other subjects and objects...because each discursive construct is never fully constituted, but essentially incomplete or lacking, the subject is also lacking and incomplete” (Glynos & Howarth, 2007, p. 127). This makes clear the impossibility of achieving a fully sutured identity. Lack is made visible at those moments when identities fail and subjects are compelled to engage in acts of identification. Such acts

can energise subjects around particular practices which raises the importance of enjoyment in the process of identifying with fantasmatic narratives. There is therefore a need to consider the interpretations subjects give to the practices they are involved in, but this is insufficient in itself as it can obscure aspects that subjects may be unaware of.

2.2.5 Epistemological consequences.

Viewing epistemology in a general sense, as relating to theories and methods of knowledge (Steinmetz, 2005a), there are certain consequences that follow from the ontological position employed. Firstly, any knowledge generated would not be considered a true or whole account of a phenomena being studied as this knowledge itself would have to be understood as contingent to be consistent with the ontological assumptions. This is why the research process is described as a process of articulation with logics being a way of characterising different aspects of the social world.

A range of empirical phenomena can be engaged with from this approach and research findings from distinct approaches can be incorporated into its knowledge base so long as the findings are understood from the ontological position described. While possible, this is not a straightforward process as it is likely to involve decoupling such findings from their own ontological and epistemological assumptions and rearticulating them. Case studies, such as this research, and comparative cases are highlighted by Glynos and Howarth (2007) as being well placed to contribute to knowledge development. While the logics approach is a relatively recent one, it has been utilised to engage with a range of empirical phenomena including, for example, health and social care reform (Glynos et al., 2015), time bank practices (Glynos & Speed, 2012), education policy (Clarke, 2012) and business consultancy board meetings (Thompson & Willmott, 2015).

To better reflect the ontological presuppositions and to distinguish this approach from those informed by a causal law ideal, the research is more helpfully framed as having a strategy rather than a method. The strategy involves three interconnected practices: problematisation, retroductive explanation, and persuasion. It entails a process of articulation

and draws upon the language of logics to characterise aspects of the social world. These five elements can be considered the moments which make up a logics approach and will now be discussed in more detail.

2.2.6 Problematisation.

The logics approach takes a problem-driven approach to research, in contrast with a theory or method driven approach (Glynos, Howarth, Norval, & Speed, 2009; Howarth, 2013). As such, explanation begins with encountered phenomena which requires consideration. This involves constituting a problem, which can be thought of as problematisation, and this process itself typically transforms initial understandings. Problematisation combines archaeological and genealogical work to see how solutions to problems have been constructed, and how the solutions developed themselves depend upon a particular form of problematisation (Howarth, 2013).

2.2.6.1 Archaeology, genealogy, hegemony.

Archaeology refers to a methodological approach Foucault elaborated in *The Archaeology of Knowledge* (2002) to characterise his previous studies of madness (2001a), medicine (2003) and the human sciences (2001b). This stood in stark contrast to the then dominant approaches taken in analysing social and historical phenomena. He critiqued approaches which gave a privileged role to the individual subject, famously echoing Nietzsche's death of God (2006) by referring to the death of man in the closing passages of *The Order of Things* (2001b). His approach was also critical of explanations informed by an essentialist understanding of mankind, such as humanism, Marxism and psychoanalysis. Instead, Foucault prioritised discourse and discursive events and articulated a descriptive approach to documenting historically specific discourses. This would allow for an understanding of the rules that govern the production of such discourses.

Howarth (2002) usefully outlines some conceptual ambiguities within Foucault's work. He has a particular concern with objects being viewed as the product of linguistic

practices and capable of being exhausted by linguistic representations. Also, he problematises origins being tied to epistemes, or historically specific discursive formations, and the restricted possibility for critique when employing an archaeological approach – although Foucault offers a critique, it is not made clear how one can offer critique and what informs this. Howarth calls for archaeological work to be supplemented by a genealogical approach.

Foucault, of course, shifted his own focus to genealogy in *Discipline and Punish* (1991) and *The History of Sexuality* (1990). Genealogy provides a way of investigating the ignoble beginnings of a research object. It starts from the view that discourse, power and knowledge are interconnected as “it is in discourse that power and knowledge are joined together” (Foucault, 1990, p. 100). This entails seeing discourse as something which can transmit, produce and reinforce power but also expose and undermine it. Power and knowledge are coupled as they “directly imply one another...there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute...power relations” (Foucault, 1991, p. 27). Genealogy is a way of uncovering the variability and contingency of discourse through a description of the procedures, practices, apparatuses and institutions involved in the production of discourses and their power effects (Howarth, 2000). In contrast with archaeology, this requires evaluation and invites critique on the part of the researcher.

Despite this genealogical move, there remains a difficulty in explaining the actual practice of resistance and its precise relationship to issues of domination and this was something Foucault did not provide analyses of. What Howarth (2000) crucially adds to archaeology and genealogy is Laclau and Mouffe’s post-Marxist concept of hegemony as described above. This allows for an understanding of how social space may be divided into oppositional sections, or projects seeking hegemonic status, through the establishment of political frontiers structured around chains of equivalence and difference.

2.2.7 Retroductive explanation and persuasion.

As an alternative to inductive and deductive modes of reasoning, which separate discovery from explanation, retroductive reasoning is employed to create an interrelated view of the three stages of research: problematising phenomena, retroductive explanation and persuasion and intervention in a community. Retroductive reasoning is traced back to Aristotle and involves “studying facts and devising a theory to explain them” (Glynos & Howarth, 2007, p. 24). It is given a central role within a logics approach where it operates in a circular, dialogical fashion.

Retroductive explanation seeks to make the empirical material intelligible through an ongoing oscillation between the phenomena and various explanations, crucially linking discovery with explanation in opposition to positivist research. It involves articulating the relevant logics involved; characterising the practices being investigated and their need for analysis using an archaeology; and explaining their political and ideological emergence through genealogy.

Explanations are to be judged not by being empirically tested for predictive purposes and statistical significance, but by how intelligible they are and the understandings they offer in line with their underlying ontological assumptions. This makes ontology transparent in a way that is not often done within social science research and so links problems, explanations and theoretical assumptions rather than obscuring the latter.

2.2.8 Logics.

As represented in Table 2, Social, political and fantasmatic logics are the three logics at the heart of this poststructuralist account of critical explanation (Glynos & Howarth, 2007). These logics enable social practices and regimes to be described dialectically and an explanation of how and why such practices came into being and how they change or resist change.

Table 2

Functions of the explanatory logics: social, political, and fantasmatic

Explanatory Logics	Function	Formal Logics
Social	Provide a synoptic or synchronic perspective on social practices and discourses	
Political	Provide a dynamic or diachronic perspective on social practices and discourses	Logic of equivalence: organises social space into two opposing camps Logic of difference: multiples difference but resists dichotomies
Fantasmatic	Account for the grip of ideology beyond the limitations of pure rationalism, through the promise of beatific or horrific enjoyment	Beatific: offers promise of social salvation in the form of complete social harmony or efficiency Horrific: presents threat in the form of spectres of inexorable societal decline

Note. Adapted from “Talkin’ ‘bout a revolution: the social, political, and fantasmatic logics of education policy” by M. Clarke, 2011, *Journal of Education Policy*, 27, p. 7. Copyright 2011 by Taylor & Francis.

Social logics are the rules or grammar of a practice or regime and therefore enable the purpose, form and content to be seen. They can be thought of as patterned social practices linked to the interpretations of key people involved. They are also tied to particular historical and political contexts, showing their open-ended character.

Political logics show the institution, sedimentation or contestation of social practices or regimes, both past and present. Laclau and Mouffe’s (2014) logics of equivalence and difference, referred to in table 2 as formal logics to describe their ability to be specified outside of particular contexts, are relevant here in showing how political logics may operate. A logic of equivalence divides social space into two opposing camps – it links groups and individuals by minimising any differences between them and uniting them against a common enemy. In contrast, a logic of difference breaks down such equivalences by highlighting individual or group differences, incorporating them into an expanding order and thus preventing a challenge to a dominant regime. This is likened to “the age-old practice of ‘divide and rule’” (Glynos & Howarth, 2007, p. 145).

Fantasmatic logics draws upon Lacanian psychoanalysis – Žižek's (2008) political employment of Lacanian thought in particular – and refers to the ideological grip of a particular practice or regime. The concept of fantasy is used to explain why practices resist or, alternatively, embrace change. Fantasy operates by obscuring the radical contingency of the social world and thus 'promising' closure (Glynos, 2001). It can have different effects such as reinforcing social practices, covering up the political dimension of a given practice or creating an energy for change. This ties affect to a universe of meaning structured by fantasmatic frames (Chang & Glynos, 2011). For example, beatific fantasy may promise a completeness or harmony once an obstacle is overcome, or horrific fantasy may warn of potential disaster awaiting if an obstacle cannot be overcome. Fantasmatic logics, then, involves considering the enjoyment subjects experience in relation to social practices and regimes. Although, this enjoyment, being psychoanalytic, can be consciously experienced as suffering.

These three logics are described as necessary in accounting for problematised phenomena as they can characterise what practices are (social logics), how they came into being, are challenged and defended (political logics) and why this is done (fantasmatic logics). This allows for a descriptive, explanatory and critical framework for investigating social phenomena through a process of articulation.

2.2.9 Articulation.

Articulation is employed as the overarching way of conducting research from a logics perspective which is seen as a process of critical explanation (Glynos & Howarth, 2007, p. 165–208). It contrasts with approaches which attempt to subsume empirical phenomena under universal laws or mechanisms, or approaches which use an empirical case as an explanation in itself.

In providing an explanation of the problematised issue, theoretical and empirical elements are linked to produce a singular explanation (singular, in that it does not necessarily have applicability beyond the case studies, although it may – see below). This is done by

constructing nodal points which partially fix meaning in a new, singular way, thus altering individual elements. The most important part of articulation is its contingent nature, thus remaining faithful to the ontological position described above. Articulation, then, requires a situated, reflective judgement by the researcher informed by being immersed in the discursive field being studied. For example, it is up to the researcher to make judgements as to when something counts as an empty signifier or a political logic and researchers' judgements are improved through practice, as they become more familiar with the grammar of concepts and logics through investigating particular cases.

The articulation offered is therefore up for debate and clearly not the last word on a topic. Its success depends upon its persuasiveness as a valid explanation for the investigated issue, and the extent to which it provides a better account than rival explanations. An articulation may have applicability beyond the case being studied and so contribute to explaining related cases. When this is the case, such an explanation would be considered paradigmatic. It cannot be simply applied to another case in a straightforward way, but through a new articulation, sensitive to similarities and differences, a justifiable 'family resemblance' can be produced. This differs from research seeking generalisability due to the different underlying ontological assumptions.

2.2.10 Critique.

As should be clear, the logics approach is a form of critique and enables both normative and ethical critique. Ethical critique is prioritised due to being more directly connected to the specified ontology. A view of the social as ontologically open brings with it a critical stance towards discourses which, through the way individuals are gripped by them, conceal such contingency. Ethical critique is therefore located at the ideological level, the point at which 'closure' is promised, and explores the fantasies informing social and political practices. Normative critique, by contrast, is directed towards the social practices people find themselves in. This involves naming them as social logics, which itself involves bringing together heterogeneous elements, and so allows alternative practices, or counter-logics, to be

thought of. Glynos and Howarth (2007) utilise Laclau and Mouffe's principles of radical and plural democracy to inform their contingent normative judgements, where emphasis is placed upon the "plural, collective and democratic dimension of social life" (p. 196).

West (2011), drawing upon the work of Norval (2005), describes three critical impulses that a logics approach can generate, all of which were considered in this research. The first of these is Derridean and genealogical, an uncovering of alternative political projects, or ways of thinking, that have been concealed through a dominant, hegemonic order. This focuses attention on the structure of social systems, which contrasts with a second, Lacanian impulse towards an analysis of the subject's identifications in response to a fundamental lack and the degree of success associated with such identifications. Thirdly, the logics approach encourages a critical stance towards its own methodology and interventions, hence the emphasis upon articulation described above, to remain faithful to its own ontology.

2.3 Empirical Context and Material

The empirical material investigated here came from a range of sources. It consisted of conceptual and empirical academic texts, policy documents, NICE guidelines, mental health texts and newspaper articles. The primary empirical material however consisted of audio recordings of duty screening assessments completed within an IAPT service. One day was also spent within the service observing processes and asking informal questions to supplement my understanding. The empirical material relating to the IAPT service will now be outlined in more detail.

The participating IAPT service was a primary care service and operates within the context of the stepped care model of service delivery previously discussed. It provides services to people aged 16 and over who have mild to severe levels of common mental health problems within a particular geographical area. The service accepts referrals from people registered with a general practitioner (GP) in the catchment area; the referrals can be from individuals themselves, from GPs or from secondary care services. The service was contacted and agreed to host this research.

The service operates a duty screening assessment when there is an indication that the referral is urgent and these assessments are then completed as soon as possible. The purpose of this assessment is to clarify the problem and level of risk, discuss previous or current treatment, provide information about the service and make a decision about appropriate support as set out in a pro forma. The assessments vary in duration but typically last between forty and fifty-five minutes.

The IAPT service specify a range of criteria for accessing their service organised around mental health problems. They provide a service for people experiencing mild to severe levels of common mental health problems including depression, generalised anxiety disorder, panic disorder, obsessive compulsive disorder, phobias (including social phobia), post-traumatic stress disorder (single event trauma), depression or anxiety in the context of difficulties coping with a chronic physical problem. If people also have other diagnoses or conditions, such as Asperger's, Attention deficit hyperactivity disorder, mild to moderate learning disabilities, mild self-harm or mild to moderate drug and alcohol problems, they may be offered a service if they also present with one of the mental health problems specified that they would like to address. Additionally, willingness to engage in the interventions is also considered important.

The IAPT service specify a range of exclusion criteria which the duty screening assessment is designed to explore. The exclusion criteria are significant levels of identified risk to self or others within the last three months, a history of repeat self-injury requiring hospital treatment, individuals experiencing severe anger management problems (e.g., a history of agitation or threatening others, physical aggression to people or animals, property destruction, being arrested in the past twelve months for violence related issues), where the primary difficulty relates to childhood sexual abuse, multiple event trauma/post-traumatic stress disorder, very poor functioning in more than one domain of life (or extensive social care needs), a current or provisional diagnosis of severe mental ill health, a current primary diagnosis of personality disorder, drug or alcohol issues as a severe primary problem which would interfere with interventions offered, current care/involvement from secondary care

mental health services, moderate to severe learning disabilities whose clinical needs would be best met within specialist learning disability services, individuals under the age of sixteen and individuals not registered with a GP in the catchment area.

As the screening assessments are the area of practice most explicitly concerned with issues of risk, these assessments were selected as the most relevant empirical material for this project. Recording the duty screening assessments was felt to offer an advantage to interviewing subjects about issues of risk as it more directly captures the actual day to day practices taking place which relate to risk. It therefore enables social practices to come to the fore and allows for subjects' self-interpretations to be seen in action as opposed to focusing on their subsequent descriptions. This passes what is elsewhere called the *dead social scientist test* as the practice being studied would take place even if the researcher was run over on the way to work (Potter, 2002, p. 541).²³ It also meets the call for a greater focus on social practices as a way of avoiding an overly hasty move towards political explanations which may reduce the complexity of social practices and the critical potential of a logics approach (West, 2011).

A day spent in the participating IAPT service was also arranged to supplement the audio recorded assessments. This provided an opportunity to observe the everyday practices and processes within the service and to ask informal questions. This was felt to add additional contextualisation and to aid with informing my own judgements as a researcher. As described above, judgement is an important element of a logics approach and so spending a day in the service was seen as a helpful way to improve my ability to make situated judgements and to become more immersed in the empirical context. My own experience of working in an IAPT service (discussed in section 1.2.4) may have been an advantage in relation to developing a contextualised understanding of the material but a disadvantage in that a pre-existing tacit understanding may have obscured certain questions. However, as the primary material was the audio recorded assessments, this did not influence the data collected but required reflection at the stage of analysis.

2.3.1 Participants.

The subjects participating in this research did so from the position of two distinct roles. One group were the practitioners who complete duty screening assessments and the other group were people receiving duty screening assessments, referred to by the service as clients. Practitioners were high intensity cognitive behavioural workers. All practitioners who complete duty screening calls within the participating IAPT service were invited to participate. All clients aged 18 and over who received a duty screening call from a participating practitioner were eligible to participate and invited by participating practitioners. Any clients who were felt to lack mental capacity to participate were not included and this judgement was made by the participating practitioners. Three practitioners ended up taking part in the research with another practitioner agreeing but her client later choosing not to take part. One other client also provided initial consent but not informed consent and so this recording was destroyed. Out of the eight assessments recorded then, six were used in the analysis. This meant six clients took part in the research. The recordings were collected from December 2015 to May 2016. The research process will now be outlined.

2.4 Research Process

The research process differed for practitioners and clients. Practitioners were informed of the study by the local collaborator within the participating service. They were provided with a consent form (Appendix A) and information sheet (Appendix B) and given an opportunity to meet with the researcher to ask any questions they may have. They were given over 24 hours to consider participating and asked to return a signed consent form to the researcher if they agreed to take part.

Those who agreed to participate were given access to audio recording equipment which consisted of a Dictaphone that could be connected to a telephone via an audio recording device. They were requested to ask clients they called if they were willing to have the assessment recorded for research purposes and a script was provided for this (Appendix C). Practitioners informed clients that they did not have to agree, there would not be any

negative consequences for not taking part and that they would be sent information about the research in the post. If clients agreed at this stage, the assessment was recorded. There was no limit to the number of assessments practitioners were able to record, so long as their clients also provided consent. The only additional process for some practitioners was that they were observed and asked informal questions during the observation day.

Clients who initially agreed for their assessment to be recorded were then sent a consent form (Appendix D) and an information sheet (Appendix E). They were given sufficient time to receive the information and return it by pre-paid envelope to the participating service. If this was not received after sufficient time had passed, they were contacted by telephone once only by an assistant psychologist from the participating service to ask if they would be providing informed consent and if so to return the consent form to the service. When clients could not be contacted, the relevant audio recording was securely destroyed.

An assistant psychologist collected the signed consent forms and audio recordings within the participating service. When clients returned their signed consent forms, these were matched with the relevant audio recording and then copies of the recordings and consent forms were securely transferred to the researcher. Once the audio recordings were obtained, they were listened to in full, transcribed and then analysed using the logics framework.

2.5 Process of Analysis

The analytical process involved engaging with the empirical material using the five *moments* of a logics discourse: *problematisation*, *retroductive explanation* and *persuasion*, utilising the language of *logics* in an overarching process of *articulation*.

More specifically, this involved selecting discourses to analyse as part of the archaeological and genealogical problematisation of risk. This was done by searching the university library catalogue for academic texts on the subject of risk and risk assessment, selecting materials of interest and consulting the references and bibliographies of selected materials. Additionally, electronic databases were searched for articles relating to risk

assessment within mental health and a Nexis search of newspaper articles relating to Christopher Clunis and Isabel Schwarz was also carried out. These cases were highlighted in the materials studied. NICE guidelines and policy documents were also obtained and searched in relation to risk assessment.

These materials were analysed following the Foucauldian injunctions outlined above but also from a discourse theoretical perspective. This involved a descriptive approach towards risk assessment in the archaeological work, drawing out the objectives linked to the discourses explored, as well as the concepts utilised and the subjects produced, and a consideration of the interconnection of discourse, power and knowledge in the genealogical work, both supplemented by the concepts of discourse theory. The puzzling issues described were developed through the problematisation of risk assessment into the more formal research questions outlined.

The audio recordings of the duty screening assessments were analysed from this discourse theoretical perspective with a more structured application of the logics framework at this stage. This involved an iterative process of reading and listening to the data with social, political and fantasmatic logics in mind, labelling empirical instances as particular logics, noticing patterns and reworking the logics as required to develop an overall articulation.

The empirical material was transformed into textual data. This involved transcribing the audio recorded screening assessments in their entirety without adding punctuation other than apostrophes. Occasional non-verbal information was also included, such as the sound of typing or coughing but other information was not included, such as the length of silences or tone of voice. Line numbers were added for ease of reference. Once the data was in textual form, the logics framework was applied. Appendix F provides an example of the transcription and early stages of analysis.

The primary focus was on identifying social, political and fantasmatic logics in the selected sections. This involved considering what was taking place within the interaction between participants in order to characterise the way risk was assessed (social logics),

considering the alliances informing the interaction using the political logics of equivalence and difference (political), and looking for evidence of beatific and horrific dimensions of fantasy in order to provide an explanation as to why risk assessment was invested in by those taking part (fantasmatic logics).

2.6 Ethics

As described above, this research adopted an ontological presupposition of there being an ethical dimension to social life. The ethical relates to practices where subjects attend to issues of radical contingency whilst engaging in social practices. Ethical considerations are therefore an important part of the broader analytic process, but here some considerations of ethics in relation to the research process for participants will be described.

Ethical approval was sought and obtained from an NHS committee, the research and development department of the participating NHS trust and from the University of Essex who acted as sponsor for the project (see Appendix G). As part of this process, a number of ethical issues were considered in relation to participants.

The duty screening calls involved discussion around sensitive topic areas such as suicide, self-harm and mental health. This had the potential to be distressing for all involved. However, as the assessments were part of ordinary clinical practice there were support mechanisms already in place. For practitioners, this included regular supervision and access to a senior member of staff for any immediate concerns. For clients, this included support from the IAPT service or referral to other sources of support. Additional information about relevant services, such as the Samaritans, was obtained and an opportunity for a debriefing session with the researcher was available.

As clinical practice was being recorded, the possibility of practitioners feeling scrutinised and judged as professionals was considered. For clients, the possibility that having their assessment recorded could lead to additional anxiety was considered, particularly as the assessment itself may be an anxiety provoking situation. It was therefore made clear to participants that they were free to withdraw from the research at any stage without having to

provide an explanation and without any negative consequences. Participants were made aware however that if they requested to withdraw after the submission deadline, it may not be possible to change information at this stage. Participants were also informed that the aim of recording the screening calls was for qualitative research only and were offered the chance to discuss any concerns they had with the researcher.

Written consent was sought from all participants and all identifying information was anonymised during the transcription process. To further protect confidentiality, the audio data was stored using encrypted, password protected software and only accessed by the researcher and relevant supervisors. Following completion of this analysis, the audio recordings were offered to the UK Data Archive to store securely for future qualitative research. This was fully explained to participants in the information sheets (Appendix B and E).

Chapter 3: Results – Articulating Logics

3.1 Chapter Overview

This chapter presents the results of the research which involves an articulation of the logics identified within the empirical material. The chapter starts by providing an overview of the results. It then considers social, political and fantasmatic logics in turn, discussing these logics in closer detail and providing illustrative extracts.

3.2 Results Overview

The analysis of the empirical material led to the identification of two key social logics that operated within the social practice of duty screening assessments in an IAPT service. These logics were a logic of well-oiled administration and a logic of preservation. In line with the ontology informing this research, these logics should be seen as a partial fixation of the overall practice enabling a critical description, examination and explanation of risk assessment within primary care. The logics articulated provide a grammar for understanding what makes risk assessment practice work in the way it does in the given social and historical context. As social, political and fantasmatic logics are considered intertwined, the inflections of these social logics were examined in relation to political logics of equivalence and difference, and beatific and horrific dimensions of fantasmatic logics.

Fantasmatic logics work as the glue that holds social practices together through driving social actors' continued investment in them. These logics consist of beatific and horrific dimensions. Beatific fantasy relates to fantasy narratives structured around ideals of complete social harmony or efficiency, and horrific fantasy, working in the opposite direction, presents a threat that needs to be curtailed to prevent catastrophic decline. In the assessments studied, a rigorously completed risk assessment emerged as a way of ensuring complete protection and security for the social actors involved leading to the service flourishing, being fully resourced and recommissioned. The pro forma promised to straightforwardly assess all risks so nothing could jeopardise this perfectly efficient administrative system. This beatific fantasy generated a view of an administrative machine

fully capable of accurately assessing risks and managing them appropriately, thus removing risk and contingency from the social world. Risk assessment took on infallible qualities and as long as practitioners completed their administrative tasks comprehensively, they were protected by their administrative risk assessment and so guaranteed continued employment and professional esteem. This meant being able to demonstrate risk had been assessed was more significant than actually assessing risk and generated an *enjoyment* in this social practice.

The other side of fantasmatic logics that generated investment in risk assessment was the horrific dimension. Here, any break down or slippage in the logics of well-oiled administration or preservation became an obstacle which could set in motion a move towards catastrophic decline. This decline could involve the service not being provided to the right clients. This included clients being deemed suitable for the service despite not needing it, clients needing the service but not being granted access, or, worst of all, clients accessing the service despite presenting high levels of risk and needing a more comprehensive service. The assessments therefore served an important gatekeeping function and mitigated the ultimate threat of the service not being re-commissioned. The pro forma that structured the assessments became a protection from these horrific possibilities and the contingency brought about by the humans completing them. Practitioners could absolve themselves of any responsibility for granting or denying access to the service by relying on the well-oiled administrative process and clients' self-reporting to ensure their own and the service's preservation. This provided an enjoyment for practitioners in what potentially is a high risk assessment for them, due to the potential for professional vilification and reputational damage should clients go on to harm themselves or others without this being anticipated. It also enabled the service to fulfil the role of guarantor as long as the assessment had been dutifully completed and so protected practitioners from anxiety associated with contingency.

Political logics work to create alliances between the various social actors involved in a given practice. They enable an understanding of how a social practice like risk assessment came into being, is maintained, or challenged. Logics of equivalence and difference were in

evidence in relation to the social logics of well-oiled administration and preservation. Logics of equivalence involve social actors creating alliances and establishing a political frontier to challenge existing social structures. Social actors can form *chains of equivalence* where they become equivalent in their opposition to a given social structure or common enemy. Logics of difference work by breaking down such political frontiers or equivalences to maintain existing social relations and practices. Regimes, or systems of practices, can be formed from social practices yet also come to structure such practices. The IAPT service studied here operated within what can be considered a regime of competition where commissioners act as an occupying power through selecting organisations to provide services in a market frame. This commissioning context broke down chains of equivalence between clients and practitioners using a logic of difference. This may work to expand the dominance of market based principles within mental health care. The logics of well-oiled administration and preservation were therefore structured by an equivalence between commissioners, the service and practitioners. This prevented an equivalence being created between practitioners and clients, particularly when the smooth operation of the social logics was challenged where the administrative aspects of risk assessment became prioritised along with managing risks to the service.

The social logics themselves then were *well-oiled administration* and *preservation*. Well-oiled administration consisted of various elements including the bureaucratic processes of obtaining information and completing a pro forma. This involved clients' problems being made to fit around the structure of the pro forma and assessment process. At times this led to practitioners performing an administrative role with the more analytical aspects of their role backgrounded. This could take the form of practitioners following the pro forma instead of using their own judgement and experience to inform the interaction. Another key aspect of well-oiled administration involved attempting to manage any contingency that arose. This was done either pre-emptively through treating clients as rational actors or reactively through denying or downplaying context and complexity. The logic of preservation involved some issues being conceptualised as risks but not others, in particular the risk of suicide. It also

prioritised the management of potential risks to practitioners and the service. A well-documented assessment became a way of managing any risks to practitioners from the process of completing assessments. Other ways of managing the risks to the service included providing choice or input in relation to treatment decisions. This provision of choice, which was a restricted choice, showed the influence of market based principles and the current dominance of the regime of competition within health care. The logics will now be further elaborated in relation to the empirical material.

3.3 Social Logics

3.3.1 Logic of well-oiled administration.

I am no doubt not the only one who writes in order to have no face. Do not ask who I am and do not ask me to remain the same: leave it to our bureaucrats and our police to see that our papers are in order. At least spare us their morality when we write.

(Foucault, 2002, p. 19)

The social logic of well-oiled administration is used to describe patterns in the empirical material where the discourse between practitioner and client was informed by an underlying logic of being administratively efficient. Indeed, this logic structured much of the overall assessment and produced a bureaucratic encounter between client and practitioner, focused on *getting one's papers in order*. This privileged obtaining and documenting information. Other aspects, such as the process of the assessment, were marginalised. This led to clients being made to fit around the institutional requirements of the service and backgrounded the analytical skill of practitioners who became tied to the pro forma and administrative processes with the institutional process of risk assessment foregrounded. This logic also involved *asking clients to remain the same*. The administrative emphasis positioned clients as rational actors, obscured a contextualised understanding of the risks that featured and minimised complexity. This functioned to manage any contingency that arose which could interfere with the process of well-oiled administration.

3.3.1.1 *Getting one's papers in order.*

The pro forma specified the structure of the assessment and has been adapted and represented in figure 4.²⁴ The pro forma highlights the importance placed upon administrative processes. Practitioners are politely requested to ask all the questions and the pro forma specifies the information to be obtained in order to make a decision about whether a client is suitable for the service or not. As shown, this involves seven key areas: main difficulties, medication, previous mental health problems and treatments, risk, safeguarding children, expectations and goals, and a treatment plan.

Figure 4. Anonymised Pro forma

Identification Number:

Assessor:

Date:

Time:

Please ask all the questions

Explain confidentiality:

“Anything you tell us is confidential, and is only shared within the service by people involved in your care, unless there is a concern about your safety or the safety of others. If anyone is at risk in anyway, I will need to discuss this with a senior colleague, and I may need to inform other professionals.”

Check with self-referrals if they agree for the GP to be contacted:

1. Main difficulties

“In a few words, how would you describe your current main problems?” (Ask specific questions that you think are relevant to the main problem, if necessary – remember this is just for suitability and is not a full assessment)

Mania/hypomania prompt

“Have there been times where you have felt very high and were talking a lot, unable to sleep, lasting several days at a time?”

Psychosis prompt

“Has it ever seemed like people were taking special notice of you?”

“Have you ever heard anything that other people could not hear or seen anything that other people could not see?”

PTSD prompt

“Have you ever been involved in a life threatening or traumatic event?

If yes: “Do you have nightmares, flashbacks or recurrent intrusive memories about it?”

Have there been multiple traumas that the client has experienced? Including childhood sexual abuse?

Anger prompt

“Do you experience any problems controlling anger?”

If yes does this lead to violence towards others/animals/property?

If yes, has this led to court action/convictions?

Self-harm prompt

“Do you ever harm yourself?” (now or in the past)

Has this required medical/hospital intervention?

Any long term physical health conditions? (if yes what are they?)

Substance misuse prompt

“Do you use drugs or alcohol?” (include frequency, amount, drug of choice.) Any other addictions, gambling, internet etc.?

“Do you feel this is your main problem?”

2. Medication

“Are you taking any medication?”

3. Previous mental health problems and treatments

“Have you had any previous mental health problems?”

“Has a mental health professional ever diagnosed these problems?”

“Have you had any previous therapy for any of these problems?”

“Are you receiving any help from a counsellor, psychotherapist, psychiatrist or mental health nurse at the moment?”

4. Risk

Cover the following

- Previous suicide attempts
- Current thoughts, plans, preparations, intent
- Risk of harm to others
- Risk of harm from others
- Risk to dependents (neglect)
- Preventative factors
- Has this been a significant problem in the last three months?

5. Safeguarding Children

Check if patient has children. Collect names and DOB. Ask if any concerns around risk and if they have any support for their children.

6. Expectations and Goals

“What would be the main thing you would want to work on?”

7. Treatment Plan

Choose from the following to conclude your conversation with the client:

Decide is this person SUITABLE – Yes/No, do you need to get information from secondary care.

If suitable, step 2 for full assessment, if complex or trauma, step 3 for assessment.

Figure 4. Anonymised Pro forma

As well as the proforma illustrating the importance placed upon administrative processes, this was well evidenced in the assessments analysed. Extract 1 provides an example of an explanation of the assessment.

Extract 1

-
- Practitioner C: just ticking the right boxes here okay...so what we what we're gonna do is we're going to go through the assessment in three parts err first of all we've got a set questionnaire to go through um now I'm not sure were you sent that in the post the questionnaire
- Client D: there was something came in the post yeah um
- Practitioner C: right have you had an opportunity to look at that
- Client D: err yeah I've had a look through it
- Practitioner C: okay so we're gonna go through that if you've had a chance to complete it we'll we'll look at what you've your responses are and what [inaudible] we've got here
- Client D: well I've looked at it I haven't actually completed it but
- Practitioner C: okay
- Client D: I can I can yeah
- Practitioner C: okay well we'll go we'll go through that now but if you do have it in front of you it's useful for the answers
- Client D: yeah
- Practitioner C: and err part of that um I've just got some other added questions relating to risk these are questions that we ask clients um just to check that they're safe and that they're okay
- Client D: mmm
- Practitioner C: okay
- Client D: mm
- Practitioner C: following on from that we'll err have the main part of the assessment an opportunity for you to explain you know what your difficulties are um and some other questions that I've got relating to other conditions just to screen those conditions
- Client D: mmhmm
- Practitioner C: and then we'll talk about what options are available based on what we've discussed (Lines 95-118)
-

This extract shows how administrative processes were prioritised. This involved 'ticking the right boxes', completing a 'set questionnaire', 'some other added questions relating to risk' and 'other conditions'. The extract also shows how the logic of well-oiled administration encouraged clients to facilitate administration through completing the questionnaires prior to the assessment or at least having them 'in front of you' during the assessment. This became 'useful' to the practitioner. It also shows how what is referred to as the 'main part' of the assessment follows the completion of the questionnaires and risk questions. Although being called the 'main part', the client being given an opportunity to

explain his difficulties was subordinated to the bureaucratic, administrative tasks. This was mirrored in the above extract where an explanation of the process of the assessment was prioritised over hearing from the client.

The logic of well-oiled administration prioritised obtaining clear, unambiguous information as seen in the following extract.

Extract 2

Practitioner A: okay so what I'm hearing really...is although things are really really tough at the moment and you do have those [suicidal] thoughts quite frequently it doesn't sound as though there is any serious risk that you're gonna act on them at the moment and that's because of the thoughts of your children
 Client A: yeah
 Practitioner A: and also the support that you've got from your family
 Client A: yeah
 Practitioner A: have I understood that correctly?
 Client A: mmhmm (Lines 157-164)

This extract shows how the logic of well-oiled administration emphasised a *correct understanding* of responses to specific questions, such as whether there was a serious risk of this client acting on his suicidal thoughts. This reduced complexity and prevented more in depth exploration. It also marginalised alternative practices such as developing a therapeutic relationship, although 'things' being 'really really tough' shows some potential for this. However, obtaining particular information was prioritised, in this case an acknowledgement from the client that there wasn't any serious risk of him attempting suicide. The importance of documenting information was evident from practitioners typing. Extract 3 shows one client commenting on this.

Extract 3

Practitioner B: [typing]
 Client C: you can type quick
 Practitioner B: just about
 Client C: ha ha ha
 Practitioner B: I am getting there when I look through there's a lot of abc corrections (Lines 563-567)

The logic of well-oiled administration prioritised some actions over others. Here, recording information that could be utilised for decision making processes, as opposed to the client's perspective or experience of the assessment, was prioritised. The client had to wait

for the practitioner to finish typing before the assessment continued. This highlights the administrative role performed by practitioners. At times this was extended and practitioners became technicians asking questions because the pro forma required it rather than it being clinically relevant as seen in extract 4. The logic of well-oiled administration could therefore place practitioners in a predominantly administrative role and in this sense presents a challenge to the development of clinical expertise.

Extract 4

Practitioner A: just so with this assessment we we'd look well I'm gonna go through a few things now just to rule things in or out okay
 Client A: yeah
 Practitioner A: a kind of general screening um so some of these questions won't relate to you but it's just to make sure (Lines 424-427)

The questions were not practitioners' questions then, but bureaucratic and administrative. This involved the pro forma being referenced, here a 'general screening', as the reason for asking questions instead of them being of clinical interest. The pro forma justified this through stating all questions should be asked. While this absolved the practitioner of responsibility for asking a given question, it also removed analytical skill from the practitioner who became tied to the pro forma. Despite this, and the client's awareness of it, practitioners continued to engage in this practice. This shows an investment in the process understood here as linked to the beatific and horrific dimensions of fantasy explored below.

Well-oiled administration could become the client's focus too showing how this logic encouraged clients to understand their own mental health in relation to the institutional working of the service. Client B had previously accessed the service and had prior experience 'volunteering in mental health' which is likely to have contributed to this. Nevertheless, he assisted with the administrative process by putting his self-harm 'in the middle range' as shown in extract 5. This suggests a form of self-surveillance, echoing Foucault's (1991) elaboration of the Panopticon (discussed further in the critical explanation below). Alternatively, or perhaps additionally, assisting with administration becomes comprehensible in relation to the goal, which clients may have, of being granted access to the service.

Extract 5

Practitioner A: when you self-harmed what did you do
 Client B: it was a couple of well I'm sure you're used to hearing this it was a couple of
 err cuts on me leg
 Practitioner A: okay and did they need medical attention or did you just dress them yourself
 or
 Client B: I just err sorted them out meself
 Practitioner A: okay they weren't too deep
 Client B: um no I've had a a lot deeper um err cos I've had some experiences yo-well
 you probably can't remember but working in um drug and alcohol and
 volunteering in mental health and err I'd put them in the middle range (Lines
 55-62)

This client's 'risk' was 'a concern', as shown in the extract below. Extracts 5 and 6 show how the logic of well-oiled administration encouraged clients to be involved in assessing their own risks as a way of assisting the administrative decision making process.

Extract 6

Practitioner A: because this risk is is um you know a concern what's your sense of that if
 you for example if at the end of the assessment we did think about putting
 you on the waiting list for treatment but you had to wait three or four months
 do you feel that you would be safe in doing that or do you think you would
 need something sooner than that to keep safe
 Client B: um I I possibly think I'd be I dunno how to answer that I think I would be
 okay but I do want something (Lines 431-436)

This shows the primary task was administration. This led to the client's problems being made to fit around the service as he was here asked to consider his safety in relation to waiting lists. Like extract 2, it provides another example of the onus being placed upon clients to confirm their own safety. The client did not know 'how to answer' and provided an ambiguous response acknowledging contingency which left the practitioner unsure at this stage of the assessment. Thus, contingency was a problem for the logic of well-oiled administration.

3.3.1.2 Asking clients to remain the same.

Contingency became a problem for the logic of well-oiled administration due to interrupting its smooth operation. The structure of the pro forma and emphasis on obtaining straightforward information positioned clients as rational, knowing subjects. Clients were

presumed to have the information required to complete a successful assessment and the challenge became obtaining the right information. One way of dealing with contingency built into the structure of the assessment process was to deny it from the outset. Another way was to attempt to disallow it as shown in extract 7, which came shortly after the client reported thoughts of being better off dead.

Extract 7

Practitioner C: okay um so if I can just ask you some more questions about those types of thoughts
 Client D: mmm
 Practitioner C: just to check that you're okay um if you can answer yes or no to these ones
 (Lines 159-161)

Requesting a simple 'yes or no' to the questions asked shows how the logic of well-oiled administration worked to prevent contingency from surfacing. This could also be seen in the types of questions asked. Extracts 8-10 contain examples of questions asked to client B about his previous suicide attempt showing the focus was on his thoughts, feelings and actions.

Extract 8

Practitioner A: more recently have you had any more sort of thoughts or desire to do that
 (Lines 108-109)

Extract 9

Practitioner A: you used to cut as a way of coping with feelings or frustration (Lines 81-82)

Extract 10

Practitioner A: when you self-harmed what did you do (Line 55)

The above three extracts show how the context linked to risk issues could become extraneous information. The client was not asked about the circumstances surrounding his previous suicide attempt or about what he had referred to elsewhere as a 'very messy divorce' which he linked to previous self-harm. The client had also mentioned being unemployed, having a criminal record and the voluntary work he used to do being cut due to funding issues, but these issues were not explored further showing how knowledge of past behaviour was prioritised over context or intention.

While the logic of well-oiled administration discouraged a contextualised understanding of risk issues, the questions asked by practitioners may have also been informed by a cognitive behavioural approach, as one practitioner explained to a client in extract 11.

Extract 11

Practitioner B: we look at the thoughts or we look at the behaviours and we try and change the things we do or don't do or the way we think and don't think so that it starts having a positive impact on all the other areas in our lives so when we was doing the assessment I was looking at them physical symptoms the thoughts and the behaviours the theory behind the cognitive behavioural therapy is we get caught up into the vicious circle between all of them (Lines 667-671).

This extract illustrates that context was not one of the things practitioners 'look at', instead the focus was on 'physical symptoms the thoughts and the behaviours'. Extracts 8-11 show the potential for an alignment between a cognitive behavioural approach and the logic of well-oiled administration. Cognitive behavioural discourse may work to restore the analytical skill of the practitioner, which the logic of well-oiled administration diminished. However, this operated here to produce an understanding of clients' problems extrapolated from the wider context of their lives. This was also evident in the emphasis on the 'main problem' which acknowledged the possibility of numerous problems but only provided space for one to be discussed which could be limited to 'a few words' as shown in extract 12.

Extract 12

Practitioner C: so now we'll move onto the other part of the assessment um first of all give you an opportunity err to to explain in a few words um your current main problem that you're seeking help for what what would you say it is (Lines 390-392).

Extract 13

Practitioner B: what would be that main problem that you're referring to our service for (Lines 62-63)

Extracts 12-13 show the logic of well-oiled administration encouraged problems to be understood in isolation and abstracted from the context of people's lives including their

own past through the emphasis on the ‘current’ problem. It also prioritised brevity as seen in extract 12, another way of precluding complexity.

Extract 14 shows how the logic of well-oiled administration did not accurately capture the risks from the perspective of clients. In this extract, the client’s response to being asked if he felt he ‘could be a risk’ was to say ‘not at the moment no’ which was repeated as ‘no’. The client qualified this by acknowledging contingency and indicating there may be the potential for him to be a risk if ‘certain situations arose’. The practitioner responded with okay and moved onto asking if the client felt ‘at risk from anybody’. The logic of well-oiled administration thus encouraged contingency to be ignored, in this case privileging the word ‘no’ over an exploration of the situations that may lead to this client posing a risk to other people.

Extract 14

Practitioner A: um the question we ask everyone is whether you feel you could be a risk to anybody else at all
 Client B: mmm not at the moment no
 Practitioner A: no okay
 Client B: well you know not un unless certain situations arose but err no
 Practitioner A: okay and then if you feel at risk from anybody at the moment (Lines 764-768)

One question that featured in all the assessments involved clients rating their intention to act on suicidal thoughts or plans numerically. This was how suicidal intent was enquired about, one of the areas the pro forma states to ‘cover’. An example is given below.

Extract 15

Practitioner B: okay on a scale of zero to ten zero means that you would not currently act on any thoughts or plans to end your own life ten means you would where would you put yourself on that scale
 Client E: err two (Lines 240-243)

This question demonstrates how questions of risk of harm to self and others were construed in terms of the probability of an event happening. It also shows the legitimacy of converting the risk of suicide into a single number to assist with administrative processes such as determining suitability for the service. In this sense, clients became involved in a

form of self-assessment which lessened the need for practitioners to make a judgement about a client's suitability.

The importance of this question was underscored by the fact it was asked to all clients, i.e. those who had, and those who had not reported thoughts of suicide. This emphasises the positivist element present in the logic of well-oiled administration whereby risk can be converted into a single number and deprived of meaning and context. It also shows the assumption underpinning the risk assessment model that everyone presents some level of risk which can be accurately assessed and managed, and that those who may not appear at risk may in fact be at risk.

This positivist element was also seen through the completion of questionnaires assessing symptoms of depression, anxiety, phobias and work and social adjustment. These questionnaires formed part of every assessment analysed and whilst being clinical tools were used to inform decisions about suitability for the service and so complement the pro forma, as shown in extract 16.

Extract 16

Practitioner C: I'm gonna just look at the scores on those
 Client F: mmm
 Practitioner C: so the first set of nine questions which we looked at symptoms of depression there you scored thirteen out of a possible twenty-seven which err puts you in the moderate range which
 Client F: right
 Practitioner C: is the sort of range actually that this service works with people so
 Client F: mmm
 Practitioner C: where people are scoring very highly severely err this might not be the best service for them
 Client F: yeah
 Practitioner C: but that's a that's sort of within our ball park (Lines 476-485)

This extract shows how the logic of well-oiled administration led to the information provided being viewed as an accurate representation of a client's difficulties. How the scores related to the service criteria took precedence. Again, this removed the need for practitioner judgement and required clients to frame their difficulties around the institutional workings of the service through being placed in a range for symptoms of depression.

3.3.2 Logic of preservation.

The experts who are being made increasingly accountable for what they do are now becoming more preoccupied with managing their own risks. Specifically, secondary risks to their reputation are becoming as significant as the primary risks for which experts have knowledge and training. This trend is resulting in a dangerous flight from judgement and a culture of defensiveness that create their own risks for organisations in preparing for, and responding to, a future they cannot know. (Power, 2004, pp. 14–15)

The logic of preservation is articulated to capture how the assessments analysed were structured by practitioners managing the risks to them and the service that emerged from the practices that accompanied the completion of risk assessments. These risks were prioritised over other risks and so preservation of professional reputations and roles, and of the service itself, took precedence. The logic of preservation involved processes that identified some issues as risks but not others. In particular, the risk of client suicide was given considerable attention. The logic worked by turning particular issues into potential threats to the service, which were then managed through discursive work. The issues conceptualised as risks could at times be shown to align with issues clients viewed as risks, but equally this logic could position clients themselves as risks. This logic complemented the logic of well-oiled administration in that an incomplete pro forma became a risk in and of itself. This led to the assessment being very much pro forma led. Providing clients with a restricted choice also featured within this logic.

3.3.2.1 Identifying risks.

The pro forma conceptualises certain issues as explicit risks. It places greater significance on the risk of suicide than other areas as practitioners are requested to ‘cover’ previous suicide attempts, current suicidal thoughts, plans, preparations, and intent. For other

areas, like risk of harm to or from others, only one prompt is provided. It also specifies the need to cover preventative factors and focus on the last three months in particular.

These issues became risks for practitioners. One assessment involved thirty-nine questions being asked about suicide and self-harm out of a total of around one hundred and twenty questions (around forty questions are specified on the pro forma and the additional questions asked were follow up/clarification questions). This assessment involved the client discussing suicidal thoughts but one client who did not report having suicidal thoughts was still asked twelve questions about suicide and self-harm. In contrast, answering no to a single question such as ‘do you feel you might be a risk to anybody else at all’ was taken as sufficient, and in line with the pro forma.

Following the pro forma meant certain issues were formulated as risks and others were not, as shown in extract 17.

Extract 17

Practitioner B: okay so in terms of your work has your mood had any impact on your work at all at the moment...

Client E: um I've had a few outbursts at the managers for being useless at their job

Practitioner B: at other staff members have you

Client E: yeah well management

Practitioner B: well if they're not doing their jobs properly [inaudible] ha ha

Client E: I know [inaudible] calling them a bunch of useless wankers probably [inaudible]

Practitioner B: I know how that feels ha ha ha ha

Client E: I think most people do don't they they just don't say it

Practitioner B: that's it exactly exactly so apart from that it actually work isn't too bad a few incidents that occurred where mainly management not doing their jobs properly and you've just pretty much told them as it is yeah

Client E: yeah (Lines 455-470)

Calling management ‘a bunch of useless wankers’ did not become a risk due to the logic of preservation which only encouraged further exploration of issues that may be a risk to the service. The potentially difficult issue was left unexplored and so any additional complexities were closed down. Issues left unexplored included whether this client was at risk of losing her job, whether her way of managing conflict created additional difficulties for her or whether her working conditions were linked to her mental health. The practitioner then

moved onto the next item on the pro forma. The logic of preservation led to an incomplete pro forma becoming a greater risk than any issue for this client linked to her work. This shows how a logic of preservation led to the service becoming pro forma as opposed to client led.

This was also evident in extract 18 which began with the post-traumatic stress disorder prompt indicated on the pro forma.

Extract 18

Practitioner A: have you been involved in any very um traumatic life threatening or very traumatic events from which you might have nightmares or flashbacks
 Client B: I have but um no I don't get nightmares or flashbacks no
 Practitioner A: yeah okay and do you mind me asking what events you were referring to then
 Client B: oh um god when a friend got attacked by a group of football supporters that were pulling out knives and machetes and that's happened a couple of times that sort of thing you know
 Practitioner A: yeah but you don't have flashbacks or nightmares
 Client B: no no
 Practitioner A: okay okay okay do you feel you have a problem handling your anger at all do you feel that gets out of control (Lines 703-712)

Again a potentially complex issue was not explored further. Here, completing the pro forma was prioritised over a more in depth discussion of this client's experiences. The response of 'no' to the question about 'flashbacks or nightmares' was taken as sufficient and then moved on from to enquire about anger. This downplayed the expertise of this practitioner who simply obtained the required information. Perhaps this means practitioners provide a legitimacy to the assessment process, or possibly their expertise comes into play in moments of ambiguity thus acknowledging some limitations to the pro forma. In this case, no more was known about the 'couple of times' this client had been in this kind of situation and so this was not conceptualised as a risk despite involving violence and happening on more than one occasion. The use of a pro forma structured clients' responses too. In extract 19, the standardised questions were answered in a very brief way which contradicted previous information.

Extract 19

Practitioner A: do you feel you might be a risk to anybody else at all
 Client A: no

Practitioner A: no um at do you feel at risk from anybody in any way
 Client A: um no I don't think so
 Practitioner A: okay you mentioned about your wife when she says abusive things does she
 ever get physically aggressive towards you
 Client A: she has done once yeah (Lines 583-589)

This extract shows how the logic of preservation worked here to open up exploration of an issue conceptualised as a potential risk to the service. This contrasts with the previous two extracts where issues were not further considered. The extract shows how standardised questions could generate short responses and a potential difficulty with the language of 'risk' as it was here conceptualised differently by the actors involved. Here, the client's wife saying 'abusive things' and being 'physically aggressive' was not something that led him to 'feel at risk', yet the logic of preservation led to this becoming a possible risk.

When the 'risk issue' was not a risk to the service, the logic of preservation reduced its significance as shown in extract 20.

Extract 20

Practitioner C: do you feel that you're at risk from anybody else
 Client D: from anybody else
 Practitioner C: yeah
 Client D: um well it not individuals but the um as I say the the sort of current political situation
 Practitioner C: right
 Client D: and the d w p err especially since they accused me of fraud by just falsifying my answers
 Practitioner C: right
 Client D: which does make me feel very vulnerable
 Practitioner C: when were you accused of fraud
 Client D: that was three years ago when they accused me of cohabiting
 Practitioner C: okay
 Client D: they cited four points of what they call evidence and they were all the opposite of what I'd said in
 Practitioner C: right
 Client D: my interview which was very frightening
 Practitioner C: mmhmm yeah so that's obviously leading you again one of the things to worry about (Lines 624-639)

In this extract, the logic of preservation legitimates the closing down of issues articulated as risks by clients when the risks are not shared by the service. This issue with the 'd w p' does not become a relevant risk and so the issue is closed down and progression

through the pro forma prioritised. The logic of preservation then emphasised risks to the service over other issues.

3.3.2.2 *Managing one's own risks.*

The logic of preservation meant the risks to practitioners completing assessments and risks to the service became the main risks to reduce or, if possible, avoid. These risks could at times align with risks to clients but this was not always the case as indicated in extract 20. The dominance of the logic of preservation led to practitioners becoming preoccupied with managing their own risks which explains why the pro forma and service procedure structured the assessments. A large focus of the assessment was on obtaining recordable information which could later be reviewed for accountability purposes, and so a risk became not getting the information or completing the pro forma. The following two extracts acknowledge the importance of recording information and following protocols.

Extract 21

Practitioner A: I'll just write that in (Line 518)

Extract 22

Practitioner B: what I'm gonna do now is um a risk assessment this is a standard procedure this'll be routinely conducted whilst you remain in our service (Lines 197-198)

The logic of preservation was particularly evident when clients reported suicidal thoughts as the following extract shows.

Extract 23

Practitioner C: I just wanna check as well that you have got things like the err the other support numbers that we give out to clients
 Client F: yeah
 Practitioner C: um things like the crisis team numbers do you have you been given those
 Client F: yes I've got all them yeah
 Practitioner C: and do you keep them on your phone or somewhere safe where you can
 Client F: they are logged in they are logged into me phone
 Practitioner C: ah that's brilliant okay hopefully you've got the main crisis number team number which is a a sort of um a seven day a week twenty-four hours a day
 Client F: yes I've got that yeah
 Practitioner C: okay you've got that somewhere I mean it's useful to put it on your phone also put it on a card somewhere where you can access it just in case you need

it or to give it to someone that you can trust that you can you know could also have access to to support if needed okay

Client F: yeah

Practitioner C: okay so we'll continue on with the assessment (Lines 359-373)

Extract 23 shows one way of managing risks was to provide support numbers to clients. This extract shows how the logic of preservation worked to prioritise providing these numbers over considering if the client would use them or further exploration of the suicidal thoughts. This suggests providing such numbers was one way of managing risks that came about from the practice of completing risk assessments. Considerable discursive effort was spent here ensuring the client had these numbers and they were accessible which became 'brilliant'.

Another way of managing risks and ensuring preservation was obtaining assurances from clients that they were not at risk as seen in extract 24. This extract occurred after the client had mentioned self-harming and a previous suicide attempt. He said he had not called the crisis numbers he had when he self-harmed and said his self-harm had 'come out of the blue'. The practitioner had subsequently asked if he had made any plans to end his life and he sighed and said 'no and yes'. He explained he had been 'stashing' pills in case he developed a serious physical illness and that he knew how to kill himself. There was a clear acknowledgement of contingency from this client then and the practitioner asked if he could reduce his risk through reducing the number of tablets he had in his house, but the client felt he had access to whatever he wanted should he decide to attempt suicide. At this point the practitioner asked the client to rate his intention to act on his suicidal thoughts.

Extract 24

Practitioner A: okay so if I were to say this is a bit of a strange question to be asked but... if I were to say out of ten how likely is it that you might act on these thoughts in the near future um nought meaning I'm not going to as things are

Client B: right

Practitioner A: you know taking out the equation of of serious illness or of wheelchair

Client B: yeah yeah

Practitioner A: and um ten being you know imminent um would you be scoring on that scale at the moment

Client B: err it would on the acting on the thoughts I'd put it pretty low

Practitioner A: yes so would it be zero

Client B: nought or one yeah err um err yeah nought or one (Lines 306-315)

This extract shows how the logic of preservation could also involve contingency management through bracketing things like ‘serious illness’ or being in a ‘wheelchair’. Obtaining a numerical rating of likely future action enabled the assessment to move on from suicidal thoughts and so having this information recorded managed the risks to the practitioner. The logic of preservation made it difficult to not provide a numerical rating. The initial response of ‘pretty low’ was met with the suggestion of ‘zero’ which was modified to include some possibility of acting on the thoughts by giving the rating ‘nought or one’. This shows how acknowledging contingency resists the logic of preservation.

The logic of preservation led to recording information as a way of managing the risks to the practitioner and service should this person go on to take his own life. It could then be demonstrated that he had been assessed but not fully disclosed his level of risk. This would obviate the practitioner and service of any blame. This shows how the logic of preservation created an incentive to get clients to say the right things as opposed to actually helping with the primary risk issue. From this view, the pro forma prioritises minimising the risk of reputational damage instead of reducing the risk of suicide, so the object of the risk assessment becomes avoiding potential damage to the organisation instead of avoiding potential damage to the client. Despite the rating of ‘nought or one’ the question *what if this client was not aware of his own risk of suicide* remains, especially as his previous self-harm came ‘out of the blue’. The logic of preservation then presents a considerable challenge to the process of supporting people who may be, as in this case, feeling suicidal. Its attempt to manage contingency, like all attempts, is doomed to fail.

The logic of preservation was also evident when treatment options were discussed as shown in extract 25.

Extract 25

Practitioner B: I teach you the techniques and I can teach you the intervention ultimately it's about how much time you put into it in in terms of sort of achieving results and making those changes so do you think that's something you could try

Client E: yeah definitely (Lines 686-690)

Here, the client became accountable for treatment not helping. The practitioner can only ‘teach’ the techniques and intervention and so it is up to the client if this will prove to be helpful. This works to absolve the practitioner of any responsibility for the treatment not being successful and grants responsibility to the client. This may be linked with discourses of choice that featured at times in the assessments analysed where clients were offered a choice of interventions despite not having any prior knowledge of them. Perhaps clients choosing interventions was another way of managing risks to the service and avoiding blame as the intervention was not recommended by the practitioner but chosen by the client. The choice of intervention may reflect the importance choice is given within market based principles and so be important within the commissioning context and overarching regime of competition. However, the choice was a restricted one and, at most, involved choosing between different forms of short term psychological therapy including counselling, cognitive behavioural therapy and interpersonal therapy; or choosing between cognitive behavioural therapy offered in different formats such as face to face sessions, workshops, telephone sessions or online programmes.

3.4 Political Logics

As introduced in the results overview, political logics work to create alliances between social actors linked to a given social practice. In the assessments analysed, various social actors were involved. At the level of the empirical material, there were the practitioners and clients. The practitioners were operating within an IAPT service provided by an NHS Foundation Trust in partnership with a national charity. The service was located within what can be characterised as a regime of competition to describe the way in which NHS Trusts, third sector organisations and private companies compete to win contracts to provide services for a limited period of time. Clinical Commissioning Groups are in charge of funding services and so occupy a privileged role in the provision of services.

Political logics of equivalence and difference were in evidence in relation to the logics of well-oiled administration and preservation. Being administratively efficient was linked with being a well-run service likely to be recommissioned, in this way they worked to create an equivalential identity between the service and commissioners. The same was also the case for preservation whereby the risk to the service was conceived in terms of the risk of not being recommissioned. As such, there was a need for the service to align with the specifications of commissioners in order to remain active as a service. These social logics then, with this political inflection, created a context where the discursive practices functioned to enable some alliances and disavow others. An equivalence between clients and practitioners, or clients and services, was a difficult one to achieve and necessarily remained subordinate to an equivalence between commissioners and the service. The social logics of well-oiled administration and preservation acquired their significance within this regime of competition and commissioning context. It became necessary to be administratively efficient as an organisation and to manage risks effectively to survive.

3.4.1 Logic of equivalence.

Utilising Howarth's (2000) elaboration of these political logics, the logic of equivalence works by dissolving the particularities of individual identities through creating an oppositional force. In relation to the assessments analysed, a logic of equivalence could hypothetically work through the creation of an alliance or equivalential identity between clients and practitioners with the opposing force being an identified risk, such as a risk of suicide or mental health problems. The providing service could form part of this equivalential chain and if this were the case the client (c), practitioner (p) and service (s) would be made equivalent ($c=p=s$) in opposition to the risk (r). This would take the form of ($r = - (c, p, s)$) where the specific differences between the client, practitioner and service disappear, and they become negated or blocked by risk (hence the minus sign), and so united in opposing it.

Indeed, there were instances of a logic of equivalence in the assessments analysed as shown in extracts 26-28.

Extract 26

Practitioner A: is it okay...if I ask you some more risk questions that are quite direct really but just to really make sure we understand...what's happening for you (Lines 245-248)

Extract 27

Practitioner B: just gaining some information from you about your current level of need so we can determine sort of the best way forward in terms of future treatment for yourself (Lines 7-8)

Extract 28

Practitioner C: if I can just ask you some more questions about those types of thoughts...just to check that you're okay (Lines 159-161)

The above extracts provide examples of equivalences between practitioners and clients indicating some residual possibility for this within risk assessment practice. The discourse here focused on help clients may need, ensuring clients were okay and finding out about any real risk. The questions asked were acknowledged as potentially direct in extract 26 but justified through claims they helped ensure an understanding. This implied a benevolent therapeutic situation between practitioner and client and thus a benign alliance.

3.4.2 Logic of difference.

However, the dominance of the logics of well-oiled administration and preservation revealed a different picture where the priority was on being recommissioned through being administratively efficient and managing risks to the service, with the risks to clients not being the sole or dominant concern. The assessments analysed were therefore better characterised as being structured by a logic of difference owing to the overarching regime of competition. The logic of difference provides an explanation of how a discursive order, such as a regime of competition within mental health care, expands through breaking down chains of equivalence, such as the hypothetical chain illustrated above. In this case, the logic of difference works by weakening the opposition to the risk of suicide or mental health problems through extending different identities and objectives for the relevant social actors, such as practitioners having a pro forma to complete and the need for the service to be

administratively efficient in order to be recommissioned. In this context, being a client led service is only one of a series of competing objectives. This logic of difference then may lead to an expansion of the regime of competition. This helps to explain instances in the empirical material where risk assessment was introduced as an administrative task, not a clinical one, as shown in extracts 29-30.

Extract 29

Practitioner A: um the question we ask everyone is whether you feel you could be a risk to anybody else at all (Line 764)

Extract 30

Practitioner C: I've just got some other added questions relating to risk (Line 109)

These extracts acknowledge the administrative aspects of the assessment; questions are asked to 'everyone' or because practitioners have them on the pro forma. This highlights a difference between administrative and clinical processes with the administrative prioritised in line with the logic of well-oiled administration. The logic of preservation also accorded with this logic of difference as it showed different risks exist for different social actors. The service had to manage a risk of not being recommissioned and so ceasing to exist within the regime of competition. Being administratively efficient emerged as a way of managing this risk. The social practice of risk assessment, another way of managing risks, created risks for practitioners whose reputations and roles could be influenced by their engagement with this practice. It also positioned clients as potential threats through interfering with the smooth functioning of well-oiled administration or through acts such as committing suicide whilst receiving support from the service.

The tension between these issues is well illustrated in extract 31. By this point, the client had mentioned a previous suicide attempt, self-harm, 'stashing' some pills for old age, as well as knowing how to kill himself.

Extract 31

Practitioner A: I understand what you're saying but um in your words you said it's actually quite dangerous for you to have that stash what do you what do you feel might be dangerous about it for you

Client B: well I was thinking I was pre-empting what ha what was probably going through your head actually

Practitioner A: okay okay what do you think might be the dangers for you though having that

Client B: um we-we-well I guess if err if if the self-control thing went

Practitioner A: yeah

Client B: I'm not so sure about the self-harm

Practitioner A: yeah

Client B: although I get the suicide thoughts I don't think I'm likely to act on them

Practitioner A: okay

Client B: um but I'm aware that just having them there is dangerous but then like I say I've got really sharp knives for the bush craft err but I don't act on that so that's I don't I'm not that worried

Practitioner A: um I know what you mean yeah okay is there anything you think you could do to sort of reduce that risk at all

Client B: of

Practitioner A: you know in terms of having that number of tablets in the house

Client B: oh right but but um thing is but um I don't you know my alcohol consumption's stayed down and I don't take drugs but if I needed to get something I could get it anyway

Practitioner A: yeah I hear what you're saying

Client B: just because I've

Practitioner A: so you don't feel in your mind having those tablets there puts you at any more risk

Client B: no and this is horrible to say but because I've done the service user stuff so much and I know a lot of people I can pretty much go and get what I wanted you know

Practitioner A: yeah

Client B: drug wise and anything and not that I ever have or I've got any plans to

Practitioner A: but you have access if you chose to

Client B: yeah I think I wouldn't have any problems at all

Practitioner A: okay so if I were to say this is a bit of a strange question to be asked but...if I were to say out of ten how likely is it that you might act on these thoughts of of taking your life in the near future... (Lines 278-308)

In this extract the client's discourse became problematic. The client indicated an awareness of this through 'pre-empting' a 'stash' of medication being dangerous to the practitioner, given his suicidal thoughts. This client's discourse here interfered with well-oiled administration and possible damage to the organisation was prioritised over damage to the client through attempting to control the situation and manage contingency which the client resisted. The focus then shifted to obtaining information that could later be reviewed as a way of avoiding blame, should this client commit suicide, by asking him to rate the likelihood of acting on these thoughts. The logic of difference therefore encouraged managing risks to the service over risks to the clients. It created practices that subordinated

supporting people with their mental health or potential risks to the risks posed to practitioners and the service that come from interacting with clients.

3.5 Fantasmatic Logics

The articulation of the logics of well-oiled administration and preservation, combined with consideration of the logics of equivalence and difference, provided an explanation of the rules that underpinned the assessments as they were analysed and how they related to the regime of competition they were situated within. Considering fantasmatic logics takes this one step further through enabling an understanding of what drove practitioners' engagement in the process of completing the assessments. Fantasmatic logics offer a way of accounting for the energy invested in this practice through narratives of fantasy that structure conscious or unconscious enjoyment. These narratives contain beatific and horrific dimensions as elaborated below.

3.5.1 The beatific.

Articulating beatific fantasies helps to describe the way in which fantasy narratives structured around ideals of complete social harmony or efficiency capture and direct energy towards pursuing such goals. These goals, of course, are never fully realisable as they contain the promise of a removal of contingency from the world. This could be seen within the assessments analysed in relation to the social logics of well-oiled administration and preservation. When inflected at the beatific level, well-oiled administration became idealised as a perfect system of administrative care. This fed into the ultimate ideal of the service being abundantly resourced and recommissioned indefinitely, with risks easily managed and contingency completely concealed. From this view, the service became a well-oiled administrative machine.

The pro forma embodied this beatific fantasy through portraying a straightforward question and answer process that led to a simple decision being made determining suitability for the service and the support needed. Beatific fantasies led to risk assessment taking on

omnipotent qualities as an infallible, flawless process of assessment able to correctly identify people's level of need and any risks. A thorough and dutifully completed assessment became a form of insurance for practitioners and a way of ensuring protection from the service. This enabled the service to fulfil the role of guarantor as a caring other for practitioners and so reduced any anxiety linked to contingency. Practitioners' enjoyment in the practice of assessment was structured by their perceived closeness to this ideal. The extracts below provide examples of assessment being a way identifying the 'right level of support' and checking clients are 'safe'. This also constructed risk assessment as being solely in the interests of clients.

Extract 32

Practitioner B: okay so what I'm gonna do now...is a risk assessment
 Client E: yeah
 Practitioner B: and this is a standard procedure and will be routinely conducted whilst you remain in our service this is to ensure the safety of yourself and to make sure that you're gonna you know you'd receive the right level of support if there was any risk identified (Lines 204-208)

Extract 33

Practitioner C: we do carry out risk assessments just to make sure that err everybody we see is okay okay
 Client F: mmhmm yeah
 Practitioner C: it's just to check out how you're currently feeling and so that we can give you the right level of care (Lines 74-76)

This infallible view of risk assessment, and the protection and insurance it offered practitioners, produced an enjoyment in the process and an ongoing investment in it. This was informed by a beatific fantasy of the 'right level of support' or 'care' being available and something the client will receive once identified. This could involve being referred to another service if the risk was too high as shown in extract 34.

Extract 34

Practitioner A: whatever level of service you need that's deserved
 Client B: um I do feel I need some help though but I don't feel I'm a I'm an emergency at the moment
 Practitioner A: no that's I I don't feel that either it's more whether we need some sort of in the middle middle range or whether you could wait for treatment with us
 Client B: yeah (Lines 820-824)

The service presumably was the *bottom range* in contrast with a ‘middle range’ and ‘emergency’ service. Together, these services form part of a perfectly benevolent system of mental health care provided to deserving clients. This provided a certain enjoyment in the process of assessment although this fantasy was threatened here by the existence of waiting times.

When the pro forma and process of assessment was cooperated with, this led to a smooth instantiation of the social logics and fed into the idealised view of a perfect system of well-oiled administration. Clients fitting around the service in this way instead of the service having to fit around clients could generate a conscious enjoyment in the assessment as seen in extract 35 where it was ‘nice’ to not have to explain.

Extract 35

Practitioner B: what would you like to um achieve or or aim to achieve from us
 Client C: um I’d to perhaps work on like learning to rethink the way I think...
 Practitioner B: ...okay so that’s quite a good goal falls within the criteria of smart goals...it’s nice when you haven’t got to explain it to someone
 Client C: ha ha
 Practitioner B: it’s almost like you knew that we would be looking for the smart goals that we support (Lines 652-665)

When clients did not fit so easily around the service, risk assessment became an essential component of a benign, well-oiled administration able to easily manage future risks as shown in the extracts below.

Extract 36

Practitioner C: so what we need to look at is ways perhaps to help you manage your mood differently to stop triggering those types of [suicidal] thoughts (Lines 255-256)

Extract 37

Practitioner C: it’s really just a case of getting you in the right service (Line 711)

These extracts show risk assessment practice as a way of finding out what the right service was for a client, or identifying types of thoughts that can then be stopped. The beatific fantasy here shows how services could provide a promise of fullness capable of putting a stop to any suicidal thoughts.

A well completed assessment offered protection in the form of insurance. A well-documented pro forma and risk assessment therefore enabled the service to take on the function of guarantor for practitioners. This offered protection from the risks involved in the practice and so from the anxiety associated with contingency. This is shown in the extract below which followed the client reporting feeling confused about having suicidal thoughts and thoughts of self-harming despite trying to stay positive, get his flat sorted and think life is still worth living.

Extract 38

Practitioner A: well sometimes people have those kinds of thoughts as a as a kind of almost you know final option almost but not one that they want to like an insurance policy if it ever got that bad if I was in a wheelchair it almost has this kind of insurance policy

Client B: mmm

Practitioner A: feel to it (Lines 331-335)

Although responding to the client, this idea of insurance showed an important function of risk assessment more generally, it provides a form of insurance for the assessor. It reduces anxiety in the assessor by providing protection from blame. This functions to generate an enjoyment in the process. In this case, this could take the form of reporting the client had rated his intention to act on his suicidal thoughts as nought or one out of ten (see extract 24) so what more could be done. Completing the pro forma, and risk assessment questions in particular then, was an important way of managing the risks posed to practitioners and the service from clients and thus ensuring preservation.

3.5.2 The horrific.

Horrorific fantasies also work by generating energy but in a different direction. Instead of an idealised vision they present a threat that needs to be curtailed to prevent the catastrophic decline of an individual, system or wider social order. This threat manifests in the idea of the obstacle which, alongside beatific fantasy, was an important aspect driving investment in the process of risk assessment which became a way of dealing with such obstacles. Clients accessing the service whose risks were ambiguous and who may then go

onto engage in a risk behaviour like killing themselves became an obstacle. Taken further, this may lead to the decline of professional reputation and status, and for the service the horrific fantasy of not being recommissioned. At a milder level of gradation, clients who were difficult to assess became a nuisance and difficulty completing the pro forma or risk assessment, through a lack of clear information, an obstacle. An additional threat became the lack of resources available within the service as indicated by waiting times which challenged the fantasy of the perfectly efficient administrative system.

There was an enjoyment in risk assessment practice when clients became obstacles through presenting risks to the service. The horrific fantasy involved the client committing suicide and the service becoming accountable for this due to an inadequate risk assessment. This generated an investment in risk assessment practice as a way of managing risks to the service. Additionally, a failure in assessment took on horrific dimensions with the possibility of denying access to those who met service criteria or granting access to those who did not. This can be seen in extract 39 where the risk was ambiguous and so the client became an obstacle.

Extract 39

Practitioner C: do you ever feel that life is not worth living
 Client D: yeah
 Practitioner C: ...have you made any plans to end your life
 Client D: um when are we talking about...
 Practitioner C: well um first of all recently has that been something that
 Client D: no not recently
 Practitioner C: okay so you've I presume that you have had thoughts like that in the past then
 Client D: yes
 Practitioner C: okay so how long ago would that be
 Client D: um three years
 Practitioner C: about three years ago okay um what what were you thinking
 Client D: um well I was um well I was being made homeless by the d w p they accused me of cohabiting
 Practitioner C: right
 Client D: when I wasn't and um I couldn't find a way out of it and it was the only the the it seemed like there would be only one solution which
 Practitioner C: that that seemed like the only solution
 Client D: yeah
 Practitioner C: to you so what what were you thinking of doing to yourself
 Client D: oh just hanging myself or something
 Practitioner C: right okay did you did you get as far as making any preparations or
 Client D: no
 Practitioner C: anything like that
 Client D: no

Practitioner C: okay what what stopped you from following that
 Client D: um um I suppose I managed to find somewhere else to live so the they had to drop their allegation
 Practitioner C: so it was that your circumstances changed
 Client D: yeah
 Practitioner C: and you felt better and you felt you were having less of those types of thoughts
 Client D: well I had somewhere to go to so there was a
 Practitioner C: yeah
 Client D: I wouldn't say I felt a lot better to be honest but
 Practitioner C: okay okay...[risk assessment continues]... on a scale between nought and ten how likely is it that you'd do anything like that at the moment...
 Client D: um well again there's two parts to it if my mum is
 Practitioner C: yeah
 Client D: alive it's a nought
 Practitioner C: given how okay so given given how things are now that would be zero (Lines 165-251)

Thirty-one questions were asked about this client's risk of suicide and self-harm. The assessment concluded with the client rating his intention to act on his suicidal thoughts. The number of questions asked shows enjoyment in this social practice linked to the way in which risk assessment both concealed contingency and protected the practitioner. This was most evident from the recording of the client's intention to act on suicidal thoughts as zero. The client's acknowledgement of contingency – it is only a nought if his 'mum is alive' – was overlooked. He was not asked what his intention would be should his mother not be alive. This contingent obstacle was dealt with by focusing on the *zero*, minimising contingency and so managing risks.

Clients who interfered with the smooth operation of the social logics could therefore become obstacles. One way in which this was evident was through not providing clear information as shown in extract 40.

Extract 40

Practitioner A: what about now how are you feeling now you say you have these thoughts are they actual thoughts of wanting to end your life or are they thoughts of just wishing it was different can you tell me what you're thinking now
 Client A: um thoughts of wishing it was different thoughts of getting away from it all um thoughts of going somewhere for two or three months closing my eyes and and hoping that when I open them up and go back that everything's gonna be okay but
 Practitioner A: yeah yeah okay so you have thoughts of wishing it was different and that you could just walk away from it all in some way

Client A: yeah
 Practitioner A: okay do you actually have thoughts at the moment of wanting to harm or kill yourself
 Client A: no no (Lines 102-112)

This extract shows ambiguous information was problematic. Ambiguity became a nuisance that led to efforts to extinguish it. The practitioner stated there could be a potential risk with this client, linked to his children witnessing his wife punching and kicking him. His wife had recently had a stroke and was receiving support from another service. The practitioner said this could become a safeguarding concern but encouraged this to be shared with the other team as shown in extract 41. Here, this issue became a potential risk which was dealt with by attempting to displace it onto this other team. This may have been linked to a fantasy of a perfectly administered network of mental health care including other services. However, the regime of competition may generate an enjoyment taken in competitive and rivalrous relations with other services. This may bring about practices aimed at making risks and obstacles another service's responsibility.

Extract 41

Practitioner A: I think it is really worth sharing and obviously it could become a concern if it was happening and the children were witnessing that
 Client A: mmm
 Practitioner A: you know it could really become a safeguarding issue
 Client A: yeah
 Practitioner A: so I think I'd really encourage you to talk to her team about that as well (Lines 654-659)

An obstacle also emerged in the form of waiting times which challenged the image of the idealised administrative system linked to a beatific fantasy of the NHS as a fully resourced service able to unconditionally meet people's needs. An acknowledgement of waiting times threatened this image and presented a horrific alternative of services being constrained and based on severity of need as shown below.

Extract 42

Practitioner A: um I will check um with my supervisor afterwards about what um what their view is in terms of a sensible treatment option for you if you like that in that takes into account the level of risk your feeling at the moment
 Client B: yes I'm aware there's a score you know if you don't hit the right score you don't get certain stuff er I fully understand that and I don't you know

- Practitioner A: yeah it's not so much and I bet it does feel that way it's not so much if you don't hit the right score it's because there is a waiting time for us
- Client B: oh I know and I know how everything's been cut so um you know I'm aware of that
- Practitioner A: we don't we certainly don't want to kind of put you on a waiting list if you're feeling more like you need help now
- Client B: um
- Practitioner A: um because this risk is um you know a concern what's your sense of that if you for example if at the end of the assessment we did think about putting you on the waiting list for treatment but you had to wait three or four months do you feel that would be safe in doing that or do you think you would need something sooner than that to keep safe
- Client B: um I I possibly think I'd be I dunno how to answer that I think I would be okay but I do want something (Lines 420-436)
-

This shows a threat to the perfectly efficient administrative system in terms of a lack of resources as well as a client whose risk is a concern, thus providing a confrontation with horrific fantasy. This was managed by encouraging the client to share the dilemma and make his own assessment which led to the client framing his difficulties around the institutional workings of the service and gave the practitioner a sense of the risks the service face if he was to be on the waiting list and not supported for 'three or four months'. It also managed the risks to the service through an explicit statement from him that he thought he 'would be okay'.

Chapter 4: Critical Explanation

4.1 Chapter Overview

This chapter provides a critical explanation of the social practice of risk assessment. It does this through revisiting the key arguments developed in the thesis and discussing implications of the risk assessments studied. Counter-logics are then projected for the purpose of critique and as part of an imagining of an alternative social practice to the risk assessments seen here. The chapter then reflects on the thesis itself, considering the approach used and the particular application that has been developed here. The chapter concludes by considering potential future research and by providing some reflections on my own position as researcher.

4.2 Retracing the Research

Following prefatory remarks and some initial consideration of the research context and strategy, this thesis began in earnest with an archaeological and genealogical problematisation of risk assessment. The archaeological work involved approaching risk assessment contextually, examining problematic aspects of risk assessment and consideration of its consequences. This showed an explosion of discourse about risk and risk assessment which began in the 1980s, grew during the 1990s and continues to proliferate. This occurred alongside the emergence of clinical governance within the NHS which included an obligation for services to have clear policies linked to potential risks and systematic risk assessment and management programmes (McSherry et al., 2011). Key elements of a market-based system were introduced in the 1990s and have been extended in recent NHS reforms (Glynos et al., 2015). Currently then, a competitive commissioning process structures the provision of mental health services, whereby service providers compete with each other to win service provision contracts and clear risk assessment and reduction programmes are an expectation of services.²⁵

Within actual clinical practice, a therapeutic relationship has been redefined to incorporate risk assessment as an essential component, and risk assessment has become

embedded within the day to day practices of mental health services (Department of Health, 2011). This research examined one such daily practice, duty screening assessment within an IAPT service. IAPT grew out of the liberal, utilitarian work of Layard and was linked with clinical governance and the increasing significance of NICE (Clark et al., 2009). IAPT services were established to provide psychological therapies for common mental health problems such as anxiety and depression. The treatments IAPT services provide are not considered appropriate for those with significant risk issues which creates an additional incentive to assess risk in this competitive commissioning context.

When considering risk assessment in more detail however, a number of problems emerged. Firstly, risk assessment has not been shown to lead to an accurate prediction of levels of risk. Indeed, accurate prediction of risks, such as the risk of suicide, has been described as impossible (The Royal College of Psychiatrists, 2008). Different methods of risk assessment have been developed and employed partly in response to the limited accuracy of risk assessment. The two dominant approaches have been clinical and actuarial approaches (Lamont & Brunero, 2009). Clinical approaches involve professionals making a judgement after an assessment and actuarial approaches involve using specific tools to identify factors known to be associated with particular risks.

Neither clinical nor actuarial approaches however have been able to resolve the problem of inaccuracy. Clinical approaches have been critiqued for being subjective and unreliable. Actuarial approaches suffer from base rate problems. As the behaviours being assessed are rare within the population, like suicide and violence, the majority of people these assessments identify as being a risk actually turn out to be false positives and so not a risk (Duggan, 1997). Actuarial tools therefore show that risk behaviours are not statistically predictable for individual patients. Owing to the problems with both clinical and actuarial approaches, a combination of the two has become the preferred method of risk assessment although of course this has not fully resolved the problem of accuracy (Lamont & Brunero, 2009). Other problems involve obtaining accurate and comprehensive information to inform the assessment, potential disagreement between actuarial and clinical aspects and accurate

assessment of risk does not necessarily lead to a reduction or prevention of the risk behaviour.

Another problem seen with risk assessment was that some risks are prioritised over others, particularly the risks posed by people accessing mental health services towards themselves or others. However, this is based on an assumption that these people pose more of a risk than the general population which epidemiological research has problematised (Wand, 2012). The risks people face from coming into contact with mental health services become side-lined despite including a potential loss of liberty through mental health legislation, forced treatment or ineffective treatment (Rogers & Pilgrim, 2014). Prioritising the risks posed by people who access mental health services to themselves or others encourages other risks these people face to be marginalised, such as the risk of inadequate accommodation or not being allowed to make decisions that involve taking risks as other people may typically do. Risk assessment also leads to a focus on the risks posed by individuals and so overlooks risks that may come from living in particular communities, such as communities that experience higher levels of poverty, unemployment and substance abuse.

Some additional consequences of risk assessment described were that patients become a source of threat to professionals, and with the contemporary cultural emphasis on accountability and litigation, professionals become preoccupied with managing their own risks (Power, 2004). Risk assessment in this context encourages professionals to develop skills in managing the risks to their reputation rather than the primary task for which they are employed. Risk assessment then generates anxiety in the assessor and can become a form of insurance for professionals who may make decisions from the perspective of having to later justify and defend the decisions taken in court (Undrill, 2007). An over reliance on risk assessment within mental health services may also maintain the problematic association between mental illness and danger and so exacerbate stigma (Szmukler, 2003). Other consequences were that it can take time away from building a therapeutic relationship and provide a false sense of security that risks have been comprehensively assessed and

understood. Risk assessment may also lead to a concealing of contingency and uncertainty, that are here viewed as inherent to both social structures and human subjects.

Genealogical work led to a consideration of risk assessment's ignoble beginnings. This showed that risk assessment as a social practice emerged, and became sedimented, within the era of community care. The Christopher Clunis case became a focal point for contestation over the policy of community care. The report into the investigation of the killing of Jonathan Zito by Christopher Clunis produced an image of Clunis as a madman that needed to be feared yet also a victim of a mental illness requiring care (Ritchie et al., 1994). The creation of risk registers, registers of patients who were or were likely to be at risk of serious violence, suicide or self-neglect, was one recommendation amongst many. Yet this recommendation was quickly formalised into governmental guidance and led to services and key professionals becoming responsible for obtaining detailed information about patients' potential risks (Department of Health, 1994a, 1994b).

This reliance on risk information and risk registers was problematised by key social actors and this problematisation echoed the problematic aspects of risk assessment described in the archaeology and summarised above. Key concerns were that the risk criteria were over inclusive and so would lead to many patients being included who would not go on to become a risk, and again problems of inaccuracy were highlighted (Caldicott, 1994). Placing people on a risk register was said to be counter-therapeutic and potentially reduce people's desire to access services. The process was felt to be time consuming and would reduce other aspects of clinical care. There was also a concern about mental health professionals being viewed as agents of social control, and the registers creating a situation where professionals could be blamed if there was a serious incident involving someone not on the register. Despite the concerns, the risk registers were introduced and risk assessment became an expectation within mental health services and increasingly formalised. Consideration of a related incident a few years earlier where social worker Isabel Schwarz was killed by Sharon Campbell had not led to an articulation of the need for risk assessment in the same way (Spokes et al., 1988). Following the introduction of risk assessment within mental health, it continued to

grow in importance throughout the 1990s and into the present day. The contemporary significance placed upon risk assessment was well illustrated with the publication of the *Best Practice in Managing Risk* where a therapeutic relationship was re-described to include an objective assessment of risk (Department of Health, 2007).

After the archaeological and genealogical problematisation of risk assessment, this thesis turned towards day-to-day clinical practice through an analysis of risk assessments completed as part of duty screening assessments within an IAPT service in primary care. Six of these assessments, which were completed over the telephone, were audio recorded, transcribed and analysed using a logics approach. This led to the articulation of two key social logics, the inflections of which were considered in relation to the more formal political logics of equivalence and difference, and the beatific and horrific dimensions of fantasmatic logics. The two key social logics were a logic of well-oiled administration and a logic of preservation.

The logic of well-oiled administration involved a bureaucratic focus on *getting one's papers in order*. This logic structured much of the overall assessment and privileged obtaining and documenting information. This meant clients had to fit around the institutional workings of the service. This involved facilitating administrative processes and their difficulties being framed around service processes, such as the pro forma and questionnaires. The analytical skill of practitioners was also marginalised. They became tied to the pro forma used to structure the assessments and had less opportunity to use their analytical judgement. The logic of well-oiled administration also involved *asking people to remain the same* through the management of any contingency. This was done by treating clients purely as rational actors, minimising complexity and overlooking context.

The logic of preservation involved *identifying risks* where some issues were conceptualised as risks whilst others were not. The risk of suicide was given particular attention. Issues were turned into potential threats to practitioners and the service and these threats were then managed in particular ways. This logic captured how the risks to practitioners and the service took precedence and so *managing one's own risks* took centre

stage. A large focus of the assessments involved obtaining recordable information that could later be utilised for accountability purposes. A risk therefore became not completing the pro forma fully and so the duty screening assessments became very much pro forma led. Risks were managed by providing clients with support numbers and obtaining assurances from clients that they were not at risk. Offering clients restricted choice in relation to treatment decisions was also evident as a way of aligning with market based principles currently dominant in health care and so managing a risk to the service. In short, risk assessment became about avoiding potential damage to the organisation rather than avoiding potential damage to the client.

At the level of political logics, the duty screening assessments were structured by a logic of difference whereby any chains of equivalence between clients, practitioners and the service were broken down by the commissioning context. A regime of competition structures the service operations with Clinical Commissioning Groups acting as an occupying power through their ability to select organisations to provide services. This logic of difference creates a difficult context for supporting people and may work to expand market based principles within health care. The logics of well-oiled administration and preservation can be considered consequences of this competitive commissioning process.

When fantasmatic logics were considered, the reason for investment in risk assessment as a social practice became more comprehensible. Beatific fantasies produced an idealised image of the perfectly efficient administrative system that operates smoothly and leads to the service being abundantly resourced and recommissioned indefinitely. Risk assessment took on infallible qualities as a straightforward way of identifying any risks that could then be quashed. A dutifully completed assessment offered protection for practitioners as a form of insurance from the risks and contingencies involved in this social practice. This enabled the service to take on the role of guarantor as a caring other for practitioners. Horrific fantasies also generated an investment in risk assessment as a way of dealing with any obstacles that arose. Horrific fantasies involved a break down in assessment which led to clients being granted access who did not meet the service criteria or clients being denied

access who met the criteria. The ultimate threat was a client committing suicide whilst accessing the service with the service being held accountable. Clients therefore became obstacles through the potential for them to cause reputational damage to practitioners or the service, with failing to be recommissioned the ultimate threat. At a milder level of gradation, any interference with the smooth operation of these social logics such as the appearance of context, potential risks or contingency became a nuisance and so an obstacle to extinguish.

4.3 Implications for the Social Practice of Risk Assessment

The articulation of the logics structuring the social practice of risk assessments is not a statement on the truth of risk assessment practice but an attempt at making the empirical material intelligible in line with a view of the social world as radically contingent. The articulation should be considered in terms of its ability to provide a valid explanation of risk assessment practice within the context studied. This means the articulation offered applies not to risk assessment practice generally across mental health settings and elsewhere, but to this particular practice of risk assessment as part of duty screening assessments completed within primary care. The present findings should not be seen as accurately representing risk assessment practice in alternative contexts. They may be relevant but this would have to be demonstrated through a process of articulation linked to the different contexts. Three implications of the logics posited here will now be considered.

1. *Clients disappear in their actuality and become obstacles known in terms of the risks they pose*

The logics of well-oiled administration and preservation led to clients being made to fit around service criteria. The practice relied upon and prioritised administrative process like completing the pro forma and questionnaires. This worked to marginalised practices that may involve ‘knowing’ clients in their actuality including the complexity of their lives and their pasts. Contextual information became noise so extraneous to administrative process and discursively closed down. This disappearance of clients aligns with what Castel (1991) refers

to as a shift from the clinic of the subject to the epidemiological clinic, which involves a move from a “concrete relationship with a sick person...[to] a relationship constituted among the different expert assessments which make up the patient’s dossier” (p. 282).

Clients became known in terms of the risks they posed which extended the myth of risk assessment’s infallibility and, depending on the risks perceived, could lead to clients becoming obstacles. It is hard to see how this context can be one which works to support people with the actual issues conceptualised as risks. Although this may happen and there were instances where equivalences could be seen between practitioners and clients, the practice and logics articulated present a significant challenge to this. The emphasis was on preservation of practitioners’ roles and reputations and minimising damage to the service rather than damage to clients.

This thesis therefore provides empirical support for Power’s (2004) description of secondary risk management where social actors engaged in risk assessment become preoccupied with managing their own risks that emerge from the process rather than the primary risks they are employed to manage. This was evident in the assessments analysed. Dutifully completing and documenting risk assessments served to protect practitioners from possible future blame, linked to uncertainty, and allowed the service to take on the role of guarantor. Reciprocally, this process also managed risks to the service. To return to Power’s (2004) description of this: “In such a cultural environment, with institutions which tend to amplify blame and the logic of compensation, it is rational for organisations and the agents within them to invest in management systems with a strong secondary risk flavour” (p. 41). This could be at the expense of clients and so shows an unintended consequence to the social practice of risk assessment, one which contradicts its stated aim.

2. *Administrative processes subordinate clinical judgement and generate practices of self-assessment*

Administrative process predominated. The practice and logics involved worked to reduce the need for analytical judgement on the part of practitioners who could become tied

to the pro forma. This manifested in practitioners taking on more of a technical role and the clinical aspects of their role being marginalised. The emphasis was on recording information which worked to minimise the risks to the service through explicit statements from clients that they did not pose a risk. The clearest example of this came from clients rating their intention to act on suicidal thoughts on a scale from nought to ten. This prioritising of administration may reflect what Rose calls a transformation of professional subjectivity where:

it is the individual professional who has to make the assessment and management of risk their central professional obligation. They have to assess the individual client in terms of the riskiness that they represent, to allocate each a risk level, to put in place the appropriate administrative arrangements for the management of the individual in the light of the requirement to minimize risk, and to take responsibility – indeed blame – if an ‘untoward incident’ occurs. (Rose, 1998, p. 184)

This research provides support for this view as risk assessment and management dominated the clinical encounters studied. Where Rose’s focus was on governmentality, the extension of administration was made intelligible here by the practice of assessment offering protection, whether real or imagined, to the social actors involved owing to the overarching competitive commissioning context.

This social practice managed risks to the service and led to clients being encouraged to share the responsibility for assessing risk through a form of self-assessment. It is tempting to see this as clients being given a greater say over their involvement with mental health services and so, to invert Jewson’s (1976) classic phrase, *the reappearance of the sick man* within medical cosmology. However, as argued above, this is not the discourse of the *sick man* as a totality but a fragmented discourse generated by service specification prioritising managing its own risks. Perhaps this is better understood then through Foucault’s description of Bentham’s Panopticon where the architectural design meant prisoners could be subject to permanent surveillance without knowing when they were being observed, and so come to act

as if they were continually being observed. This technology meant a subject would “inscribe in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection” (Foucault, 1991, pp. 202–203). Although a different context with important nuances, perhaps risk assessment practices generating a form of self-assessment does have significant elements of these power arrangements with clients inscribing discourses of risk. In this sense, risk discourse becomes part of the canon of mental health service users’ discourse (cf. Speed, 2007). From a slightly different angle, the guards in Bentham’s prison did not need to be physically present due to the architectural arrangements. Risk assessment as a social practice may perform a similar function with the practices in place enabling an invisibility for the commissioning context which governs the practices seen.

3. *Extension of market based principles within health care*

The logic of difference that operated within the empirical material meant different identities and tasks were extended for the social actors involved so being a client led service became one of a series of competing objectives. This was linked to the regime of competition that the service operates within whereby *any qualified provider* – private, public or third sector organisations – can bid for contracts provided by Clinical Commissioning Groups (Sanderson, Allen, & Osipovic, 2016). Risk assessment and management featured as a crucial practice within this context as a way of preventing damage to the service and so maintaining its commercial viability. Risk assessment practices therefore work to maintain the hegemony of market based principles currently structuring health care.

While only one aspect of this research and further empirical work would be required, other services did feature within the analysis. These other services could form part of a beatific fantasy of a perfect system of mental health care but also part of a horrific fantasy where other services appear as rivals and so enjoyment is taken in making clients who emerge as obstacles another service’s responsibility. Further empirical work would be needed to

better elucidate this including detailed analysis of practitioner discourse and service practices relating to the interface with other services.

Risk assessment practices also worked to legitimise under-resourced services. Risk assessment became a way of ‘knowing’ how urgent clients’ needs were to receive support and so assisted decisions about service suitability. Instead of waiting lists being conceptualised as indicating a lack of resources, waiting lists were accepted as a ‘reality’ and converted into another measure for gauging someone’s level of risk, i.e. would they be safe whilst being on a waiting list for three or four months. In this sense, waiting lists became useful and so discourses contesting a lack of resources were minimised.

Choice was also evident in the assessments analysed, although the choice was a restricted one and involved choosing between cognitive behavioural therapy delivered in different formats or between different forms of short term psychological therapy. The provision of choice in this way positioned clients as consumers as well as people with common mental health problems and so worked to extend market based principles. This competitive context and extension of market based principles encouraged risk assessment and management practices which prioritised managing risks to the service which at times occurred at the expense of clients. To consider the possibilities for combatting this and the other malign implications of risk assessment practice in its current forms, counter-logics will now be articulated.

4.4 Projection of Counter-logics

The social logics of well-oiled administration and preservation structured the practice of risk assessment within the empirical material. These logics complement and so extend the regime of competition they are situated within. This does not mean that risk assessment within IAPT services will always look the same or be dominated by these two social logics to the same extent. It is likely that the dominance of these two social logics will vary and some practitioners may well reject or challenge them. The articulation of these social logics

assumes they are worthy of being contested and speaks to the logics approach as a form of critical explanation with critique being a key aspect.

4.4.1 Practices.

To facilitate critique, counter-logics can be described and contrasted with the dominant logics to offer critical potential. Here, two counter-logics are proposed to contrast the dominant logics seen within risk assessment practice. The counter-logics relate to the level of practice as opposed to the level of regime. To clearly differentiate the practice studied and the projected practice, it may be necessary to develop a new nomenclature to move beyond current understandings of risk. Here, a notion around *clinical perceptions of risks* is offered as a more appropriate way of thinking about the practice of trying to understand risks, or at the very least risk assessment could be reformulated as intelligent risk assessment. Two logics are projected into the social practice of perceptions of risks, a logic of contingency and a logic of care as shown below in table 3.

Table 3

Logics and counter-logics

Administrative Risk Assessment	Clinical Perceptions of Risks
<p>Logic of well-oiled administration</p> <p>Risk assessment viewed as essential, unproblematic and capable of accurately assessing risks</p> <p>Clients treated as rational, knowing subjects aware of their risks</p> <p>Reliance on pro forma and standardised questions</p> <p>Context and complexity obscured or minimised</p> <p>Homogenous approach to risk assessment, focused on obtaining information</p> <p>Risk assessment indicates service provision</p> <p>Clients fit around pro forma and service</p> <p>Practitioners' analytical skill obscured</p>	<p>Logic of contingency</p> <p>Risk viewed as contingent and assessment as imperfect perceptions of risks</p> <p>Perceptions include clients' perspectives and practitioners'</p> <p>Does not use pro forma or standardised questions</p> <p>Risk behaviours considered contextually and within the context of people's lives, complexity accommodated</p> <p>Risk perceptions follow clients leads and so varies in practice</p> <p>Does not dictate the service provided in isolation from other issues</p> <p>Perceptions of risks adaptive to clients</p> <p>Practitioners develop expertise over time</p>
<p>Logic of preservation</p> <p>Practitioners define risks and close down other issues</p> <p>Risks to practitioners and service prioritised</p> <p>Clients become obstacles</p> <p>Risk assessment becomes insurance for practitioners, emphasis on recording information</p> <p>Focus on avoiding future blame, incentive to get clients to say the right things</p> <p>Risk assessment and management seen as infallible</p> <p>Risk assessment brings risks for the assessor</p>	<p>Logic of care</p> <p>Certain areas asked about like suicidal ideas and aggressive feelings and followed up if necessary, openness to issues clients see as risks</p> <p>Prioritise supporting people with 'risk' issues through attempting to understand</p> <p>Risk or clients' difficulties become obstacles</p> <p>Perceptions of risks one aspect of the care someone receives, emphasis on the interaction having possible clinical benefits</p> <p>Practitioners reflect on own role in assessment process</p> <p>Openness to contingency and the impossibility of preventing some risk issues</p> <p>Practitioners not held accountable for 'inaccurate' perceptions of risks, supported institutionally</p>

Table 3 provides a comparison of the social logics articulated from the empirical material and the projected social logics of contingency and care articulated here as making up the practice of *clinical perceptions of risks*. The logic of well-oiled administration presented risk assessment as essential, unproblematic and capable of accurately assessing risk. Clinical perceptions of risks would begin from a contingent view of risk with assessment being

incapable of accuracy and so the practice being better defined as one of perceptions of risks. This involves the soberer position that a perfect system of risk assessment can never be realised. A logic of contingency invites *risk* to be pluralised to *risks* to allow both clients and practitioners to develop their views on what the 'risks' are for someone and how significant they are. This logic rejects the use of a pro forma and standardised questions, and expects, accommodates and explores complexity and contradiction. Particular issues seen as risks are attempted to be understood by considering the context in which they occur and in relation to the context of people's lives, not just focusing on the recent past. This opening up of complexity works against the 'beautiful promise' offered by the logic of well-oiled administration of risk assessment being a discrete, limited task. It means more issues could potentially be articulated as risks but the crucial element would not be for anything and everything to be potential risks but for the clinical to be reoriented above the administrative, and so issues conceptualised as risks would be clinically not administratively informed.

The logic of well-oiled administration treats clients as rational, knowing subjects aware of the risks they pose and face. Contingency, context and complexity is denied, obscured or minimised and clients have to fit around the institutional workings of the service including the proforma. The assessment indicates service suitability and due to its homogenous structure, obscures the analytical skill of practitioners. The logic of contingency would lead to a varied practice in clinical perceptions of risks and risk issues alone would not dictate the service someone received. Instead risks would be integrated within other aspects of clinical care. The logic of contingency would provide less structure and guidance for practitioners and so the practice would become a clinical skill that practitioners develop over time. This would challenge the expanding administrative aspects of practitioners' roles. Mitigating the threat of the horrific, such as a catastrophic training error putting the service at risk, would require an ongoing articulation of the limitations and imperfections of the social practice of clinical perceptions of risks and alternative protection of the social actors involved. It would also require an articulation of this fallibility within commissioning practices, and so a greater tolerance of uncertainty and contingency which could be achieved

through directly challenging current commissioning practices or working around them as discussed further below.

Clinical perceptions of risks would also be structured by a logic of care which would involve asking about important areas in people's lives like suicidal ideas or feelings of aggression. These areas would be opened up for clients to discuss without being introduced as a *risk assessment*. This would follow a client's lead and not be completed as an administrative duty. If there was no clinical indication for ongoing exploration this would become unnecessary. The logic of preservation prioritised the risks to practitioners and the service from completing risk assessments. This involved practitioners and the service defining what constituted a risk and risk assessment itself was viewed as infallible. The logic of care counters this stance and prioritises supporting people with particular issues viewed as risks. This is done through attempting to understand the issue from the client's perspective and so requires an openness to clients and the issues they see as risks as well as issues practitioners see as risks for clients, not for themselves or the service. This requires an acknowledgement of the limitations or fallibility of *clinical perceptions of risks* and so a supportive stance towards practitioners who do not become accountable if someone does go onto harm themselves or others. It is suggested here that an openness to understanding enables consideration of risks to become more properly integrated within clinical care, rather than an isolated part of an assessment process. Nevertheless, the logic of care does not assume omnipotent qualities and reflects on the reality that some risk issues will continue to occur despite practitioners' and services' best attempts to prevent this.

The logic of care also encourages practitioners to reflect on their role in the process which may include their own experience of the clinical encounter as well as ways in which they may have influenced the client's engagement. This was not evident within the logic of preservation where clients could become obstacles to the process and an incentive to get clients to say the right things was evident. This was linked to the fact that a well-documented pro forma and risk assessment could become a means of insurance for practitioners even if this was just a way of managing the anxiety associated with horrific fantasies of damage to

their professional reputation from poorly completed assessments. The logic of care frees up practitioners from this anxiety through articulating perceptions of risks as imprecise and so limiting opportunities for blame.

4.4.2 Regimes.

The above counter-logics are focused on the social practice of risk assessments. This is therefore aimed at what could pragmatically be considered a micro level issue. As described in the analysis however, the social logics articulated were closely linked with the commissioning context in contemporary mental health practice, characterised as a regime of competition due to the influence of market based ideas. The projected social logics of contingency and care are clearly a challenge to this dominant regime of competition. Considering a regime as a system of practices elevates regimes to a more macro level. It may therefore be that an intervention at the level of practice is constrained by this regime of competition which may serve to blunt any radical potential offered by this alternative practice.

It is therefore important to contest the regime of competition as well as the practice of risk assessment. This necessitates consideration of political logics which work to contest, transform and institute practices (Glynos & Howarth, 2007). It is beyond the scope of this research to comprehensively engage with this issue but one way of contesting a regime of competition would involve an alliance between key social actors in opposition to the market based principles informing health care and an articulation of alternative demands. In short, a hegemonic struggle. Hypothetically, this could involve clients, practitioners, researchers and so on forming a chain of equivalence in opposition to market based principles within mental health care. This would involve drawing upon the discursive resources available to produce an alternative project. In addition to the counter-logics posed, two such discursive resources are the logic of care and the politics of uncertainty discussed below.

One alternative to a direct challenge to the hegemonic structure could involve attempts to work around it. One example of this can be seen in the regulation of competition

within the NHS since the introduction of the Health and Social Care Act 2012 (Sanderson et al., 2016). The introduction of such legislation may have little effect on the ground due to being absorbed within existing practices. For example, mergers have progressed despite reducing competition as they have been seen to promote high quality services and regulators have taken on the role of translating between NHS and competition authorities informally to avoid mergers being subjected to competition law (Sanderson et al., 2016). This shows that working around the regime of competition or articulating discursive resources such as ‘high quality services’ provide alternative means of contestation.²⁶

Market based logics can be contrasted with health care logics as articulated by Mol (2008) in *The Logic of Care*. Here, Mol, studying the practices involved in the treatment of diabetes contrasts the logic of care with the logic of choice and shows how choice, a market based idea, is incompatible with important aspects of health care and so a challenge to the provision of quality health care:

Articulating the logic of care is an attempt to contribute to improving health care on its own terms, in its own language. A language in which the main emphasis is not on autonomy and the right to decide for oneself, but on daily practices and attempts to make these more liveable through inventive doctoring. In care-specific terms, care is bad when people are being neglected. When there is not enough time to listen. When physical parameters are isolated from their context; when patient’s daily lives are not taken into consideration. (Mol, 2008, p. 84)

Although discussing the treatment of, and life with, diabetes, this may have a family resemblance to mental health care and problematises the influence of market based ideas in health care. Her thesis also suggests a need for articulating the elements that constitute quality health care from within clinical discourse without uncritically accepting all aspects of clinical thought. This work therefore provides a useful counter to the regime of competition.

Another useful way of contesting the regime of competition can be found in Power’s (2004) discussion of the need for a *politics of uncertainty*. Power calls for a political discourse of uncertainty that rejuvenates expert judgement, enables critique and develops a

discourse that acknowledges the possibility of failure. This would involve debunking the myth of perfect manageability in favour of “necessarily imperfect, humanly designed and operated, risk management systems [that] continue to support an engagement with unknowable futures” (p. 58). This could foster an honest engagement with the unknowable future and minimise the expansion of secondary risk management.

Taken together, the logic of care and politics of uncertainty provide an alternative way of engaging with risk assessment practice within mental health care. Combining these with the counter-logics articulated above contests the regime of competition and provides alternative possibilities for practices within mental health care. These alternative possibilities are not new ideas but lay dormant within already existing practices as seen in the fleeting glimpses of an equivalence between clients and practitioners in the empirical material. This articulation can be considered an excavation of them that hopefully contributes to their revitalisation and the possibilities this would open up.

4.5 Considering the Logics Approach and its Present Application

Howarth (2000) provides a pragmatic way of evaluating research utilising discourse theory which involves considering the persuasiveness of the argument constructed and its influence within the research community. This involves consideration of consistency and coherence but also a discursive account’s ability to “add new and interesting insights to their various objects of investigation” (p. 141). The shape and tenor of judgement of this research then extends beyond my own evaluation of this study to the research community. However, some consideration of the strengths and limitations of the study will be offered.

One strength of this research was the empirical material it utilised. This allowed for the routinised, everyday practices within an IAPT service to be analysed. Much research within the qualitative tradition draws upon interview data which helpfully allows for consideration of subjects’ self-interpretations which can then be utilised in various ways, e.g., contextualised or analysed discursively. What this generates then is an analysis of what actors say about the practices they are involved in as opposed to an analysis of the actual practices

and this line of research has been critiqued for insufficiently attending to the role of the interviewer (Potter & Hepburn, 2005). This research was novel in this regard as it captured the actual clinical practice of completing risk assessments.

This also points to a limitation as interviews were not completed and so the ability to comprehend subjects' interpretations of their involvement in risk assessments was limited.²⁷ Completing interviews with practitioners would have provided more material to consider when attempting to articulate the various logics. This is particularly relevant with fantasmatic logics which here attempted to provide an explanation as to why practitioners engage in the practice. This was based on the empirical material and observations but being able to hear from practitioners directly as to how they interpret their involvement would have added a further useful dimension to enhance the understanding offered which should therefore be considered provisional and tentative. However, the view here would be that such interpretations would need to be contextualised and understood in connection with radical contingency and the view that people may not be fully aware of why they participate in a particular practice. This study would therefore have benefited from interviews being completed with practitioners to discuss various aspects of risk assessment practice including, for example, the way practitioners conceptualise their use of the pro forma. This would also have been able to shed light on reasons why some practitioners may not have wanted to take part, with only four of ten practitioners participating and thus a longer than anticipated period for obtaining recorded assessments. When discussed during the observation day, some practitioners expressed concerns about not having the time to read the information about the study and fears that taking part may have a detrimental impact on their job security. This would need to be explored further to be better understood yet suggests an anxiety about the implications of an inadequately completed risk assessment, in line with the fantasmatic logics specified.

The present application of the logics approach was also a novel use of this relatively recently developed framework where the majority of research has engaged with policy issues. One study has utilised the logics approach to analyse board room interactions in terms of the

ontological dimensions of social space (Thompson & Willmott, 2015). West (2011), an advocate of the logics approach, considers it in relation to what is termed a materialist turn in social and political research, and argues that “a more materialist engagement with practices has the potential to assist the post-structuralist logics approach in the delivery of its critical agenda” (p. 415). Attending more closely to practices is said to advantageously allow a fuller engagement with their complexity and offer utility in understanding political agency.

West (2011) draws upon material semiotic relationality to describe how social practices within the logics approach can take on a singular quality with the social logics of a practice emphasised over “activities, things that are done, embodied and materially furnished” (p. 420). This can lead to social practices being overlooked in favour of logics and regimes which may marginalise the nuanced minutiae of practices. West calls for further empirical exploration of the logics approach and “more subtle understandings of practices and the multiple realities and goods they enact and the more silent work of hegemony” (p. 429). While West’s critique may lead to a focus on analysing empirical material such as risk assessment practice, interestingly it also applies to the articulation developed here. This is one useful critique of the logics articulated then, that there has been a reduction in complexity through the analytic process and an “explaining away [of] multiplicity” (p. 422).

While the logics articulated here may have involved explaining multiplicity away, this was viewed as worthwhile in attempting to critically explain the dominance of problematic aspects of risk assessment practices and the commissioning context in which they are situated. It is also felt that the social logics articulated provide an important insight into the way a practice ostensibly defined as a benign way of supporting subjects with risks they may face is in contrast structured by a prioritising of managing reputational damage to the service. Nevertheless, this work may be assisted by ethnographic work that looks more minutely at the complexity of risk assessment practices including the way in which the social logics articulated are variously resisted or rearticulated.

4.6 Future Research

This research has indicated several avenues of related work that could offer useful developments, contrasts or rearticulations which will now be rehearsed. As suggested, this research would have benefited from interviews being completed with the social actors involved. In a move to prioritise practices, this research somewhat neglected the self-interpretations of actors other than as was evident in the assessments analysed or through the observations completed. Interviews with practitioners could shed light on their conceptualisations of the pro forma and practice of risk assessment, and interviews with clients could further explore the issue of being made to fit around the service, the loss of context and the inscription of risk discourse including self-assessment. The research also pointed towards the significance of exploring the relationship between services to better understand how the regime of competition may structure these relations. Some questions of interest include: do issues of rivalry become enacted between services? What practices are involved in people being referred to other services due to issues of risk? What constitutes constructive cooperation between services?

This research was also completed within a primary care setting and so it is likely that significant differences exist within related settings like secondary care settings in the community or inpatient environments. It would be of interest to explore family resemblances to consider whether the social logics posited here have application in these alternative contexts. This research also suggested that it would be helpful to elucidate the elements that constitute quality care within mental health through drawing upon clinical discourse as a way of combatting the imposition of elements from a market-framed discourse. This may involve a focus on process rather than outcome. It may also be useful to restore the visibility of the commissioning context through examining commissioning practices and interviewing commissioners to see how risk assessment practices are interpreted and enacted at this regime level.

4.7 The Position of Researcher

One element of the counter-logic of contingency involved practitioners developing expertise in the practice of *clinical perceptions of risks* over time. This aligns with the view that researchers using a logics approach develop their analytical judgement through practice across cases and as they become increasingly familiar with the theoretical concepts. This includes knowing at what point to fix the practices investigated in order to characterise them in an analytically useful way rather than attempting to describe their totality. This was my first piece of research using the logics approach which undoubtedly influenced the analysis produced as it involved attempting to understand the motley array of theoretical concepts and how to articulate them in relation to the empirical material. Fortunately, the research benefited from my research supervisors being experienced qualitative researchers including with the logics approach.

As a social actor, while writing this thesis, I was located within the field of clinical psychology and so the varying discourses connected to this discipline: cognitive, behavioural, psychodynamic, systemic, social constructionist and so forth. While writing this research, I was engaged in delivering psychological therapies (cognitive-behavioural, cognitive-analytic and psychodynamic) as part of my training in clinical psychology and working in various contexts. This influenced my approach to the project and my engagement with the issue of critique. I was aware of being a subject enacting the practices I was simultaneously critiquing. Rather than aiming at a state of fragmentation, my aim was to produce an integrative piece of research that took the importance of critique seriously and was able to problematise the taken-for-granted daily practices within my field in a way that could speak to and inform clinical practices with the necessary antagonism. The extent to which this has been fruitful remains for others to judge.

4.8 Reflexivity

This research emerged from my own experience of working within IAPT and thus from an engagement with the practices I have here critiqued. It was also influenced by my

continued engagement with clinical work and practices including risk assessment during my training in clinical psychology. As I hope is clear, my aim was not to produce a project that criticises clinical work from the outside, seeing practitioners as agents of the state or as governed by malign forces for example, but to develop a meaningful engagement with clinical work that usefully draws upon ideas from a range of disciplines with the overall aim of improving practices. Hence, my elaboration of *clinical perceptions of risks* outlined above.

Having completed this research, my own view on clinical work is that it remains a valuable activity that is multifaceted, complex and varied. It is influenced by a wide range of factors, at present this includes problematic systemic issues such as the regime of competition described and the increasing focus on accountability and blame. Good intentions can often get lost in this context. This project has led me to the conclusion that paying attention to risks, including negotiating what constitutes a risk and for who, is an important and integral part of clinical work, and can be enhanced by a greater openness towards the idea of radical contingency and through reflection on its own limitations as a clinical endeavour. It seems to me there is a danger of risk assessment descending into a static, bureaucratic process that focuses on managing risks to the reputation of services and professionals rather than the actual risk issues that assessments were initially designed to understand and reduce. I see a need for an ongoing critical reflection on these issues to improve practices surrounding risks and thus the overall support provided to people accessing services. I hope to take some of this with me in my own perceptions of risks in my future clinical work, drawing upon and refining the elements I outlined above as linked to a logic of care and a logic of contingency. I also believe future research, such as the ideas suggested in section 4.6, is a vital part of this process and will help shed further light on ways of improving clinical work and risk practices, and I hope this thesis has been a contribution in this respect.

Footnotes

¹ NICE have since altered their name to the National Institute for Health and Care Excellence (n.d.) to reflect that they provide guidance in the areas of public health and social care. When IAPT was initially set up it related to aspects of the NICE guidelines in use at the time, emphasising treatments for mild to moderate depression and anxiety disorders (NICE, 2004a, 2004b).

² NICE guidelines specify a range of other interventions at step 2 and step 3 for depression and anxiety, including other therapies such as Interpersonal Therapy. IAPT services differ in their provision of recommended treatments but what they do provide is informed by these guidelines. They also provide treatments for other issues including post-traumatic stress disorder, obsessive-compulsive disorder and panic disorder.

³ By discourse here, I am referring to discursive (i.e., textual, linguistic) and non-discursive (i.e., material, practices) elements, in short, the entire social space.

⁴ These professional groups are, of course, far from being homogenous entities with theories and ideas being in a continuous state of flux. However, it is helpful to keep this network of competing professions in mind and to reflect on the hegemony of psychiatric discourse in the area of mental health.

⁵ For a historical overview of the development of the quality agenda within psychotherapy and mental health, as well as key political milestones, see McPherson, Richardson and Leroux (2003).

⁶ Glynos, Speed and West (2015) make the case that the empty signifier *integration* served as a master political logic in these reforms which normalised provider-blind provision and obscured important ideological influences.

⁷ It is worth noting that the mental health act is not actually about mental health, but about controlling individuals seen as mentally disordered. It has been critiqued as “illogical and discriminatory only to legally control the risky behaviour of one defined social group (psychiatric patients) rather than of all citizens, independent of their mental state” (Rogers & Pilgrim, 2014, p. 225).

⁸ These sensitivity and specificity values are unrealistically high – values of 80% are rarely achieved (Large, Ryan, Singh, Paton, & Nielssen, 2011).

⁹ Recent focus on the area under the curve of the receiver operating characteristic curve has not resolved this problem and it remains the case that the better a test is at identifying true positives, the worse it will be at identifying true negatives (Szmukler, Everitt, & Leese, 2012).

¹⁰ This discourse takes the psychiatric, diagnostic approach of discrete mental illnesses for granted, an approach best understood as just one way of thinking about human distress and which obscures important and relevant moral, political and phenomenological issues (Rapley, Moncrieff, & Dillon, 2011).

¹¹ See Vassilev and Pilgrim (2007) for a discussion of the concepts of ‘trust’ and ‘risk’ in a broader argument that ‘mental health services’ are actually a myth and would be more accurately described as ‘social control of mental disorder services’.

¹² Like risk, uncertainty is a concept which has been understood differently across time and place. See Undrill (2007) for a distinction between different models of uncertainty.

¹³ Foucault’s oeuvre has to be one exemplary of this, and Kuhn (2012) made an important theoretical contribution in a move away from a linear view of history as progress with his emphasis on paradigm shifts and truth being defined through consensus. In Psychology, Danziger (1994) and Richards (2010) have provided critical and reflexive histories.

¹⁴ For a discussion of the role that race and gender played in relation to the reporting and investigation of this incident see Neal (1998).

¹⁵ This review also referenced an incident involving Ben Silcock, who, also diagnosed with schizophrenia, was badly mauled after climbing into the lion’s den at London Zoo (The Guardian, 1993).

¹⁶ For a helpful analysis of the framing of the Clunis and Schwarz incidents in newspaper coverage see Paterson (2006). Paterson shows the success of the Clunis incident in being reframed in terms of social policy as opposed to personal tragedy.

¹⁷ At the time, the NSF was a charity campaigning for people affected by schizophrenia (now known as Rethink Mental Illness). SANE was also initially established to campaign on behalf of people with schizophrenia. Jayne Zito went onto establish the Zito Trust (n.d.), a charity which focused on protecting the public from people with mental illness and advocated community treatment orders.

¹⁸ For a genealogy of the care programme approach see Hawksley (2013).

¹⁹ Two distinct ways of analysing discourse predominate within psychology, these are approaches which have grown out of the work of Potter and Wetherell (1987) and the work of Parker (1989).

²⁰ Positivism has a long and complex history and many contemporary mainstream researchers are unlikely to refer to themselves as positivist researchers.

²¹ An in-depth review of this critique is beyond the scope of this project, but see Steinmetz (2005b) for a philosophical engagement with positivism and alternative epistemologies.

²² Howarth (2000) describes the four theoretical traditions of discourse theory as being Marxism, structuralism, analytic philosophy and psychoanalysis, all being understood within a poststructuralist frame.

²³ Although, as should be clear, the way in which this data will be understood will move beyond subjects' own interpretations.

²⁴ The participating IAPT service provided permission for an anonymised version of the pro forma to be included as part of this research.

²⁵ While competition structures the provision of services, it may not be applied in a straightforward manner. Sanderson, Allen and Osipovic (2016) discuss how the nature of health care activities can lead to quasi market practices rather than full market practices where for instance quality and safety may be prioritised over choice and competition.

²⁶ Sanderson et al. (2016) interestingly point out that the most recent NHS strategy document 'Five Year Forward View' fails to mention competition or the market perhaps indicating a decline in the competition imperative, although they do state that the new regulatory regime cannot be easily reversed.

²⁷ See Godin (2004) for interview based research on risk assessment practice.

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Project contact details for further information:	
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Appendix B

Anonymised practitioner information sheet.

I would like to invite you to take part in some research. Before you decide, I would like to explain why the research is being carried out and what it involves for you. I am available to go through the information sheet with you and answer any questions you have. It should take around 10 minutes to read this sheet. Feel free to speak to others about the research if you want to. Part 1 tells you about the research and what will happen if you take part and part 2 gives more detailed information about the research.

Please ask if there is anything unclear.

Part 1

What is the purpose of the research?

The aim of this research is to look at the way risk assessments are completed within Improving Access to Psychological Therapies (IAPT) services. Risk assessments involve clinicians asking a series of questions to gain an understanding of whether an individual is at risk of suicide, self-harm or neglect, or a risk to or from other people. The focus in this research is on analysing the assessment that takes place, not the individuals involved. It is hoped that this will provide a better understanding of risk assessment practice. This research is being completed as part of a professional doctorate in clinical psychology.

Who is organising and funding the research?

No funding is being provided for the research. The research is being sponsored by the University of Essex. The sponsor is the organisation which takes on ultimate responsibility for the initiation, management of and financing (or arranging the financing) for that research. The sponsor takes primary responsibility for ensuring that the design of the study meets appropriate standards and that arrangements are in place to ensure appropriate conduct and reporting.

Why have I been invited?

You have been invited as you are a practitioner who completes duty screening assessments.

Do I have to take part?

It is up to you to decide if you are willing to take part. I am available to discuss this information sheet with you if you have any questions or concerns. My contact details are provided below. You will be asked to sign a consent form if you do agree to take part. You are free to withdraw at any time and do not have to give a reason. This will not affect your employment in any way.

What will happen to me if I take part?

If you choose to participate, a day would be spent observing your routine clinical practice and asking informal questions about the process. You would be provided with audio recording equipment and asked to record your duty screening assessments with your clients if they consent to this. This would be the only change to routine care provided.

The research will use a qualitative research method called discourse analysis to study the assessments.

Expenses and payments

Unfortunately, I do not have the funds to offer any incentive for participating in this study. If you choose to participate, a copy of the final project can be provided to you along with a summary of the main findings.

What will I have to do?

One day will be spent observing the work you do and asking informal questions about the process of completing duty screening assessments. You will be given audio recording equipment and asked to ask clients who receive duty screening assessments if they are willing to have the assessment recorded for research purposes. If people agree, you would be asked to audio record the assessment and provide a copy of the assessment to the researcher once the service has received a signed consent form for this.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks expected from participating in this study.

What are the possible benefits of taking part?

I cannot promise the research will help you but it may help improve understandings of risk assessment practice.

What happens when the research study stops?

The audio recordings will be offered to the UK Data Archive to store securely for future qualitative research. The UK Data Archive is a centre of expertise for storing, managing and providing research data securely. They are responsible for the largest collection of research data used in the social sciences and humanities in the UK. More information about this is provided in Part 2.

What if there is a problem?

If you have any concerns about the way you have been treated then this will be dealt with accordingly. More information about this is provided in Part 2.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal recommendations and information about you will be handled confidentially. For more details, see part 2.

If you are considering participating following the information in Part 1, please read Part 2 before deciding.

Part 2

What will happen if I don't want to carry on with the study?

If you decide you do not want to carry on with the study before the data has been analysed, the audio recording will be securely destroyed. There will be no negative consequences for doing this and you do not have to give a reason. However, in some circumstances it may not be possible to remove your data from the research. The only circumstances in which this would occur would be following submission of the project, publication of an article or following the UK Data Archive accepting the audio recordings for future research (see below). This means that it may not be possible to remove data after April 2016 when the project will be formally submitted to the clinical psychology department at the University of Essex.

What if there is a problem?

If there are any complaints about the research, the lead researcher should be contacted using the contact information provided below. If you remain unhappy with the outcome of this contact and wish to complain formally, you can do so by contacting... In the event that you are still not happy, you should contact ...

Will my taking part in this study be kept confidential?

Yes your confidentiality will be safeguarded before and after the study. The researcher will only be given access to your contact information to discuss your participation.

The researcher will be given copies of the signed consent forms and the audio recorded assessments. This data will be stored securely and transferred using encrypted, password protected devices. Any identifying information within the audio recordings will be made anonymous.

What will happen to the results of the research study?

The results of the research will be written up in article form and submitted to an academic journal for publication. A copy of this, along with a summary sheet, can be provided to participants. Please let the researcher know if you would like a copy. You will not be identifiable in the article unless you have given consent for your name to be used. The research will also be written up in a longer format as a thesis for the doctorate in clinical psychology programme. A copy of this will be stored in the Albert Sloman Library at the University of Essex.

Following completion of the publication process, the audio recordings will be anonymised and offered to the UK Data Archive to be stored for future qualitative research.

What is an archive?

An archive is a secure place where data is stored indefinitely. Data may include paper records and increasingly electronic records are being stored by many archives. The UK Data Archive contains several thousand data sets.

Why put information in an archive?

Information is put into archives for many reasons. One reason is that it allows researchers to look at different aspects of the data. It allows other researchers to explore the data for many years to come and allows other researchers to check the way the initial research was completed. It can be expensive to complete research and so storing data may save money. Archives are also good places to keep data safe and secure as archivists are experts in protecting data.

How do I know my data will be used ethically?

Archivists will make sure that research participants are protected. They do this by ensuring that informed consent has been obtained to share data, that data has been made anonymous and by protecting access to data.

What does anonymising mean?

Anonymising means the removal of anything that could identify someone in the data. One way of doing this is changing the names of people and places. Personal contact details are never made available.

How might data be used?

Data can be used in many different ways. Other researchers may check the way the research was completed or look at different aspects of the data.

Who owns the data and what is copyright?

You will be asked to sign a copyright statement which means that the researcher will have the legal right to use your contributions on agreed terms. This means the researcher will be able to publish an article on the research which may quote some of your words. A researcher can sign a licence with an archive which allows the archive to distribute the material to other researchers.

How do archives store my data safely?

Data will be stored in conditions that meet national and international security standards. Data has licences and controls to ensure that only authorised users are given access.

Who has reviewed the study?

All research in the NHS is considered by an independent group of people to protect participants. This is called a Research Ethics Committee. This research has been reviewed and agreed by ...

Further information and contact details:

For any further information or questions about the research please contact:

Thank You!

Appendix C

Content of practitioner script.

Please read the following script to your clients when asking them to consider having their duty screening assessment with you audio recorded:

'Our service is currently taking part in a research project looking at these assessments. The research is being undertaken as part of a professional doctorate in clinical psychology. Would you be happy for this assessment to be recorded for research purposes? You do not have to agree and you can withdraw at any stage without any negative consequences. You will be sent full details of the research in the post and a consent form which you would have to return for the recorded assessment to be used in the research.'

Appendix D

Information included on client consent form.

Please initial each statement to indicate you consent with it	Initials
I have read and understood the project information sheet, version number 1.2, dated 09/05/2015	
I have been given the opportunity to ask questions about the project.	
I agree to take part in the project. I agreed for my assessment to be recorded and I agree that this can be used for research purposes.	
I understand that my taking part is voluntary; I can withdraw from the study at any time and I do not have to give any reasons for why I no longer want to take part.	
Use of the information I provide for this project only	
I understand my personal details will not be revealed to people outside the project.	
I understand that my words may be quoted in publications, reports and other research outputs.	
I understand that my real name will not be used in this project.	
Use of the information I provide beyond this project	
I agree for the audio recording of the assessment to be archived at the UK Data Archive.	
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other genuine researchers may use my words in publications, reports and other research outputs, only if they agree to preserve confidentiality as requested in this form.	
So we can use the information you provide legally	
I agree to assign the copyright I hold in any materials related to this project to the University of Essex.	
Name of participant [printed]	Signature Date
Researcher [printed]	Signature Date

Project contact details for further information:	
--------------------------------------------------	--

Appendix E

Anonymised client information sheet.

I would like to invite you to take part in some research. Before you decide, I would like to explain why the research is being carried out and what it involves for you. I am available to go through the information sheet with you and answer any questions you have. It should take around 10 minutes to read this sheet. Feel free to speak to others about the research if you want to. Part 1 tells you about the research and what will happen if you take part and part 2 gives more detailed information about the research.

Please ask if there is anything unclear.

Part 1

What is the purpose of the research?

The aim of this research is to look at the way risk assessments are completed within Improving Access to Psychological Therapies (IAPT) services. Risk assessments involve clinicians asking a series of questions to gain an understanding of whether an individual is at risk of suicide, self-harm or neglect, or a risk to or from other people. The focus in this research is on analysing the assessment that takes place, not the individuals involved. It is hoped that this will provide a better understanding of risk assessment practice. This research is being completed as part of a professional doctorate in clinical psychology.

Who is organising and funding the research?

No funding is being provided for the research. The research is being sponsored by the University of Essex. The sponsor is the organisation which takes on ultimate responsibility for the initiation, management of and financing (or arranging the financing) for that research. The sponsor takes primary responsibility for ensuring that the design of the study meets appropriate standards and that arrangements are in place to ensure appropriate conduct and reporting.

Why have I been invited?

You have been invited as you recently agreed to have an assessment you received from an IAPT service audio recorded.

Do I have to take part?

It is up to you to decide if you are willing to take part. I am available to discuss this information sheet with you if you have any questions or concerns. My contact details are provided below. You will be asked to sign a consent form if you do agree to take part. You are free to withdraw at any time and do not have to give a reason. This will not affect your treatment in any way.

What will happen to me if I take part?

If you choose to participate, your recorded telephone assessment and your signed consent form will be provided to me. The recording of the assessment would be the only change to routine care provided.

The research will use a qualitative research method called discourse analysis to study the assessments.

Expenses and payments

Unfortunately, I do not have the funds to offer any incentive for participating in this study. If you choose to participate, a copy of the final project can be provided to you along with a summary of the main findings.

What will I have to do?

The audio recording of the assessment, which you verbally agreed to, will be given to the principal investigator. You will be asked to complete and return a signed consent form to the IAPT service. The service will then provide the researcher with the audio recording.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks expected from participating in this study.

What are the possible benefits of taking part?

I cannot promise the research will help you but it may help improve understandings of risk assessment practice.

What happens when the research study stops?

The audio recordings will be offered to the UK Data Archive to store securely for future qualitative research. The UK Data Archive is a centre of expertise for storing, managing and providing research data securely. They are responsible for the largest collection of research data used in the social sciences and humanities in the UK. More information about this is provided in Part 2.

What if there is a problem?

If you have any concerns about the way you have been treated then this will be dealt with accordingly. More information about this is provided in Part 2.

Will my taking part in the study be kept confidential?

Yes. I will follow ethical and legal recommendations and information about you will be handled confidentially. For more details, see part 2.

If you are considering participating following the information in Part 1, please read Part 2 before deciding.

Part 2

What will happen if I don't want to carry on with the study?

If you decide you do not want to carry on with the study before the data has been analysed, the audio recording will be securely destroyed. There will be no negative consequences for doing this and you do not have to give a reason. However, in some circumstances it may not be possible to remove your data from the research. The only circumstances in which this would occur would be following submission of the project, publication of an article or following the UK Data Archive accepting the audio recordings for future research (see below). This means that it may not be possible to remove data after April 2016 when the project will be formally submitted to the clinical psychology department at the University of Essex.

What if there is a problem?

If there are any complaints about the research, the lead researcher should be contacted using the contact information provided below. If you remain unhappy with the outcome of this contact and wish to complain formally, you can do so by contacting... In the event that you are still not happy, you should contact...

Will my taking part in this study be kept confidential?

Yes your confidentiality will be safeguarded before and after the study. The service you received an assessment from will retain your contact information in line with their routine clinical practice. The researcher will only be given access to your contact information to discuss your participation. This information will be stored in the service.

The researcher will be given copies of the signed consent forms and the audio recorded assessment. This data will be stored securely and transferred using encrypted, password protected devices. Any identifying information within the audio recordings will be made anonymous.

What will happen to the results of the research study?

The results of the research will be written up in article form and submitted to an academic journal for publication. A copy of this, along with a summary sheet, can be provided to participants. Please let the researcher know if you would like a copy. You will not be identifiable in the article unless you have given consent for your name to be used. The research will also be written up in a longer format as a thesis for the doctorate in clinical psychology programme. A copy of this will be stored in the Albert Sloman Library at the University of Essex.

Following completion of the publication process, the audio recordings will be anonymised and offered to the UK Data Archive to be stored for future qualitative research.

What is an archive?

An archive is a secure place where data is stored indefinitely. Data may include paper records and increasingly electronic records are being stored by many archives. The UK Data Archive contains several thousand data sets.

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Information is put into archives for many reasons. One reason is that it allows researchers to look at different aspects of the data. It allows other researchers to explore the data for many years to come and allows other researchers to check the way the initial research was completed. It can be expensive to complete research and so storing data may save money. Archives are also good places to keep data safe and secure as archivists are experts in protecting data.

How do I know my data will be used ethically?

Archivists will make sure that research participants are protected. They do this by ensuring that informed consent has been obtained to share data, that data has been made anonymous and by protecting access to data.

What does anonymising mean?

Anonymising means the removal of anything that could identify someone in the data. One way of doing this is changing the names of people and places. Personal contact details are never made available.

Who owns the data and what is copyright?

You will be asked to sign a copyright statement which means that the researcher will have the legal right to use your contributions on agreed terms. This means the researcher will be able to publish an article on the research which may quote some of your words. A researcher can sign a licence with an archive which allows the archive to distribute the material to other researchers.

How do archives store my data safely?

Data will be stored in conditions that meet national and international security standards. Data has licences and controls to ensure that only authorised users are given access.

Who has reviewed the study?

All research in the NHS is considered by an independent group of people to protect participants. This is called a Research Ethics Committee. This research has been reviewed and agreed by ...

Further information and contact details:

For any further information or questions about the research please contact:

Thank You!

Appendix G

Anonymised front sheet confirming ethical approval from NHS ethics committee.



Health Research Authority

08 June 2015

Mr Adam Flintoff
School of Health and Human Sciences
University of Essex
Wivenhoe Park, Colchester
CO4 3SQ

Dear Mr Flintoff

Study title: Talking about suicide: An investigation of institutional risk assessments
REC reference:
IRAS project ID:

Thank you for your letter of 19 May 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Anonymised front sheet confirming ethical approval from research and development department of participating NHS trust.

Adam Flintoff
School of Health and Human Sciences
University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

Dear Adam,

Permission for research

I am writing to inform you that permission has been granted on behalf of [REDACTED]
[REDACTED], for the following research project, on the basis described in the application form, protocol and supporting documentation.

Study details:

Study Title	Talking about suicide: investigating institutional risk assessments
Chief Investigator	Adam Flintoff
Sponsor name	University of Essex
[REDACTED]	

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
[REDACTED]	02/09/15	All sites within this organisation subject to local management approval

Front sheet confirming ethical approval from the University of Essex.**University of Essex**

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29 September 2015

Mr Adam Flintoff



Dear Adam,

Re: Ethical Approval Application (Ref. 14045)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the Research Director.

Kind regards,

Lisa McKee
Ethics Administrator
Health and Human Sciences

cc. Academic Supervisors
Research Governance and Planning Manager

