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CONCEPTUALIZING AND MANAGING DYNAMIC RISK

by

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LIST OF ABBREVIATIONS

- DTC: Democratic Therapeutic Community
- crisis team: Crisis Resolution Home Treatment Team
- CBS: Central Booking Service
- NRM: new risk marker
- EIT: Early Intervention Team
- STORM: Skills Training On Risk Management
- AMHP: Approved Mental Health Practitioner

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To my children Gregory and Zosia.

DECLARATION

I hereby declare that this thesis contains my own work. Where I draw on the insights of other author's research, these works have been clearly acknowledged. This thesis has not been submitted for a degree at another university.

*“Have no fear of perfection; you’ll never reach it”.
Maria Skłodowska Curie*

ABSTRACT

Organisational research is dominated by viewing risk as static predictable and calculable probability of harm or hazard that is subject to scientific measurement and analytical reasoning. Risk that can be managed by following recommendations, plans and protocols informed by historical data or scientific analysis. However, this is in stark contrast with the micro perspective of a professional in acute mental health services, where our study is situated. Risk there is ambiguous, unpredictable, ever changing and characterised by immediacy.

In this thesis, we first investigate how do mental health professionals conceptualize risk in such an intense dynamic setting. We develop a generic Dynamic Risk Model that systematizes the sources and characteristics of dynamic risk. The model describes a layering of three dimensions: Emerging Apprehension, relating to what can be understood about the risk; Remaking of Risk, relating to what can be done about the risk with available resources; and Evolving Risk Trajectory, relating to how risk may evolve over time. Developing a concept of risk that accounts for time and change provides a basis for understanding time pressures and urgencies of actors situated in dynamic risk settings.

Subsequently, we ask what do the risk actors do in their day-to-day work to contain dynamic risk in real time. We turn to study the riskwork of the mental health professionals and find out that they structure their riskwork into four interrelated and time sensitive practices: Interpreting and Reinterpreting, aimed at recognising what is the risk, how big is the risk and what causes the risk; Corroborating, aimed at confirming how and when to act in order to manage dynamic risk; Securing Efficacy, aimed at being responsive and remaining responsive to risk; and Counterbalancing, aimed at preventing recurrence of high risk levels.

CHAPTER 1

INTRODUCTION

“Can we know the risks we face, now or in the future? No, we cannot: but yes, we must act as if we do.”

“[...] my own perception of how I view risk, or manage risk, is to be very alert and very aware. Because things could change. You could go from no risk to risk. You could visit somebody today and there's no violence, or whatever. You don't know what you are getting into. So, you've got to be aware [...] So, the way I see risk now is, the perception and the skill of assessment, the foundation is there. But you need to be adding more to it because the risk is different every time [...]. [...] that's what I mean by risk continual assessment, because of the unpredictability of the people we work with.” (AMHP 5)

The first quote is the famous phrase from Douglas and Wildavsky (1983: 1) that marked the beginning of the grand narrative of risk management. Driven by the increase in social expectations about management of dangers, it underpinned the formation and growth of risk governing institutions, regulating standards and providing guidelines in form of previously produced scenarios, plans and protocols (Power, 2007).

The second quote, in stark contrast with the first one, is from a professional at our research site, the Crisis Resolution Home Treatment Team (called the crisis team), where the key elements of risk, such as risk objects, putative harms and causations are emerging over time, ambiguous, and ever-changing. Recognizing and actioning on them requires continual reassessment, consultation and improvisation as circumstances dictate.

In developed countries the management of risk and uncertainty is an increasingly important concern for individuals and institutions (Beck, 1992), who became so preoccupied with it that, as Beck argues, safety and freedom from risk became the new wealth. At the organizational level, the risk guidelines, plans and protocols, that boomed over the last three decades, are being created from existing risk knowledge that is based on the rational analysis of experts, and assumes that risk “can be determined accurately and objectively, through the application of scientific knowledge derived from the past in highly institutionalized ways, such as employment of scientific measurement and analytical reasoning, and the application of specific,

widely-accepted risk analysis and measurement techniques” (Hardy and Maguire, 2016:84, after Knights and Vurdubakis, 2003; Lupton, 2013). In this way, risk is becoming normalized - unpredictable and uncontrollable hazards are supposed to be converted into known and manageable risks.

In contrast to measurable and predictable risks, in our research we acknowledge and examine risk that has a very different character. We term it dynamic risk. As demonstrated by the second opening quote, the risks in our research setting cannot be determined accurately and objectively a priori or on the spot. Dynamic risk is emerging and unstable, is neither static, nor characterised by historical data, and cannot be scrutinised by analytical reasoning. Yet the dangers are immediate and typically dramatic.

Thinking about emergence of risk and understanding it emergently over time, about risk that is erratic, constantly remade by context, rather than static and calculated in advance, is important. It helps understanding the immediacy of risk and its role in justifying actions and making decisions in real time risk management. By looking at risk at a very micro level, we are acknowledging that the individuals are repeatedly facing risk and risk-related decisions in their work place. This is important because we need to understand the nature of human organising in view of dynamic risk, of professional services, and how actors are managing and reshaping risk in their everyday practices.

Our research site, the crisis team, is an outpatient acute mental health service. It deals with clients in mental health crisis, frequently suicidal. Mental health services are an important area for many reasons. According to NHS (NHS England, 2016), mental health problems represent the largest single cause of disability in the UK, and one in four adults experiences at least one diagnosable mental health problem in any given year. The total cost of mental health problems to the economy is estimated at 105 billion GBP a year, equivalent to the cost of running the whole NHS. However, we argue that while the crisis team is a saturated example of a service where dynamic risk is encountered, such risks are in fact abundant. They typically occur at the micro level, when working with and managing individual risk cases, such as clients, patients, or other risk objects, to which scientific scrutiny, such as repetitive testing, cannot be applied.

Consequently, the first research question that we address is the following: How do the professionals conceptualize the dynamic risk they are dealing with in the mental health services? What is the nature of this dynamic risk and how can it be described systematically?

We add to the existing literature by accounting for the rich and multi-layered dynamics of risk that we observe in the crisis team. We develop a Dynamic Risk Model that describes a layering of three dimensions: (1) Emerging Apprehension, relating to the question: what can be understood about the risk?; (2) Remaking of Risk, relating to the question: what can be done about the risk with available resources?; and (3) the Evolving Risk Trajectory, relating to the question: how may the risk evolve over time? These three dimensions constitute a rich generic description of dynamic risk, informing about the structure and sources of the dynamics. They also inform that dynamic risk develops simultaneously on different time scales that refer to the three dimensions. Sensitized to the role of time in this conceptualization, we interpret the dynamic risk encountered in the service as a process that is evolving over time. In analyzing the three components of dynamic risk we view it through the lens of process theory, focusing on events that mark shifts in risk over time (Langley, 1999). We observe the risk actors engaged in their everyday activities and how they identify the points in time when their perception of risk changes.

We believe that developing a model about the dynamic nature of risk complements the static view of risk in the literature and responds to the “great need to better understand the human, social, and organizational issues involved in detecting, managing, and remediating risks, crisis, and emergency events” (Gephart, et. al., 2019: xv).

Having elicited how the risk actors conceptualize dynamic risk, the next step was to understand how they manage it. The dynamic nature of risk, it’s emerging and elusive character, simultaneously introduces ambiguity and urgency. While in the dynamic context risk can be only gradually understood over time, it may materialize immediately. Therefore, decisions and actions cannot wait until “enough clarity” about risk is reached. In the case of the crisis team, for example, any delay in addressing the elusive risks may result in their suicidal patient taking their life. Hence, our second research question was the following: what do the risk actors do in their day-to-day riskwork to contain dynamic risk in real time? In particular, how do the crisis team

professionals justify taking or not taking actions? How do they ensure they are capable of delivering a timely response to risk? Elusive risks may have many interpretations, as we shall see when analysing our data, so how do the risk actors agree on what to do and how do they know they are doing the right thing?

We address our second research question about how the risk actors manage dynamic risk through a practice theory lens (Orlikowski, 2010:37) that “entails a theoretically grounded understanding of the recursive interaction among people, activities, artefacts and contexts, is particularly well positioned to address organisational phenomena that are posited to be relational, dynamic and emergent.” We advance the literature by showing how in the dynamic risk context the actors structure their riskwork into four risk practices for which time is central: (1) Interpreting and Reinterpreting that relates to the question: how can the team members figure out the current status of risk? (2) Corroborating that relates to: how do the risk actors know they are doing the right thing?; (3) Securing Efficacy that relates to: how do the risk actors respond and remain responsive to risk?; and finally (4) Counterbalancing that relates to: how can the risk actors prevent recurrence of high risk levels in the long term? The identified practices enable the riskworkers to (a) recognise the risk as it emerges, (b) deliver a tailored response in a timely fashion, confidently and efficiently, and (c) take measures in anticipation of the future dynamic evolution of the risk and we detail their workings in the analysis and discussion.

The remainder of the dissertation is organised as follows. In the following Chapter 2 we review how the concept of risk has been developed in the literature and pay particular attention to where notions related to dynamic risk have been considered by researchers. We also review the recent research that has looked into the risk practices of actors and their everyday riskwork. In Chapter 3 we outline the methodology and data collection. We present our research setting and discuss its suitability for investigating dynamic risk. In particular, we flesh out the type of risk that is encountered in the service. Next, we present our methodological approach and provide supporting material, such as the thematic tables. Chapter 4 contains analysis that leads to formulating the concept of dynamic risk and lays foundations for the Dynamic Risk Model with its three contributing dimensions. In Chapter 5 we analyse the riskwork of the crisis team, and isolate the four risk practices that they enact to contain dynamic risk in real time. We discuss our findings in Chapter 6. First, we complete the

development of the risk conceptualisation through the Dynamic Risk Model. Then we demonstrate the dynamic character of risk by showing how the three contributing dimensions of the Dynamic Risk Model evolve jointly in time. Next, we turn to risk practices and present a model of riskwork that illustrates the relation between the four interdependent practices and how they jointly lead to managing dynamic risk. We discuss their temporal structuring and synchronisation with risk urgency and intensity. We conclude in Chapter 7, giving an example of where our findings are potentially relevant in other situations where dynamic risk is encountered.

CHAPTER 2

LITERATURE REVIEW

2.1. The concept of risk and how it accounts for dynamic aspects

The concept of risk is closely related to that of uncertainty or danger and encompasses adverse events that may or may not happen. It has evolved and matured in both society and literature growing out of such notions as fate and destiny in pre-modern times (Ewald, 1991; Giddens, 2013). Reviewing the various framings of the risk in the literature, we pay particular attention to how its dynamic aspects have been understood and accounted for.

The first formal definitions of the concept of risk were introduced with probability theory as early as the 17th century (Hacking, 2006). They were based on the understanding that events such as accidents cause objective harm and can be interpreted as an outcome of a trial or an experiment with certain fixed, and hence static, characteristics. This experiment, if repeated, would result in an accident with unknown but fixed probability. Keeping a record of accidents allowed researchers to employ probabilistic and statistical tools and led to the interpretation that such events, and consequently risks, were calculable (Ewald, 1991; Hacking, 2006). This resulted in the rapid development of its quantitative applications in actuarial sciences, finance, game theory and economics, all of which not only assume static, calculable probabilities but also, at least in principle, require certain monetary value assignments to possible scenarios that may happen.

Nowadays, in some areas of science, a dynamic view of calculative risk is dominant over its static counterpart. Maybe most notably in financial engineering, where risks are modelled as rigorously defined mathematical objects evolving over time. These dynamic risk models allow development of methods for risk management that also evolve over time, in line with risk. For example, hedging is a well-established continuous response strategy to dynamic risk in this context (Wilmott et al., 1995). Similarly, dynamic automated risk management systems that monitor, detect, assess, and follow-up with action to reduce risk, have been introduced to engineering e.g. for

protection of computer systems (Bahl, 2011). Moreover, specific dynamic concepts of risk or risk factors have been utilised in the literature addressing most acute risk settings in criminology and psychiatry, and relating to risk of violence (Douglas and Skeem, 2005), to sex offenders (Thornton, 2002; Hanson and Morton-Bourgon, 2005), child sexual abusers (Beech et al., 2002) or man to man violence (Whitehead, 2005).

Sociologists, however, progressed in a different direction and approached the concept of risk from a very different and less restrictive perspective so that it could refer to a much wider range of phenomena and it would also encompass more aspects than just calculable likelihoods of events equated to financial consequences (Zinn, 2008). Risk society, governmentality and the cultural approach, constitute the main fundamentals of the risk theorizing in social sciences. We shall discuss these approaches as they underpin many of the current literatures in management and organization theory.

Cultural risk theory stems from the work of Mary Douglas (Douglas, 1992; Douglas and Wildavsky, 1983) and “directs attention to the ways in which notions of risk are used to establish and maintain conceptual boundaries between self and Other (...) deal with social deviance and achieve social order” (Lupton 1999a:24, 36). Blame is a leitmotif of the cultural approach to risk, and of central interest is the understanding of relations between accountability, responsibility and blame, in particular, the political use of attributing blame for a specific risk that is threatening a given social group. Consequently, the cultural approach aims to understand blame in relation to the boundaries between self and Other: “the use of risk as a concept for blaming and marginalizing the Other, who is positioned as posing a threat (and thus risk) to the integrity of self” (Lupton, 1999a, p. 40). The cultural perspective is rooted deeply in Douglas, 1966, *Purity and danger*, where purity is associated with order and dirt with disorder. Consequently, impurity, anomalies and ambiguities threaten social order and ties that are maintained through purity. “Victim blaming facilitates social control; outsider blaming enhances loyalty” (Douglas, 1986, p. 59), and both strategies are used to protect the integrity of the community. One of the key observations of the cultural risk theory is that the assumption of rationality in individuals, typical for economic approaches to risk, cannot explain differences in interpreting and responding to risk between individuals and between groups. Systematic variations in perceiving, interpreting and dealing with risks result from different cultural preferences and social

formations. According to this perspective, groups share their collective notion of risk, and have their distinct risk cultures in which members “notice, address, and respond to particular phenomena as risks and fail to attend to other potential risks based on cultural logics and beliefs” (Gephart et al., 2009: 144). Consequently, there is no single agreed assessment of risk, which explains differences in individual approaches. In particular, there may be competing views on large-scale and global risks between different social groups. According to the cultural perspective, risk disputes are not rooted in varied or poor risk education and risk communication. The disputes typically result from differences in moral, political or aesthetic assessments of risk, and not from misguided perception. An area of particular research activity in the managerial sciences is that of organizations with cultures where risk is viewed as collective responsibility of all organizational members, such as research on safety cultures that view and acknowledge safety as number one priority (Hofmann and Stetzer, 1998; Cooper, 200; Barton and Sutcliffe, 2009). Hence, the cultural approach focuses on inhomogeneities of risk between groups and individuals in the society and how risk becomes a tool that helps emerge and maintain certain social structures. It also relates to risk concepts underpinned by valuation theories, that we discuss later in this chapter and that are currently at the frontier of research. However, from the temporal perspective, the cultural approach views risk as a static concept and overlooks the role of time.

Governmentality is a concept introduced in the philosophical works of Foucault (e.g. Burchell et al., 1991). Governmentality is not primarily preoccupied with defining and understanding risks. Instead, it elaborates on the new style of governance in modern societies that, rather than being centred and well localised, is formed by “institutions, procedures, analyses and reflections, the calculations and tactics that support a particular rationale of power and apparatuses of security, with populations as their target” (Burchell et al., 1991:102). However, governmentality uncovers how these heterogeneous governmental techniques, gradually formed in a society, employ risk as “one of the strategies of disciplinary power by which populations and individuals are monitored and managed” (Lupton, 1999b). More generally, investigation of risk from the governmentality perspective relates to the question “How do discourses and practices around risk operate in the construction of subjectivity and social life?” (Lupton, 1999b). In this perspective, risk is static, and is

present as a tool for governing and influencing society and is also seen as a threat that should be avoided or minimised by employing governance techniques. Numerous risk related techniques have been developed and became standard in the society. These techniques include collection and usage of financial, actuarial, epidemiological and other risk related data, the establishment of insurance institutions and insurance obligations, administrative and governmental documents, surveillance, screening, reporting, performance measures and benchmarking but also ethical and moral norms, and good practice as understood by certain professions and or occupational groups. These technologies help not only to measure, recognise or mitigate risk, but also to regulate populations towards low-risk behaviour. An often discussed phenomenon, resulting from the treatment of risk within governmentality, is privatisation of risk (Althaus, 2005). It reflects the way in which risk-related responsibility is transferred from societies and their governance towards individuals, who are expected to make continuous effort to meet their moral, and also in many contexts formal, obligation to be risk-averse. A byproduct of privatization of risk is blame and blame culture. It has been investigated in the healthcare context and observed to often have a damaging effect to the core service, resulting in defensive practices (McGivern and Fischer, 2010; McGivern and Fischer, 2012), box ticking (McGivern and Ferlie, 2007) or resulting in conflicts regarding organisational aspects of risk reporting (Waring, 2005; Waring, 2007).

While risk understood through governmentality is static, and it is only the responsibility for risk that is moving down the bureaucratic system, the lens governmentality offers is very powerful and attractive to researchers analyzing aspects of risk from a number of different viewpoints. In the more general context of professions and their autonomy, the governmentality approach is particularly useful for the analysis of various regulatory regimes imposed by the state, professional bodies and the ethics of individuals. In the case of medical professions in healthcare services, these regulatory regimes result from clear but competing aims and logics, and from balances of power. Firstly, they are shaped by the competing goals of minimising health risks and maximising service quality (as measured by various factors other than health risks) under budgetary constraints. As noted in Webb, 1999, and discussed in Flynn, 2002 (p. 170), “the state’s obligation to control total expenditure and health risks, and to secure improvements uniformly across the system has led to increased

attempts to intensify performative control in which service provision and performance are driven by measurable indicators of output”. Hence, in the development of modern clinical practice, the government aims to gradually impose more risk mitigating regulations on health professionals whose system of rules is traditionally based on professional autonomy. This leads to uncovering the second aspect, namely competing logics of bureaucratic and managerial risk control and of professional self-regulation. Professional autonomy can be understood as an “individual professional’s capacity to make decisions based on internalised norms and expert knowledge rather than conforming with instructions or codified rules” (Flynn, 2002, p. 161) and results in demand that their work be evaluated and assessed in the context of risk measures by peers or their profession’s governing bodies rather than other supervisory management. Therefore, rather than introducing bureaucracy in obedience to rules and management directives, clinicians engage in their own surveillance and self-management to accept responsibility for improving quality and accountability for performance including self-discipline, normative commitment, discretion, flexibility and entrepreneurship (Flynn, 2002).

A remarkable study that understands risk through governmentality and that unveils certain dynamic aspects of risk is that of Fischer and Ferlie, (2013). In a Democratic Therapeutic Community (DTC), which is a specialized type of mental healthcare hospital, the authors examine an escalating conflict between two modes of clinical risk management. The first one was ethics-oriented clinical self-regulation that underpinned the type of treatment provided by the unit and staff and residents’ carefully “negotiated order”. The other one was rules-based clinical risk management, the standard risk regime that is in place in most NHS entities, and that has been imposed in the DTC by external NHS officials after an incident. These two regimes resisted hybridization, which led to the erosion of the ethical basis of the self-regulation and the development of intractable conflict. The tensions between these contradicting modes were interwoven into intensifying risks and incidents, and triggered a crisis that led to organizational closure. An additional change in risks that has been observed in the study is that while initially safety risks of staff and patients were the main concern, as the situation deteriorated, other second order risks e.g. reputational, came into focus. In a related study of this DTC, Fischer and McGivern (2016) focus on the emotional dimension of the riskwork and affective tensions that

built up during the operation of the unit, and led to the escalation of risks. The authors also recognize an emergent process of risk identification within micro-level interactions through which individual patients are being actively constructed as being risky or at risk.

Beck's Risk Society (1992) conceptualizes risk as a dynamic phenomenon at the macro scale. It considers risks and hazards that are "a wholesale product of industrialization, and are systematically intensified as it becomes global" (p. 21) and the role they play in the society, in the context of economical, industrial, technological, educational, social, and political changes that have occurred in the last century. Risk Society pioneers the perspective that as societies transform, new global and unknown risks emerge and intensify, and that information and understanding of these new risks unfolds over time and is often inaccurate. Being new and unknown, these risks cannot be recognized and managed based on historical data through recognized procedures and techniques. The focus of this approach is the systematic intensification of the entirety of risks, and of the role that they play in the society which, on the other hand, develops systematic ways of dealing with these hazards, as they emerge, through reflexive modernisation. Reflexivity plays a central role in Beck's risk society (Beck, 1992), and in social theories to understanding risk more generally (Lupton, 1999a). It denotes an active response to risk in contemporary developed societies. "(Reflexivity) involves the weighing up and critical assessment of institutions and claim-makers, including those who speak with expert voices about risk" (Lupton, 1999a, p. 15). Beck proposes that the reflexive modernisation contains two phases. In the first phase, the society transforms from industrial to risk society and risks are produced as a wholesale of modernisation, but are not yet debated or addressed. In the second phase the awareness grows and the society sees itself as a risk society that is capable of self-criticism and self-transformation. Risks become subject of public or personal debates and sources of political conflict. Hence, risk society acknowledges and is concerned with dynamics of the entirety of risks at the macro scale and at societal level. In contrast, our focus is on the micro scale with attention to individual risks and their intrinsic dynamics.

Although the organization literature, that we discuss next, extensively builds on the fundamental findings and interpretations of the social sciences, it often passes over its complex and elaborate risk definitions in favor of a more operational risk

conceptualization suitable for analysis, regulation and policy development. Consequently, this body of literature often describes risk in simple and inclusive terms that easily appeal to common-sense such as the definition adopted in the UK Royal Society Report where risk is defined as “the chance, in quantitative terms, of a defined hazard occurring” (Warner, 1992).

Moreover, also in organization literature the perspective on risk is predominantly static. For example, in risk regulation and governance, the perspective is dominated by a static view of different aspects of risk in complex systems. It focuses on describing and analysing risk regulatory regimes that are “the complex of institutional geography, rules, practice, and animating ideas that are associated with the regulation of a particular risk or hazard” (Hood, et al., 2001:9). Of interest are their components, such as the type of risk, the preferences and attitudes regarding risk, and the interests of involved parties. While the interest may also lie in how the standards and goals are being set, or in regulating how information is being gathered, the risk considered in such cases is static and the focus is on a fixed picture. A well-established dynamic aspect in this field is how the risk regime components relating to risk handling (rather than the risks themselves) may change over time. Such changes may be triggered by technological innovation, by pressures for change from the public, or by tensions between stakeholders. These phenomena have been also studied in the healthcare context. In particular, McGivern and Fischer (2012) explore how the move towards regulatory transparency affects the work and practice of doctors (psychotherapists and counsellors). The study observes that these health professionals perceive regulatory transparency “as an attack based upon exaggerated risks and misunderstanding of their complex practices” (McGivern and Fischer, 2012:295) and consequently, the doctors focus on their own liability risks, and on producing evidence of good practice more than on treatment itself. Barrett, Oborn, and Orlikowski (2016) on the other hand, study online healthcare platforms and the values they create for the public. Their findings may be interpreted as consequences of the changing risk regime, in which technology has influenced information gathering and communication and enabled patients to become risk actors who are able and willing to make risk-related decisions together with doctors.

As discussed in the beginning of the chapter, the prevailing social research is informed by the static model of risk, however there is an emerging cluster of literature

that accounts for its dynamic aspects and some scholars in organisation theory build on this perspective. As Lupton argues (Lupton 2006:15), “risk can never be separated from the social and cultural lens through which we view it and understand it”, and hence classifying a phenomenon as a risk is a result of certain value judgements and a certain decision-making process. Consequently, risks can be regarded as dynamic and changing in time and space because these value judgements change, or in the public’s consciousness are replaced by others. In a similar spirit, Hilgartner (1992:40), formalized the risk conceptualizations further and observed that “definitions of particular risks include at least three conceptual elements: an *object* deemed to ‘pose’ the risk, a putative *harm* and a *linkage* alleging some form of causation between the object and the harm” (emphasis in original). This observation provides a framework to understand risk as a social phenomenon, and shifts the attention from trying to define what risk is towards trying to establish what makes people understand something as a risk. Building on Hilgartner (1992), Boholm and Corvellec (2011) examine how risks emerge and propose a relational theory of risk where “risk emerges from situated cognition that establishes a relationship of risk between a risk object and an object at risk so that the risk object is considered (...) to threaten the valued object at risk” (Boholm and Corvellec, 2011:175). The completion of Hilgartner’s framework through the valuation aspect brings it close to the dynamic characterisation offered by Lupton and opens up the possibility of considering the valuation process in time as a dynamic phenomenon. Valuations need to be established and are also subject to change. Indeed, in their subsequent research (Boholm and Corvellec, 2016) the authors put their relational theory of risk to work and focus on risk identification as the organizational practice of valuation. In a railway planning context, they observe riskwork undertaken by the actors and conclude that it is a blend between following formal risk identification protocols and other anecdotal, or socially situated types of knowledge and it “relies on expertise, expectations, and social roles embedded in particular organizing settings” (Boholm and Corvellec, 2016:112). It is worth stressing that the risk identification through valuation takes place in the planning phase, prior to the time when risks could materialize, and hence the role of time in the study is in viewing the valuation process, rather than in recognising time pressures of risk urgency or the evolution of the underlying risk itself. Focusing on the construction of risk through the valuation process implies that the risk dynamics present in the study is

solely a result of the actors enacting their valuation practices, rather than an exogenous phenomenon that is imposed on the actors and that they need to face and deal with.

Valuation of the object at risk and the process of its identification is not the only dynamic aspect that may evolve in time. Establishing whether the risk object is indeed likely to harm the valued object at risk, that is establishing the linkage in the Hilgartners' definition, may be difficult and the resulting perception regarding this may be unstable. Changes of risk perception have been recently studied by Maguire and Hardy (2013) and Maguire and Hardy (2016). They investigate the riskwork carried out by the Canadian government in regulating the usage of possibly toxic chemicals and identify that objects become risky or safe as a result of actors enacting practices of social ordering that can be classified as "normalizing" and "problematizing". An object becomes risky through "problematizing" practices that emphasize "the reflexive acknowledgement of potential inadequacies in knowledge, discontinuity in organisational practices, and the use of open-ended deliberations as basis for action" (Maguire and Hardy, 2013:240). The chemicals studied by Maguire and Hardy (2013) are in the continuous process of becoming (risky or safe), as an effect of the organisational practices that they identify and in view of new information or reinterpretation of old information. The authors also distinguish the riskwork concerning established chemical risks, where "the hazard is familiar and its casual connection to some entity is generally recognised to exist" from emerging chemical risks that are "emerging or novel risks that arise when unfamiliar hazards (...) are not widely recognized or accepted, and which are only in the early days of becoming casually linked - often tenuously - to particular practices or products", and observe that emerging risks involve considerably more scope for struggles over scientific methods and epistemology than established ones (Maguire and Hardy, 2016:133, 136). These studies uncover change and dynamics that may take place when establishing the linkage between risk objects and objects at risk; however, the actual underlying risk of the chemical is stable, and it is the perception that changes over time. The actors act in the context of risks that are subject to scientific measurements and can be investigated through well-established scientific methods. Therefore, the risks posed by chemicals are thought to be subject to scientific scrutiny, and are implicitly measurable and calculable in repeated experiments. Consequently, normalizing and problematizing structure the discursive work of actors, that is, producing, distributing

and consuming texts that are or relate to normal science, on which risk assessment and management is based in their research setting. Normalizing practices invoke “certainties that are known and accepted, include scientific findings, precedents and routines” while problematizing practices relate to questioning these scientific findings, procedures and routines, and invoke “uncertainties and the need to manage risks in precautionary manner” (Maguire and Hardy, 2013:249). The actors have a conclusive assessment in view that needs to be accomplished over a considerable period of time, within a deadline seven years. By this deadline they are to resolve the problem, that is, declare a specific chemical to be safe or dangerous, and only following that, appropriate action will be taken. Hence, the dynamics of risk results from actions of the actors and their evaluations of scientific evidence and not from pressures of risks actually changing during the process, or potentially realizing in real time or from external circumstances changing.

Putting aside the theoretical underpinnings of risk for a moment, a lot of attention to risk is inspired by headlines and anxieties that risks tend to prompt in individuals and groups (Slovic, 2016). This relates to the well-studied observation that both individually and at the level of groups or the whole society, some risks or dangers tend to be magnified while others ignored (Slovic, 2016; Dake, 1992; Tansey and O’Riordan, 1999). Disasters and accidents always draw the attention of the media, the public, and also of researchers. Turner (1976), Turner and Pidgeon (1997), followed by Perrow (1984) analysed a variety of disasters and accidents and recognised the role of management practices in organisations as sources of risk. They discovered that the origins of disaster could be typically tracked down to “climates of tolerance for routine operational errors, to failures in legal compliance, and to weak monitoring and control practices” (Power, 2016:1) rather than intentional wrong-doings or blatant rule violations. As a result of these findings, Perrow (1984) introduced the concept of “normal accidents” which since has been extensively studied and refined in a large body of research. However, researchers have realised that a post hoc analysis of disasters, of what went wrong and if it could have been prevented, is not necessarily enough to provide insights into the nature of everyday risk processing activity in a wide range of organisational domains. As noted by Power (2016:2) “the normal, non-post disaster, work of organizational actors has received much less attention”. Consequently, researchers concluded that little was known about what risk actors

actually do, what is their situated effort through which governance practices and risk management come to be constructed, and turned to explain these questions – coining a new term “riskwork”. As Power (2016:8) puts it “the idea of riskwork makes no presumptions of coherent practice and directs attention to the actions and routines through which organizational actors make sense of risk, of themselves and their roles, and collectively try to enact institutional scripts”. The increasing interest in riskwork occurred within a more general “turn to work” trend in organisational sciences that shifts the research focus from outcomes of action to the action itself and to the actors involved (Phillips and Lawrence, 2012), and is often referred to as the “bottom-up” approach. It sheds light onto how actors make sense of risk in complex environments. Notice that the discussed works of Boholm and Corvellec (2016) on risk identification as practice of valuation and also Maguire and Hardy (2013) and Maguire and Hardy (2016) on changes of risk perception regarding chemicals, are indeed studies of riskwork in their specific settings. In both cases the actors identify and make sense of the risks through their practices that exhibit dynamic aspects. Furthermore, compared to analysing written risk policies, or regulated risk regimes that are already in place, studying work practices, what the risk actors do in their day-to-day work, provides a more accurate account of socially legitimate activities, namely what the situated riskwork actually looks like and how actors make decisions in their day-to-day risk encounters. It is particularly important to emphasize how risk dynamics is implied from the riskwork presented in these literatures. Thus, when the actors are performing their practice of valuation (Boholm and Corvellec, 2016), the valued object at risk from the risk definition of Boholm and Corvellec (2011) (following Hilgartner, 1992) is subject to change as a result of their riskwork. When the actors are performing their practice of establishing the existence of harm caused by the risk object to the valued object at risk (Maguire and Hardy, 2013; Maguire and Hardy, 2016), the existence of threat is subject to change as a result of their riskwork. Therefore, in both cases the risk dynamics is a result of the day-to-day riskwork of the actors. It is crucial to contrast it with the opposite setting that we shall consider, namely where the risk dynamics are external to the risk actors and imposed on them, therefore shaping their daily riskwork.

Another perspective on risk organising is offered by Hardy and Maguire (2016). They view organising risk from the perspective of discourse and observe that

the existing risk literature has developed in separate streams, where risk is organised in three modes: prospectively, in real time, and retrospectively. The prospective organizing of risk aims at avoiding or minimizing future harms, hazards and dangers through effective risk management that is based on prior formal assessment techniques. It is based on the assumption that risk is an objective phenomenon that can be identified, described in quantitative terms, and then mitigated to tolerable levels so that it becomes accepted and taken for granted (Maguire and Hardy, 2013). Organizing risk in real time aims to control risk incidents and contain their consequences, when they begin to materialise, often unexpectedly and unpredictably. It does so through implementation of predetermined plans and protocols. Finally, risk is organised retrospectively after risks have (or almost have) materialized in a single or multiple incident. Various forms of post hoc analysis, such as (public) inquiries, reviews and opinions of experts are being used aiming to improve how risk will be organised in future. Due to the dominant discourse of risk, in all the three modes “risk is widely understood to be the probability of an adverse effect or negative event of some magnitude – a harm, hazard, or danger of some kind – that can be managed if the likelihood of its occurrence and nature of its effects can be accurately assessed” (Hardy and Maguire, 2016:83 after Danley, 2005). Consequently, they notice that risk assessment is based on evidence and facts “through the application of widely recognised and institutionalized procedures and techniques” (Hardy and Maguire, 2016:84). The risk literature tends to focus on a single mode of risk organising “even though situations commonly arise that require organisations to engage with multiple modes” (Hardy et al., 2020:1034). To address this issue, Hardy et al. (2020) propose an integrated approach that yields insight into how organisations engage with multiple modes, often with a cycle of organising risk in all the three modes, and how they transition between them. An important insight that they offer, and that is relevant to our research context of the Crisis Resolution Home Treatment Team, is that the different modes are not necessarily clearly demarcated. Hardy et al. (2020) illustrate how organizations are often organizing proxy risks in real time as a way of organizing high stakes, consequential, risks prospectively.

Most relevant to the notion of dynamic risk is organizing risk in real time, which is focusing on what is happening at the present and where typically, risk is assessed and managed in time and space proximity to where it is materializing. At

present in the literature, risk is organized in real time by the means of a ‘control and contain’ strategy with “clearly defined rules, detailed and well documented operating procedures, and a clear-cut chain-of-command authority” (Hardy and Maguire, 2016:88, after Hood, 2005) resulting from the dominant discourse of risk. It aims to avoid or reduce the extent of negative effects through the “implementation of expert risk knowledge derived from empirical information about the past, which has been abstracted into (...) plans, scripts, and protocols” (Hardy and Maguire, 2016:94). These scholars further argue that such plans or strategies may perform well if risks materialize in line with predicted scenarios, however, they “are less effective when risks deviate from expectations and when organizations face unknown or unexpected situations where risks may not be self-evident” (Hardy and Maguire, 2016:89). Indeed, Horlick-Jones (2005:293) observes a slippage between formal and informal risk practices. He argues that actors often exercise a “wide variety of situationally-specific risk-related practices”. The findings of Horlick-Jones support the view that pre-existing scripts and protocols often cannot be applied coherently when risk is already materializing. Hardy and Maguire (2016) provide more examples. They elaborate and draw on the disasters and crisis management literature (such as Sauer, 2003; Ash and Smallman, 2008; Maitlis and Sonenshein, 2010) to conclude that a general set of practices and procedures cannot be adequately formulated without understanding conditions in local environments, and “will require contextualizing, customizing and adapting” (Hardy and Maguire, 2016:90), as the involved actors must filter the right signals from rich stimuli, adapt as circumstances dictate and improvise to deal with situations not covered in existing guidelines. In the study of emergency and disaster it is well established that individuals may diverge from predetermined guidelines, plans and protocols (Macrae, 2014; Weick, 2010; Whiteman and Cooper, 2011).

As discussed by Hardy, et al., 2020, real time risk organizing encompasses more diverse settings that go beyond high-profile risk incidents. Risks are also being organised in real time when it is recognised in the prospective mode that it is impractical, impossible, or too costly to aim to eliminate risk completely. It may also be that risk is associated with a worthwhile return. Hence, certain level of risk may be accepted a priori. It is precisely this reasoning that incentivizes taking the risks associated with provision of acute inpatient mental health services at the research site where we collected our data. As discussed in detail in the next chapter, compared to

hospital treatments, the service of the Crisis Resolution Home Treatment Team is less disruptive for the clients, results in better social reintegration, and is characterised by superior long term effects. To maintain such prospectively accepted risks within prescribed standards, real time organising involves monitoring risk levels through formal, and typically quantitative, risk assessment frameworks, reporting and controlling. Many of these tools are highly mathematized, such as limits on ‘value at risk’ for an investment portfolio (Pearson, 2011). Importantly however, Hardy, et al. (2020) notice that risk can be also organized in real time through informal practices and that little is known about risk organization in such settings when these practices are emergent rather than planned.

These broad literatures that address organizing risk in real time, recognise that many of the risks, that are being managed as they realize, may unfold in unexpected ways, different from predicted scenarios and the actors need to adapt to the encountered dynamics; however, a more detailed characteristics of what constitutes the risk dynamics has not been developed.

To summarize, in the sociological and organisational literature at the micro scale, there are two established ways of conceptualising risk dynamics. They both rely on the approach where risk is defined by identifying a risk object that is considered to threaten a valued object at risk (Boholm and Corvellec, 2011). The first way is through valuations that need to be established and are subject to change. The second way is through evolving assessment whether the link (that is the threat) between the risk object and the valued object at risk exists or not (or equivalently, whether something is a risk object or not). In both these theoretical conceptualisations the risk dynamics results from the actions of risk actors. However, we still have little understanding of how risk actors conceptualize dynamic risk with evolution that does not result from their actions. Dynamic risk that is emerging may result in unpredictable risk realizations, that may not follow predefined scenarios for reasons external to the actors. Such risk results in time sensitivity and urgency that is imposed on the risk actors in specific riskwork contexts.

With its many definitions and perspectives, risk is a broad concept, and the contributions in recent volume by Gephart et al. (2019) integrate risk, crisis and emergency management, the three related areas of research and practice that are often treated in isolation. The volume illustrates the many perspectives on risk and related

concepts that can be assumed by scholars and professionals. In this spirit, Latuszynska et al. (2019) present a framework to explain how different stakeholders, such as patients, physicians, healthcare managers and government, understand, identify and manage risks in healthcare contexts in different ways, owing to their different views on value.

Among the many perspectives on risk and on the ways to investigate it, the turn to work (Phillips and Lawrence, 2012) in the context of risk management results in a growing body of research that focuses on the day-to-day riskwork of risk actors. We shall review the literature taking this approach a little further. This direction of research is, among other motivations, rooted in the observation that organizing risk retrospectively, in particular, investigations of incidents and near misses initiated through public inquiries and internal reviews, fails to improve efficiency and practices of risk mitigation and preventing accidents (Boin, 2008; Dechy et al., 2012; Hayes and Maslen, 2019). The inquiries describe what happened and result in “know-what” knowledge which is very different to the “know-how” knowledge of those who were acting at the time (Dekker, 2002). Indeed, as Hardy et al., 2020:1040, notice “when carrying out their work in situated contexts, actors have only partial views of risk and know only of conditions as they unfold around them. By contrast, for investigators reviewing an incident, the outcome is known and the sequence of events leading to it is reconstructed with the outcome in mind.” Hence, turn to work focuses on what the actors actually do, as perceived from their immersed contextualized perspective. It directs its attention at risk-related everyday practices that enable normal functioning of organisations. The literature identified different types of riskwork that were broadly classified into 'frameworks and designs', 'negotiating risk objects and values' and 'conflict, emotion and practice' (Power, 2016). Focusing on the riskwork perspective, researchers revisit and obtain new insights into many of the familiar and highly institutionalised tools and notions related to risk. For example, Jorgensen and Jordan (2016), study the day-to-day work of developing, revising and drawing upon risk maps as well as the issues that the actors encounter when using them. In a research context somewhat related to ours, Labelle and Rouleau (2016) study how the work of managing safety risks is accomplished through risk practices of multiple actors in the organisational daily life of a mental health hospital. The authors seek to understand how riskwork both contributes to and aims to resolve tensions between patient

autonomy and safety. They identify and describe four forms of riskwork, namely techno-scientific, regulative-normative, political, and interpretative. When reviewing the literature, they argue that “(interpretive riskwork) seems to be the most neglected one in the literature to date” (Labelle and Rouleau, 2016:226). This is despite the fact that actors performing interpretative riskwork aim to establish interpretations, perceptions and values that build around patient safety culture (Bagin, 2005), and go beyond it, by finding ways to humanize it by respecting the rights and choices of individual patients. In particular, they conclude that in the context of interpretative riskwork, the regulative-normative approach that “aims to transform tacit ways to manage safety risks into an explicit and repetitive form of best practice (...) cannot altogether override improvisation and situated judgement” (Labelle and Rouleau, 2016:226, 227). This observation resonates with similar conclusions drawn from investigating high reliability organisations (Perin, 2005; Sauer, 2003) where it has been noted that “improvising practices emphasize emergent, exceptional action during incidents (...) [by] frontline workers who are often better placed to recognize unanticipated trajectories than their superiors located further afield” (Hardy, et al., 2020). Another view offered by Labelle and Rouleau (2016) is that interpretative riskwork is symbolic and results in casting issues in a particular light that enables or suggests possible response. In this sense it can be understood as a practice of valuation where often competing sets of values are considered every time risks are discussed or acted upon. However, none of these works, recognising riskwork from many different perspectives, considered the role of time and viewed riskwork in the context of dynamic risk, where urgency and the temporal aspects are pivotal to situated, lived in understanding of risk context. Hence, the existing literatures have not accounted for how individuals interpret unfolding risks with only partial and fragmented information in view of their immediacy, necessity of taking action, the possibility that they evolve and change, and the possibility of being remade by external circumstances.

In this work we aim to close this gap and propose a systematically-developed model of dynamic risk that identifies and explains different sources of risk dynamics that are external to the actors and exist independently of what the actors choose to do. This makes it possible to understand time and urgency that is imposed onto the risk actors and comes from the dynamics of risk. Within this model, we study situated risk practices and show how in the dynamic risk context the riskworkers structure their

riskwork into a range of practices for which time is central. To this end, we observe risk and riskwork through the lens of practice, process and temporality, as explained below.

Dynamics is inherently interconnected with the notion of time, and riskwork necessarily happens over time as a routine day-to-day activity. However, as remarked by Power (2016:20) in the current riskwork research “temporality (Langley et al., 2013) of riskwork processes is at best implicit”. As observed in Sandberg and Tsoukas (2011) (c.f. also Langley et al., 2013:4), not accounting for time in theoretical considerations, implies that the “temporal structure of social practices and the uncertainty and urgencies that are inherently involved in them are passed over” and consequently “the practices that make knowledge actionable – what to do, at what point of time, in what context – are not included in the timeless propositional statements”. Dealing with dynamic risk is precisely about adjusting the actions to circumstance and doing the right thing at the right time. More generally, conceptualizing risks as dynamic phenomena requires not only understanding how they appear, develop, realize and dissolve, but also what is the source of their dynamics and change. As Langley et al., (2013:1) put it “process studies address questions about how and why things emerge, develop, grow, or terminate over time”. In fact, we shall aim at viewing the dynamic risk itself as a process, because “Process is fundamental: The river is not an object, but an ever changing flow; the sun is not a thing, but a flaming fire. Everything in nature is a matter of process, of activity, of change” (Rescher, 1996:10). Hence, the process studies literature will be a fundamental tool in developing the concept of dynamic risk.

Adopting the conceptualisation of dynamic risk as a process that evolves over time and exhibits certain characteristics (defined and described precisely in the analysis chapter), is a key step in an attempt to understand the situated riskwork. As Power (2007:25) notices “Risk management is always a practice under some description or other, a description that embodies ideas about purpose and which embeds practices in larger systems of value and belief”. Therefore, risk practices of individual actors are framed by their belief about and conceptualisation of the dynamic risk they face. Having a more accurate concept of dynamic risk at our disposal allows a better understanding of riskwork that turns out to be a timely and purposeful reaction to developing dynamic risk characteristics. In order to account for time accurately and

robustly in our understanding of dynamic risk and riskwork, we employ the concept of temporal structuring (Orlikowski and Yates, 2002). Temporal structuring is a way of understanding and studying time as an enacted phenomenon within organizations. It suggests that through their everyday action, actors produce and reproduce a variety of temporal structures which in turn shape the temporal rhythm and form of their ongoing practices. Hence, temporal structuring looks at time through the lens of the practice perspective: time is experienced in organizational life through a process of temporal structuring that characterizes people's everyday engagement in the world. In doing so, people establish and reinforce (implicitly or explicitly) those temporal structures as legitimate and useful organizing structures for their community. We employ temporal structuring to facilitate the understanding of what to do, at what point in time, and in what context, in particular to gain insights into how risk dynamics triggers riskwork and how riskwork affects risk dynamics.

2.2. Are risks real or constructed?

The concepts of risk are diverse and constantly evolving in the numerous and rich strands of research discussed in the preceding section. Consequently, the epistemological underpinnings of these views on risk are also varied.

In the literatures that conceptualise risk assuming the realist approach, the real pre-existing risk is there and is being discovered by risk actors. In the realist approach risks are objective features of reality (Jasanoff, 1998; Zinn, 2008) subject to analysis, scientific scrutiny, measurement and analytical reasoning, and hence they can be managed in formal institutionalized ways. Quantitative risk literatures in finance, insurance, economics or management, all take the realist approach, and so does the broader scientific discipline of risk analysis as a community of practice (Whittaker, 2015) with its professional associations, organisations and bodies that recognise this formalized and systematized approach to risk assessment, management and communication (Fjeld et al., 2007). Nevertheless, even in the realist approach, the “very definition (of risk) is subject to debates” (Borraz et al., 2007:989) and stakeholders may present conflicting views about what is at risk and why (Huault and Rainelli-Weiss, 2011; Latuszynska et al., 2019), while ambiguous data may lead to

divergent interpretations and disagreements among experts (Van Asselt and Vos, 2008).

Concepts of risk informed by theories of sociology focus on how risk and meanings in relation to risks are being constructed. In particular, the cultural perspective, risk society and governmentality, the three fundamental approaches to risk theorizing, range from weak to strong constructionist in their epistemological approaches (c.f. e.g. Lupton, 1999a). The weak constructionist perspective assumes that risk is an objective danger, threat or hazard which however, cannot be measured objectively because it is necessarily influenced by social and cultural processes and cannot be observed in isolation from these processes. The cultural/symbolic perspective and risk society are leading theories that take the weak constructionist approach. In the strong constructionist position objective risks do not exist. What is seen as risk, danger, hazard or threat is perceived as such because of the way it is interpreted in the historical, social or political context. Governmentality is one of the leading examples of a theory taking this perspective.

It is precisely the construction of risk that is addressed by Hilgartner (1992) in their model of a risk object, a putative harm, and a linkage alleging causation between the object and the harm, and in the research strand that builds on Hilgartner's model, in particular the valuation extension of Boholm and Corvellec (2011, 2016), as discussed earlier. Construction of risks and related meanings often arises through a clearly structured organizing process, as demonstrated by Maguire and Hardy (2013). Such a process may not always be facilitated and consequently the constructionist perspective acknowledges that "not everything that could be seen as risk becomes recognized and represented as one" (Hardy et al., 2020:1037). An important question arising in the constructionist perspective is that of the role of scientific analysis and quantitative techniques. Leading researchers agree that they remain highly important, however their role is reinterpreted: rather than revealing risks, "these techniques constitute the rhetorical means by which risk objects are constructed" (Hardy and Maguire, 2020:5) and that their status of validity produces "'truth' on risk that are then the basis for action" (Lupton, 2013:113).

CHAPTER 3

METHODOLOGY AND DATA COLLECTION

In this chapter we present the research setting of an acute mental health service, and the nature of work that the mental health professionals are carrying out with their clients in the service. We also explain the types and character of risk encountered in the service and the context in which risk is being investigated so that the reader can then better follow the findings in the subsequent chapter. Secondly, we discuss data collection and the process of data analysis. Thirdly, we present the coding structure for dynamic risk and for practices used in managing the dynamic risk. We finish, by explaining the theoretical approach used in our research.

3.1. Research setting

The research has been developed within a broader umbrella of CLAHRC (Collaboration for Leadership in Applied Health Research and Care West Midlands) funded by the NIHR (National Institute of Health Research) and matched funds provided by local health and social services.

The main case setting is an outpatient Crisis Resolution Home Treatment Team (called crisis team) managing significant mental health challenges faced by individuals residing within a particular geographic location. To standardize the terms patient and client used interchangeably by the crisis team professionals, throughout this document we refer to the individuals using the crisis team service as clients. The crisis team is an emergency response outpatient team that provides an around the clock support to people during a mental health crisis who would otherwise be admitted to an acute hospital bed (Johnson, 2013). Crisis team treatment is considered a preferable alternative to hospital treatment in acute crisis episodes as it allows the clients to remain with family, in their social environment, and consequently results in better long

term treatment effects, more successful social reintegration and is also more cost effective (Johnson, 2013). It is composed of doctors (psychiatrists), nurses, Approved Mental Health Professionals (AMHP), social workers, assistant practitioners, support workers as well as an administrative team who schedule staff hours on a 24 hour basis, and who distribute the workload of incoming crisis referrals. The city has 4 similarly organized outpatient crisis teams, which loosely organize around the geographic span of the midsized city and its surrounding towns and villages. Their role is to “(...) act as a round the clock community based rapid assessment and short-term treatment team for those people presenting with crisis as part of a mental illness, where there was an identified need for urgent intervention by mental health professionals. The aim is to treat clients in the least restrictive environment with the minimum disruption to their lives” (Barnes, 2014:1).

The crisis teams work closely with other entities, such as the Early Intervention Team for those individuals that are experiencing a first episode of psychosis (EIT), the Community Team that provides a community age-independent service for individuals who are classified as non psychotic, including depressed mood, anxiety, obsessive compulsive disorder (OCD), or other disorders not including psychosis (IPU cluster 3-8), and another Community Team which provides a community age-independent service for individuals that are grouped in the IPU cluster 10-17 - psychotic, which includes first episode of psychosis or individuals that have a history of psychotic symptoms ranging from low to severe problems, psychosis, affective disorders and psychotic crisis. The crisis team is also working closely with the inpatient psychiatric team at the local nearby hospital, as well as with a ‘place of safety’ where individuals detained under Section 135/136¹ of the Mental Health Act² remain until professionally assessed.

¹ Section 135 and 136 allows the police to enter a client’s home and take him to (or keep at) a place of safety so that a mental health assessment can be done. In Section 135 the police must have a warrant from the magistrate’s court allowing them to enter the clients home (in Section 136 the police don’t need the warrant). (Charity Mind report, 2017)

² Mental Health Act (1983) is an Act of the Parliament of the United Kingdom which applies to people in England and Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes, informally known as "sectioning". Its use is reviewed and regulated by the Care Quality Commission. The Act has been significantly amended by

The crisis team has handover meetings between professionals twice a day as shifts change. In addition, there are several weekly case review meetings with representatives of all professional groups in the service. In these meetings different types of clients, including those highly risky are summarized and discussed.

Managing clients with significant risks is the core focus of the crisis team. Clients referred to this crisis team face complex and serious risks, which are subject to abrupt changes. Whilst some clients are well known to the service, having used it in the past, others are new referrals with no or little information about what to expect in their case. The key risks are the dangers of suicide, self-harming, or harming others. Clients may also be vulnerable to others, or may create new risks of varied nature for their dependents (such as cutting themselves in-front of young children). Intervening in clients' circumstances may create new risks, such as social service interventions, stigma, loss of autonomy in fragile circumstances, as well as overload on the service already operating at full capacity; thus, balancing assessment of clients' condition and risk is complex and decisions on treatment strategy entail balancing different types of risks. Hence, professionals working in the crisis team work in a dynamic environment charged with numerous and varied risks. The crisis team members include doctors, nurses, social workers, assistant practitioners, support workers and service management, who are seasoned mental health workers themselves, and represent different perspectives on client risk dynamics resulting from their differing backgrounds and roles in managing the client and their associated risks.

One of the key decisions that the team may need to make is to section a client. Clients are sectioned when it is deemed that they should go into care, such as a hospital or 'place of safety', but the client is unwilling. In order to coerce the client into institutional custody, they need to be deemed 'unfit to make decisions for themselves' as outlined in the Mental Health Act that regulates the process of sectioning the client. Specially trained social workers in the team, called AMHPs (Approved Mental Health Professionals) trained to implement the Mental Health Act, have formal decision making power regarding grounds to section a client. AMHPs hold responsibility for

the Mental Health Act 2007 and the Mental Health Units (Use of Force) Act 2018 (Wikipedia, https://en.wikipedia.org/wiki/Mental_Health_Act_1983).

organising, coordinating and contributing to this decision. This is a pivotal role in the team, always initiated by an AMHP and undertaken after consultation with two doctors.

Working with mental health clients experiencing a crisis is demanding and the crisis team is under constant pressure. High levels of burnout and emotional exhaustion of the staff in such and similarly organized services, compared to hospital based inpatient and outpatient services, is well documented (Prosser et al, 1996). The professionals need to balance the teams' workload, support each other and ensure service continuity and efficiency. When it is deemed appropriate, risks may also be transferred to other publicly funded services, including hospitals, different mental health services, or GPs (general practitioner, who in the UK context is a gatekeeper to all other medical referrals). In situations of direct danger, the crisis team will rely on blue light emergency services, typically ambulance and police.

The researcher, being supported by CLAHRC, and building on its extensive network of collaboration, also obtained access to three other NHS services (no 2, 3 and 4). The first one of these services (no 2), was a Police Street Triage (PST) team. The PST team attends to incidents where it is believed that an individual involved is experiencing mental health difficulties, is vulnerable or suicidal. The aim of the service is to support the police who are not trained in dealing with mental health issues and in particular to reduce the number of people unnecessarily detained under section 136 of Mental Health Act (mentally disordered in a public place). It consists of two policemen, one paramedic and one Community Psychiatric Nurse (CPN). The researcher conducted 20 hours of observations of the PST team responding to intervention requests and held informal conversations at the service. Similarly, to the crisis team, the PST team deals with risks of acute mental health services and these observations have been used to support data collected at the main research site.

Of the remaining two services (no 3 and 4) where the researcher obtained access, one has been scoped through nonparticipant observations of 12 formal meetings, 1 workshop and 5 informal meetings, about 20 hours in total, however this data has not been used in the present study. In service no 4 no data has been collected. However, both service no 3 and no 4 have been recognized as attractive sites for future studies.

3.2. Risks in mental health acute services

In management sciences risk is commonly understood to be the probability of an adverse event of some magnitude – a danger of some kind that can be managed if the chances of it occurring and the magnitude of its effects, if it does occur, can be accurately assessed (Danley, 2005). The health care policy documents typically adopt a similarly inclusive definition that risk is composed of two elements: (i) an event with potentially harmful outcomes for self and others and (ii) the likelihood of this event. In the mental health context (see Morgan 2007; Northamptonshire Healthcare NHS Foundation Trust, 2018) risk is further classified into frequent risk categories that include: suicide, neglect, aggression and violence, risks for healthcare service providers and carers, physical medical risks, social risks, substance misuse risks, risks of being abused, harassed or exploited by others. These categories are interwoven and only indicate the most common occurrences, rather than exhausting all possibilities. The mental health professionals from the crisis team explain what the risks are:

“There's risk of, a lot of patients [clients] see risk as suicidality or self-harm, also risk of aggression, risk to family members, risk to children, risk to the general public so that's the sort of risk we're looking at. Obviously risk to self and others by suicidal thoughts or self-harming, aggression, sometimes people will come to us through the police that are in cells and we do follow up there, so that's what we're looking at really”. (AMHP 3)

“The common risks are serious mental health deterioration, suicide, significant self-harm, self-neglect, neglect by others, harm to other, which would come under safeguarding too. That could involve children or other individuals. They could be at risk of harm from other individuals. So, I suppose it's on a whole lot of different levels really. Risks of non-engagement with the community team, and what that might mean in the long term. So, there's a whole lot of risks that you have to work through quite systematically. Because each area has got its own level of I suppose expertise (...) risk to yourself. Because I was racially assaulted and had criminal damage done to my car from a patient [client] (...) harm to other (...)”. (social worker 1)

The following vignettes further illustrate that the individual cases are typically very complex with overlapping interdependent risks, and not necessarily falling into one of the main categories. They also demonstrate the range of possible risks that explains why the crisis team members often stress that they can expect “anything” in the service. The purpose of these vignettes is to “set up the scene”, illustrate the nature of risk and the nature of work with clients in the service, so that the reader is better prepared to follow the subsequent analysis chapter.

When we present vignettes, interview excerpts, or other bits of data relating to crisis team members, we encode them by the profession (e.g. nurse 1, nurse 2, doctor

1, etc...). If a name of a professional is needed for the narrative, the name is always changed. Whenever we present data related to specific cases, the names of clients are avoided or changed.

The next vignette presents a figurative client that has been elicited from and is representative of complex cases and scenarios that the crisis team is dealing with.

---Vignette 1---

Ashley (29) was walking back from his mother's. He was avoiding main streets where he did not feel safe and knew he would have been observed and followed. Even when taking these quiet roads, he wasn't sure if he was alone and he always carried a knife for protection. Ashley visited his mother frequently and the visits made him feel safe and calm. Unless they ended in an argument, like today. Mom insisted he took his medications regularly, but he did not feel the need of any, and did not trust the intentions of the doctor who prescribed them. He requested his depot medication to be stopped a few months back. He took the same path as usually, along the tracks and heard a train coming. This time again, he heard the familiar voice commanding him to jump under the train. But he could not do it. Not yet. Not before he kills his father and avenges the abuse he and his mother suffered from him. He could not understand how his mother could protect this beast from him and claim his father died years ago when he was still at primary school. One day she will tell him his whereabouts, he will make her talk. It must have been around 11:40, he knew the train timetable by heart. Ashley had a mental health support visit coming at noon so he had to hurry up to flush the piling medications down the toilet before she comes. He hasn't talked to his nurse for weeks. If he didn't answer the phone or didn't let her in, she would call his mom to ask what was going on. Mom is always so much help. She objected to him being sectioned under Section 3 of the Mental Health Act when they found out he wasn't taking medication a couple of month ago. But today he needed the nurse's help because his welfare benefit has stopped.

Ashley's case illustrates multiple and interdependent risks typical for mental health service users. Firstly, Ashley is carrying weapons and has developed a delusional belief system in which he believes his late father is still alive and had abused him and his mother in the past (a claim that seems unsubstantiated and is now difficult to verify). He also believes he is being spied on and does not trust his doctors. This indicates the risk of him harming other people, including his mental health care providers. Moreover, the belief that his mother is protecting his father from him puts her at risk ("I will make her talk"). Secondly, his request to stop depot medication, noncompliance with oral medication, and poor engagement with mental health services, imply an acute risk of further mental health deterioration. His mother, with whom he is in regular contact, plays a key role as a carer and a protective factor for the client, and as an informant for the mental health services. However, Ashley's mother objected to sectioning him under Section 3 of the Mental Health Act, commonly known as "treatment order" which allows for the detention of the service user for treatment in the hospital and her protective role here is questionable. If a

nearest relative objects, detention under Section 3 cannot go ahead unless legal action is taken to remove the title of nearest relative (and the rights that accompany the title) from the person who is objecting. Finally, Ashley is hearing voices commanding him to commit suicide. The likelihood of this happening is difficult to evaluate since he would only listen to these voices after killing his father, which will not happen, because his father passed away many years ago.

---end of Vignette---

The following vignette presents a subtle convolution of different risks: medical, cultural and legal, among others.

---Vignette 2---

A social worker from the crisis team and I are talking about Mental Health Acts and sectioning clients. I ask her for an example where this has happened recently. I hear a story of a boy with paranoid schizophrenia in a Muslim family:

“The last one we had to execute a warrant because his family were planning to take him abroad for some spiritual intervention, and we didn’t know how long that would be. They felt that he was possessed by an evil spirit. Very nice family, it was very much in keeping with Islamic beliefs. But there was a hint of other things influencing the family, like superstitious beliefs and unscrupulous individuals and people after their money. So, they’d booked the tickets and we were trying to work with the family to respect their spiritual beliefs, but get an intervention in the UK rather than abroad. Now, his mental health has been steadily declining over a long period of time, so the risk of mental health deterioration has always been there right from the very start. The question always was when do we do the Mental Health Act assessment? The mother was saying can we delay a Mental Health Act, can we delay looking at possible hospital admission until Ramadan finishes. She just said that we’re celebrating Ramadan, it’s a very important occasion, and lots of family were around, and we just want that time with our son [the client], to celebrate that. And Ramadan at that point was going to finish in a few weeks. So we had a discussion that this is a really important thing to both him in his former life, and the family, and we’ll respect that. We’ll respect the family in terms of Ramadan, fasting, because they wanted that. But when it came to actually looking at what the risks were of him travelling abroad, we felt he was acutely mentally disordered, lacked mental capacity, it wouldn’t be safe for him to travel. We had a best interest meeting under the Mental Capacity Act, and decided that we needed to go for a Mental Health Act assessment with a view to detention. Because we weren’t sure how the family would receive that, he had a brother who was a little bit, he was fixated on getting him abroad, and we weren’t sure. [The family] wanted to help him, but there are abusive practices which happen abroad. We wouldn’t have any jurisdiction abroad”.

I interrupt to ask if the practices were abusive towards the client...

“Yeah, to exorcise evil spirits. (...) The brother [of the client] was saying he had a very malicious form of evil spirit, which might take longer, more invasive treatment to exorcise. His brother yeah, was saying, so we didn’t trust what was happening. So, we ended up getting a warrant. (...) We felt his treatment could not be delayed, any medical treatment could not be delayed any further. And going abroad for a non-negligible period of time would have increased the risk of even further mental health deterioration. Because cognitively he was very impaired. So, it was like well we’ve worked with the family for a few months now, still no medication is being given because they’re favouring the spiritual interventions. Now this has gone onto a different level, and the risk cannot be managed abroad, we need to be managing it here under the Mental Health Act and getting him treated. (...) Then we detained him

under section two [of Mental Health Act]. [The reaction of the family was] dreadful, absolutely dreadful. They could not understand why we hadn't told them that he couldn't go abroad. And we argued that we had said that we would work with them with spiritual interventions in the UK, and we weren't aware that they were going to go abroad. (...) They told us after they'd booked the tickets. And then we were worried that they may take him abroad without informing us, so we had to get a warrant through the magistrates. Consulted legal services. That was very reassuring from a legal perspective as well as a risk perspective. It's like are we doing the right thing here? And it was judged that we were, so that helped. I think risk management is, and assessment of management is always really helpful when you've got so many different learned colleagues around you discussing it. For me it certainly changes the way I think about risk. (...) I mean there wasn't a risk to others, there wasn't a risk from others, although arguably you could say the spiritual interventions were potentially a safeguarding issue. We felt that there was enough time to consult colleagues. (...) We consulted with the psychiatrist, we had a meeting with Dr [Name]. And then we consulted legal services, and I also consulted a chaplaincy Imam to find out. I thought there's no, what we're saying needs to be grounded in evidence. Will these practices abroad be abusive, or is it just us assuming that? So, I spoke to the chaplaincy Imam, and he said he absolutely must not go abroad, because it's a world of abuse out there. So that was significant for the risk assessment in terms of the best interest decision" (social worker 2).

This case illustrates the convolution and subtlety of different risks. A cognitively impaired boy referred to the crisis team and diagnosed with paranoid schizophrenia is not taking medication. As time progresses the client, who is lacking mental capacity, is deteriorating. He is not being sectioned for a rigorous assessment in a hospital, and is not being treated because the family wishes their religious event to be respected (Section 2 of the Mental Health Act is for the people who need an assessment for a mental disorder and due to their presentation and risks this assessment needs to take place in a hospital setting). Unexpectedly, a safeguarding risk is being recognised, namely that the family intends to take the boy abroad to execute an abusive treatment to exorcise evil spirits from him. The client's family believes that their son's paranoid schizophrenia is resulting from being possessed by an evil spirit rather than from medical reasons. They prefer exorcism to medical treatment. The understanding of the crisis team is that going abroad and the unconventional treatment methods (exorcism), instead of receiving medication, will create a high risk of further mental deterioration in the long term. The crisis team consults legal services and issues a warrant to minimise legal risks of their actions. Finally, they consult an Imam to get another interpretation of the exorcism practices.

---end of vignette ---

The next vignette illustrates that the rationale behind some acute risks, including the risk of suicide, may be difficult to recognize even for close family of the client.

---Vignette 3---

With an AMHP from the crisis team we are having a conversation about suicidal clients and different ways they may intend to commit suicide. Train tracks is one of the riskiest suicide plans as it results in immediate death. She shares with me a story of one of the recent cases.

“Some guy was driving across [city] and he stopped at a train line, with only a crossing above it. He didn’t park his car, he “abandoned” it and then was walking on to the train line, he asked a woman what time is it, when is the next train due? Then he mumbled to her do people kill themselves here”.

After a short pause she carries on:

“So, she called the police, she was quite frantic, and they brought him down to the 136, do you know about being mentally disordered in a public place? Okay, so I can’t come into your home and drag you out without lawful authority. Whereas in a public place if people thought you were going to harm yourself, harm anybody else, or were mentally disordered, then they can force you to come into a place of safety. So, they moved him to a place of safety and we did an assessment there. Was he going to do it? I think at that moment in time he was going to, if a train had been passing he would have jumped (...) He would have done it, but at that point he had been thinking about it for a long time, the family is saying he’d actually done a suicide letter, but it wasn’t I’m going to commit suicide, it was all the bank details and all that, passwords for his thing. So, they think he had planned to do it, he said he’d be doing it. But the reason he was doing it was that he was delusional in that he thought he was going blind”.

The AMHP pauses again noticing my puzzlement and explains:

“I don’t know if you know about delusional people, especially with fixed delusions, nothing is going to move it. He had spent thousands and thousands of pounds going to doctors, saying he was going blind, so to him he’s going blind, and he’s going blind next week, or he’s going blind in two weeks. This had been going on for 18 months, and his family are tearing their hair out. So, in reality he was so distressed by his delusions, and we still haven’t stopped those delusions. But somehow, we’ve done the risk, he was admitted to hospital but he was released within a few days, and he is now, or was, with the day services. It’s a difficult one, isn’t it, when you think about somebody who was going to kill themselves a week ago, and now they’re out in the community?” (AMHP 2)

The case of the delusional client illustrates how some real risks and their real causes are difficult to recognise even for the closest family members. The family of the client has believed his delusions about going blind for 18 months. We don’t know it, but we may assume the family was caring and supportive, however, at the same time, no one in the family has realized the acute risk of suicide.

---end of Vignette---

While in the above vignettes we have been given a full and clear picture of these very complex risk situations, it is only because we learned about them post factum, retrospectively, after the case has been understood by the crisis team. However, when mental health practitioners meet a new client, they will start from tabula rasa, a blank space of information about the case. Moreover, the client, or their family (if involved in the case), or both, would often be suspicious towards the team professionals, further obstructing any progress in understanding the risks. Thinking about risk in terms of its

simple definition will not be practical since neither the potentially harmful event, nor its probability, are known, and even if they magically were, they would change over time, as the condition and circumstances evolve. In the next chapters we shall develop a Dynamic Risk Model that accounts for the way in which risk understanding unfolds over time, for how the available resources to manage the risk are reshaping its intensity, and how the risk may evolve in future.

It is anticipated that owing to the wealth of intense and urgent risks in acute mental health services and the wide range of involved healthcare professionals, who differ in backgrounds, standpoints and likely also views on how these risks should be understood, prioritized, managed and addressed, the context of the crisis team will provide an extreme case in the sense of Yin (2017) and ensure data richness allowing inductive theory building for the proposed research question.

3.3. Data collection

The author gained access to the Crisis Resolution Home Treatment Team (crisis team), for the period of 12 month, between March 2017 and February 2018. During this period data collection followed established ethnographic techniques (Hammersley and Atkinson, 2007) and rich data has been collected using multiple approaches. In particular, a total of 51 semi-structured interviews with opened-ended questions were conducted with representatives of all roles in the crisis team. These interviews were supplemented with approximately 10 hours of informal chats and discussions scheduled or held spontaneously. Beside interviews, nonparticipant observations of formal and informal meetings and ethnographic observations of how the team works were taken. In addition, documentation regarding the accountability model adopted at the site, risk related documents and procedure manuals were analyzed. Table 1 displays the type and quantity of data collected over time, and the data sources are now discussed in more detail.

Table (1): Summary of the collected data.

Type of data	what/who?	how many?/how long?
Interview data		
51 interviews; semi-structured, which lasted from half an hour up to 2 hours	Managers	4
	Doctors	10
	Nurses	13
	AMHP (Approved Mental Health Professionals)	6
	Social workers	4
	Asiastant Practitioners	2
	Support workers	6
	Psychologists	2
	Counsellor	1
	Admin	1
	Service Manager witin the Trust	1
	Clinical risk and suicidal leader in the mental health services within the Trust	1
Discussions with the team members	Formal and Informal discussions/chats with crisis team (lasted between 1,5 hours and 2 hours each)	5
Observational data	Observations of morning handovers	11 (ca.11 hours)
	Observations of clinical review meetings	11 (ca. 33 hours)
	Observations of how the team works and discusses in the team office	5 hours
	Observations of internal team meetings	2 (ca 5 hours)
	Observations of bed waiting meeting for hospital admissions	1 (ca. 30 min)
	Observations of the crisis team interaction during a social event	4 hours
Archival data; Review of documentation regarding the accountability model adopted at the site, risk related documents and procedure manuals	Internal documents about Crisis Resolution Team	1
	Risk Management Strategy of health organisation	1
	Mental Health Clustering Tool Version 3.0 (2013)	1
	Risk assessment forms used by the crisis team;	1
	Student Nurse Learning Pathway documents - Crisis Resolution Team.	1

Interviews

A total of 51 interviews were conducted with different staff members related to the crisis team. Out of the 51 interviews, 49 were conducted with different professionals working in the crisis team and 2 interviewees (the service manager in the Trust; the clinical risk and suicidal leader in mental health services within the Trust) collaborating with the crisis team were employed in the same Trust, but in different entities. The time and location of interviews were mutually agreed between the researcher and each interviewee. Interviews were arranged so that they didn't impact practitioners' work or clients' care. For this reason, 50 out of 51 interviews took place in the mental health services during the working hours and there was only one interview conducted in the Trust headquarters. Because the crisis team is a 24/7 service, one interview was taken at a night shift. All interviews were registered as a formal meeting with an annotation where will they take place and how long will they last. In some cases, they were either interrupted or postponed because the interviewee was urgently called for an intervention. All interviews were semi-structured with opened-ended questions, in order to create space for explanations and characterizations about discussed topics. Questions were not provided beforehand. All conversations were conducted in person, face-to-face, recorded and transcribed.

A Participation Information Leaflet (Appendix A) was used to describe the purpose of the study, researchers' and participant's involvement during the interview, and nature of confidentiality. Consent to interview was obtained through a Consent Form (Appendix B). This included the participant's consent to be interviewed and to have the interview audio recorded. It was also made clear to each interviewee verbally, and also via the Consent Form, that the interviews were voluntary and the interviewees were free to withdraw their participation at any time without providing any explanation.

Given the inductive nature of the research study, all questions allowed for researchers to pursue emergent themes not originally anticipated at the outset of the study. In the pre-study we did a scoping period where we talked to a few team members in order to flesh out the interview protocol and identify the key informants. In the first stage the interview protocol (Appendix C) was broadly divided into 5 themes related to risk, accountability, value, interactions between risk and value, consequences of managing risks. The interview structure was evolving over time in a manner consistent

with emergent findings, and reflecting the gradual evolution of the research perspective and focus. The researchers have pursued the five initially identified themes, following with additional questions deepening the interview with regards to more specific aspects, among others including: individual's involvement with the service, their risk conceptualizations, their perceived risks, risk accountability, risk prioritization, collaborations regarding risks with other professional groups, risk measures and risk reporting, interactions with other actors, personal assessment of risk management systems.

Snowball sampling (Atkinson and Flint, 2001) was used for selecting interviewees. Given the first contact by the Medical Director of the Mental Health Services we followed the social network of subjects to identify the next respondent, who was again used to refer researchers to other possible interviewees. As the researcher familiarized herself with the roles of individuals and got to know them personally, purposive sampling was increasingly used to conduct interviews from knowledgeable representatives of different professions and to maximize the investigator's ability to take adequate account of local conditions (Lincoln and Guba, 1985).

Other discussions with the crisis team members

In addition to the interviews that aimed at themes related directly to our research question, the researcher held 5 meetings with several crisis team members to discuss and better understand the organization of the service, underlying documentation, procedures and protocols that are in use. Each of these meetings lasted between 1 and 2 hours.

During breaks between or after finishing formal team meetings (handovers, clinical review meetings, team meetings) the team was continuing chats about their clients presented before. The crisis team members' openness and collaborative approach allowed the researcher to listen to those conversations and ask questions when appropriate. These informal chats were happening either at the corridors, in the kitchen or in the room where the formal meeting was held. In one case the researcher was invited to lunch outside of the NHS services to get to know some of the team members better. The researcher also participated in a charitable social event organized

by the crisis team further developing trust and friendly relations with crisis team members.

Observations

Our observations were conducted during the formal and informal meetings, where risk related issues were discussed between involved professionals. The varied types of meetings that have been observed are summarized in Table 1. Observational notes were taken during the meetings and then expanded and written up in full within 24 hours (Emerson et al., 2011).

Rich and saturated observations were conducted during clinical review meetings that lasted approximately 3 hours each, at which all clients opened to the service were discussed by different team members. Clinical review meetings were particularly informative from the research point of view, allowing observations of the team collaboration in managing clients' risk, how decisions regarding risk were made, how the same risk case was assessed by various team members with different backgrounds and experiences. During the meetings the researcher could observe accompanying emotions and engagement of crisis team members when discussing risk presentation of various clients. Observing dynamics of the discussions, body language, how agreement was reached between team members about the client's treatment, as well as support in dealing with tough cases, gave a deep insight into how the crisis team enacts their risk management practices.

Further insight was obtained during the morning handovers which lasted around an hour, and where the night shift was reporting to the day shift main events of the night and how they may develop further during the day with particular emphasis on high risk cases that may need prompt reactions.

The crisis team internal meetings as well as the team social events revealed how both collaboration and supportiveness among the team members tighten all coworkers together giving the confidence and empowerment in everyday riskwork.

The bed waiting meeting for hospital admission provided the researcher with observational data of who was admitted into the hospital and how and when, in particular, how the risk argument was constructed in prioritizing clients.

Finally, rich observational data was collected at the crisis team open working space where a lot of important team interactions took place. The riskworkers asked for

quick opinions, informally discussed patients, expressed emotions regarding the risk cases they were dealing with. They often also asked for help with particular issues, swapped tasks to facilitate and coordinate their schedules. The number of observed participants varied, as there was a big rotation of professionals coming in and out.

Concluding, non-participant observation of meetings where risk related issues were discussed between involved professionals shed a lot of additional light on the research question and supplemented the interview data. Attending meetings and conversations without interaction enabled the researcher to observe proceedings with a minimum impact on meeting dynamics.

Documentation

All documentation listed in Table 1 was collected, reviewed and analyzed in order to get a better sense of the crisis team work. Various practical aspects of how this documentation is implemented and how it shapes the riskwork of the crisis team were also clarified in focused discussions with several crisis team members. This was essential for informed interview conversations and for developing a deep understanding of the nature of the everyday work of the crisis team members.

Fieldnotes, theoretical memos

One of the data-gathering strategies used in ethnography during the observations was to describe social interactions among different actors within the crisis team as fieldnotes. Reflecting on how the team members were discussing risk and taking actions towards managing clients risk complemented future analysis and interpretations. Collecting the rich observational data of events and interactions let the researcher bring observed events back from the past. The fieldnotes were “a detailed account of descriptive, methodological and analytic facts” (Montgomery and Bailey, 2007:70) for writing up memos used to document the researcher’s thinking process (Montgomery and Bailey, 2007) and capture the “meanings and ideas for one’s growing theory at the moment they occur” (Glaser, 1998:178). In particular, observational notes from formal and informal meetings, teamwork and discussions helped capture the dynamics and atmosphere of risk practices, engagement, hesitation, confidence, and other complex aspects of the feel and mood of the risk workers. Notes were also taken during most of the recorded interviews to account for interviewees

body language, and to record emotional reactions and other nonverbal reactions, signals of engagement and attitude towards the discussed issues and topics.

Data triangulation and critical reflections

The researchers undertook several strategies guarding against uncritical approach to collected data. Firstly, despite having professional experience with NHS, the researcher still perceived themselves an outsider in the particular type of acute mental health service, especially in the initial stages of the fieldwork. To accelerate familiarization with and immersion in the service, and to guard against an uncritical perspective in relation to data analysis and subsequent conclusion, single instances of data collection activities have been arranged at a time. Sequences of arrangements, such as one interview after another, or an interview right after observations, have been avoided. This allowed to engage in critical reflections and rethink the activity each time, revise and enhance fieldnotes, rethink execution of the interview protocol, reflect on questions and answers. Additionally, the doctoral researcher has regularly discussed the observations, interviews and interpretations with the supervisors, often returning to past interviews and fieldnotes and rethinking them afresh in light of more recent data and their own evolving and maturing perspective.

Further measures against taking an uncritical perspective or misunderstanding the data has been taken by applying triangulation (Webb, 1966; Creswell, 2013). To ensure most valid and reliable findings, the accounts presented by interviewees have been checked against each other and observations have been checked with interview questions to determine whether we could have misunderstood what we have seen. Documentation has been reviewed and further discussed regards how it is being interpreted and used by the team members. In particular, we have compared and verified against each other the many account of how the crisis team members interact with clients as we have not been able to observe this in person due to the limitation of the type of access we have gained.

The researcher to in-depth data collection and were in particular attentive to capturing the whole spectrum of working conditions and different dynamics that the crisis team is subject to. The Crisis Resolution Home Treatment Team is an around the clock service. While its main scheduled activities, like meeting with clients and regular team meetings are taking place during the standard office working hours, many

of the key activities ensue day-and-night. The phone line support for clients open to the service is operating non-stop so clients may call when they require help or conversation. Interventions may be needed following such calls. Other services, like the police may call the crisis team and ask for an intervention. Also, some of the scheduled visits to clients, especially regarding application of medicines, may be due late into the evening. Hence the main crisis team office is always working and operational with some of the staff physically there, and some available over the phone. The researcher has visited the site and conducted observations and interviews at different times of the day and night to better understand the service and to capture the varying dynamics of the team and of the activities. This allowed to have a better overall understanding of the nature of the work outside of the more structured 9 to 5 working time and to have a broader comprehension of the nature of the work when conducting interviews.

3.4. Epistemology

As discussed in literature review, epistemological approaches in risk research take the whole spectrum from a strong form of realist to the strong constructionist position. Research works that build on the theories of sociology, typically have ethnographical character, and assuming a constructionist standpoint, tend to focus on what makes the individuals consider something to be a risk and what such a construction involves.

In our qualitative study, we are also looking at constructions. However, the model we develop is grounded in reality. The risks and various aspects that shape or contribute to these risks, are real. The clients may really kill themselves, cause or be subject to other serious and real harm, or not take their medicine. Hospital beds may really not be available and the police may really refuse to come or be late. Furthermore, there are elements, like the hospital bed availability, or client's health condition, that are unquestionably changing over time. The risk, and in particular, the dynamic risk, that the crisis team is facing and managing, and that is central to our study, exists beyond doubt. This does not mean, however, that we are trying to adopt a reproduction model and try to portray the dynamic risk faithfully and comprehensively, as a

phenomenon, accepting that such a goal would not be feasible (Hammersley, 1990). Instead, we adopt Hammersley's subtle realism (Hammersley, 1992, Ch. 3). It asserts that accounts of real phenomena are selective constructions that, while represent the phenomena more or less accurately, are always created from some point of view that makes some features of the phenomena represented relevant, and others irrelevant. Subtle realism also recognizes that "all knowledge is based on assumptions and purposes and is a human construction" (Hammersley, 1992:52). Consequently, when we ask how do the risk actors conceptualize the dynamic risk they encounter in the service, we ask about their risk related beliefs, understandings and knowledge, that constitute a construction - their conceptualization of dynamic risk. Their concept of dynamic risk results from the meanings that are associated with risk encountered in the service, meanings that are constructed collectively by the crisis team members through their interactions, and based on experiences and shared orientation towards understanding and managing dynamic risk. Therefore, our goal was to provide an account of these understandings of the dynamic risk built upon interactions with each other and with clients. In the micro perspective of the service, each individual client is managed by the crisis team through appropriate actions of various team members, who must agree on their doings in view of shared perspective on risk and how it may change. Furthermore, we, as researchers, are subject to the same logic and our account is also a construction.

In assuming the subtle realism approach, it is crucial that we "make explicit the relevances on which [our] account is based" (Hammersley, 1992:54). We acknowledge that our interest and focus were on the role of temporality when encountering and managing dynamic risk. We were particularly sensitive to understanding and reporting the role of time both in the conceptualization of dynamic risk, as well as in eliciting the practices that the risk actors enact in order to manage it.

Our research comprises two parts: firstly, understanding and explaining how do risk actors conceptualize dynamic risk in fast paced ever changing contexts, like the crisis team, and secondly, eliciting the riskwork through which the risk actors manage this dynamic risk. It remains to argue how to interpret riskwork under our subtle realism assumption. Indeed, the actions and practices of the risk workers are constructions that are again embedded in the broader realist elements. While the practices themselves may be about constructing views regarding risk, or constructing

ways of dealing with risk, or about reaching common ground about interpreting the situation, like the practice of interpreting and reinterpreting, or the practice of corroborating, that we identify and describe in later sections, these practices then result in real actions that have an explicit effect on risks and on whether these risks realize. The practices of risk actors are also driven by observable aspects of reality and are developed and evaluated by the crisis team with this in mind. Hence, also in the context of studying riskwork and risk practices, assuming subtle realism standpoint is well suited.

3.5. The choice of inductive approach

The researchers applied for access to the Crisis Resolution Home Treatment Team expecting and being attracted by a prospect of a risk intense setting where different health professionals are in a continuous effort to strike a balance between possibly different orientations of values and possibly different conceptualizations of risk. The researchers were driven by an observation that, for example safety and liberty, in such a context, are expected to be conflicting. The initial plan was to investigate how the layering of different risks and the diverse orientations of values of the many professionals are integrated into the service and with what effect. In particular, a fragment of the application letter read as follows:

“My proposed research topic concerns how different professional groups perceive and manage risk. In particular, in a complex organization, like healthcare, there is a multiplicity of risks and there are many stakeholders involved. Consequently, different stakeholders, having their individual conceptualisations of risk, need to cooperate on different aspects of risk. As a result, the way in which risk is being managed will affect stakeholders’ value and stakeholders’ process of contributing value to the organisation. My goal is to develop new insight into how the layering and managing of risk (for example what kind of risk different stakeholder groups are held accountable for and by whom) might affect healthcare services. [...] An understanding of the dynamic phenomenon of how layering of risk and risk regimes influence stakeholder value and stakeholders process of contributing value, is missing in literature.”

However, already in the scoping phase, in early interviews it became apparent that when asked about what risks and values they primarily care, the interviewees were predominantly focused on explaining how risks were urgent, but at the same time

elusive, ambiguous, ever changing, and how they lacked information of what risks exactly their clients are bearing. These aspects seemed to be of utmost importance to the crisis team members and the dynamic and elusive character of risk was overshadowing all other aspects. It has challenged our conception of what aspects of risks and managing risks were important, interesting and special in the service. It was therefore natural to shift the attention towards these characteristics that were clearly central to the risk encountered in the service. The researchers conducted a search of literature to identify works related to urgency, elusiveness or evolving character of risk and concluded that a systematic development of such a concept was missing. Approaching the subject with a clean slate and a thorough inductive investigation of what actually happens in the service and how to conceptualize the risk encountered there, was a natural consequence of these initial stages of research.

3.6. Data analyses

The data was analyzed following the Gioia method forged in Gioia and Chittipeddi (1991) and further established in Corley and Gioia (2004), c.f. also Gioia (2004). The method is particularly suited for “establishing a process model or novel concept” (Langley and Abdallah, 2015:149), therefore was suitable for our research question. We used an inductive, interpretive approach (c.f. Lincoln & Guba, 1985) iterating between data, codes and emerging ideas, using NVIVO (qualitative software) as well as working with a piece of paper (Figure 1 displays the phases of analyses we followed). In the research we took an individual level of analysis that focused on what individuals were thinking about risk, on how were they describing the risk and its changes, and how their decision making was affected by their conceptualisation of risk. Relying on the Gioia method during the analyses of interviews and observations, first order themes, second-order categories and aggregated dimensions were built (Gioia, Corley, Hamilton, 2103). In order to overcome some of the limitations of the Gioia approach, such as limiting authors’ ability to showcase the richness of supporting data in the findings, we follow the recommendation of Langley and Abdallah (2015) and in the “Gioia table” and provide additional quotations for each theme.

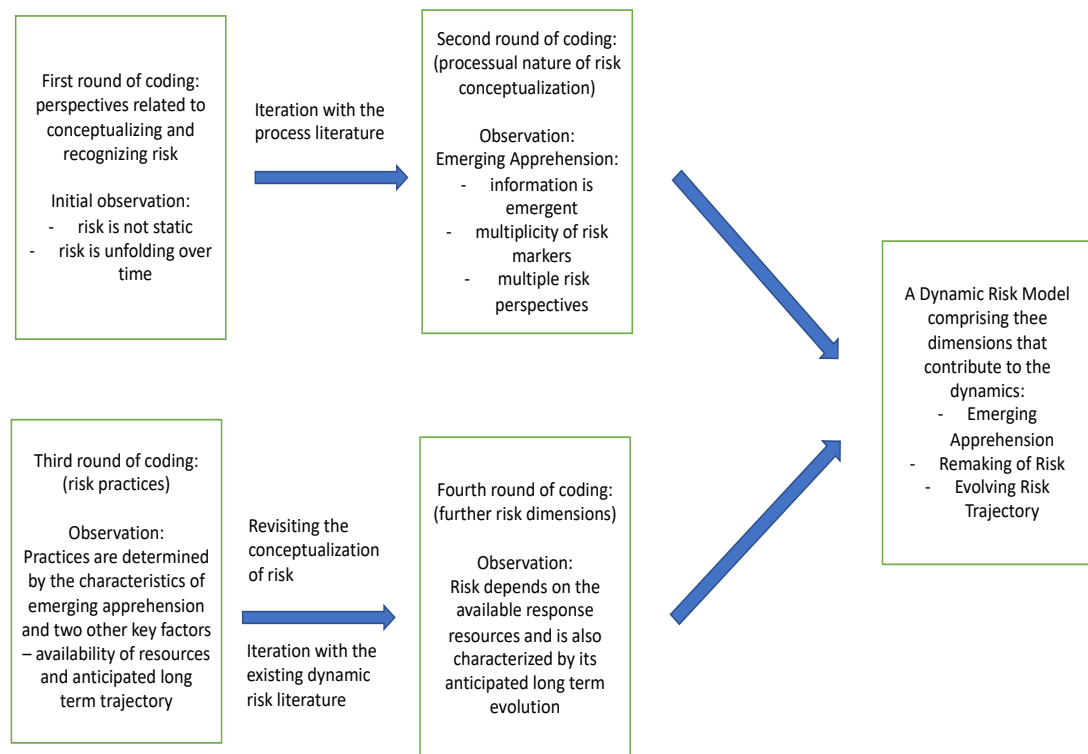
In the first stage of analyzing data we systematically summarized the interviewees perspectives related to conceptualizing and recognizing risk. These narratives (Locke and Golden-Biddle, 1997) revealed that the professionals refer to such concepts as ambiguity or scarcity of information, “figuring out things”, or becoming knowledgeable about a client and their risk. It became apparent that risk was not being perceived as a static and well defined object. Instead, the crisis team professionals conceptualized risk as something unknown that is only gradually unfolding over time, and they focused on how their risk apprehension in every individual case is emergent over time. We turned to the process literature (Langley 1999; Pentland 1999) to inform our further coding and analysis when viewing risk encountered in the mental health crisis services as a process associated with a client. We viewed this process through the rich collection of possible events that mark its evolution, that is mark a change in how risk is apprehended. Among others, such events include: when a relevant piece of information becomes available; when actors realize a relevant piece of information is missing, is inaccurate or is conflicting with some other pieces of information; when actors interpret the case or realize it requires further interpretation from them or their colleagues. This helped us identify in the second round of coding, the three contributing components of Emerging Apprehension of risk, namely the multiplicity of risk markers, inaccuracy and scarcity of information that unfolds over time, and the multiplicity of interpretations.

In the second stage, we started with the aim of examining the risk practices of the crisis team. We realized that besides being directed towards or resulting from Emerging Apprehension, the practices were also determined by other factors contributing to risk. Factors that Emerging Apprehension did not account for. Firstly, statements such as “*if there is no hospital bed available, we have to maintain very high levels of risk in the community*” or hinting that lack of coordination between the service and the police escalates risks, indicated that coordination and availability of resources also contributed to the risk and also to it changing over time. Another recurring aspect was the concern with the anticipated long term evolution of client’s risk trajectory reaching beyond the time in the crisis team service. This observation made us revisit the conceptualization of risk in our interview data. We consulted literature that addressed changing or evolving risk (e.g. Beck 1992; Lupton 1999; Maguire & Hardy 2013) for a juxtaposition of what dynamics has been observed in literature and what

we see from our data. *The third round* of coding led to eliciting a more comprehensive concept of risk, adding two new components. The first was Remaking of Risk that accounts for dynamic changes in risk intensity resulting from certain risk response actions being feasible or not, or from interactions between the team and the external environment, including other services, such as ambulance and police. The second component, Evolving Risk Trajectory, comprised the anticipated future risk evolution and the general trend of its trajectory. Together with Emerging Apprehension, these new components constitute a Dynamic Risk Model and account for three different sources of dynamics and change in presentation of risk.

The analytical process of coding data, iterating between data, codes, emerging ideas and literature is in Figure 1 and illustrates how we arrived at the Dynamic Risk Model, consisting of three dimensions that contribute to the changing character of risk as conceptualized by the crisis team professionals. Our coding structure relying on the Gioia method (Gioia et al., 2013) for a Dynamic Risk Model is set out in Table 2 which provides additional quotations for each theme that enhance and shed additional light on the analysis chapter.

Figure (1): Analytical process of coding data to elicit a Dynamic Risk Model.



Our coding structure relying on the approach of Gioia (Gioia et al., 2013) for a Dynamic Risk Model is set out in Table 2. The Gioia table provides additional quotations for each theme.

Table (2): Coding structure for eliciting a Dynamic Risk Model.

Examples	1st order themes	2nd order categories	Aggregated Dimensions
<i>nurse 3</i> : their background history (...) gives us ideas and triggers and how they used to be compared to how they are at present.	client mental health history as a risk marker	multiplicity of risk markers	Emerging Apprehension
<i>nurse 7</i> : So when we do a triage, we (...) ask what their forensic history is, so we try to work out as much as we can before we go there [to a client home].	forensic history as a risk marker		
<i>social worker 3</i> : there might be ongoing sexual abuse, ongoing domestic violence that is happening to that individual.	abuse, violence history as a risk marker		
<i>nurse 4</i> : you need to check on the risk assessment if they've got risk to themselves, to others, criminal convictions, drug/alcohol history; <i>AMHP 4</i> : are they a known drug user?	drug, alcohol use information as a risk marker		
<i>nurse 12</i> : referral form is presenting problems, triggers points (...), with referral details we've got information about patient [client] risk.	client past referral risk information	fragmentation and incompleteness of information	
<i>social worker 4</i> : have a look at his [client] previous documentation (...) a decent in-depth look at his history on the other system.	past service information about client risk		
<i>nurse 8</i> : we'd make a triage phone call, and we assess the risk then.	present client risk information during the phone call		
<i>support worker 5</i> : always get some information from the patient [client] because they do behave so differently.	ongoing visits and client assessments information		
<i>doctor 5</i> : (...) maybe the patient [client] might not be giving you the right information or maybe he's confused at that time. So the better way is I think you have to get collateral history from a person who knows this person well. For example, if he is living with his wife or partner, or with his parents. So you can get collateral information from them, verify the information, or maybe you will get some new information which the patient [client] has not given you. So you get more information from them as well.	ongoing visits and client family information		

<i>AMHP 5</i> : an AMHP is to kind of like make sure you are there, one, as an advocate for that person. To look at the social history of that person. Because it's not just about mental health, it's everything else that is around which could be social stresses affecting that person; <i>nurse 5</i> : social workers are qualified in the social aspects of people's care. So they look at like the whole social aspect.	social worker's holistic perspective on client risk	multiple risk perspectives	Remaking of Risk
<i>AMHP 5</i> : the doctors will be assessing to see how their [clients] mental health is affecting them; <i>support worker 5</i> : I think that nurses can be very clinical; <i>nurse 5</i> : nurses are more medically trained. So we just go in and we generalise on the medical.	doctor's and nurse's perspective on client risk		
<i>doctor 4</i> : I spoke to the psychologist because I thought the problem is better to be resolved with some psychological input. And maybe we need a psychological assessment and formulation, because medication definitely will be helping, but maybe not the main treatment for that patient [client] in that situation.	combining perspective on client risk		
<i>doctor 2</i> : well obviously we have people who need admission and there are not beds. Then that person remains in the community, so the relative risk is high isn't it.	hospital admission issue in acute cases	systemic problems increasing risk	
<i>AMHP 2</i> : there are some people that would say that threats to kill are also, in terms of a police matter, but the police would look at it, and the police rarely take it seriously anyway.	delayed coordination with police service		
<i>AMHP 2</i> : the problem is time, because one of the other issues, which is a serious area of risk that we have, is that if we're going to admit somebody under the Mental Health Act (...) and you can wait up to four hours for an ambulance.	delayed coordination with ambulance service		
<i>AMHP 6</i> : I think we're under massive strain at the moment, I think there's a fine line around burnout and I think it's an extremely tough place to work;	stressful work, high service demand	team capacity	
<i>nurse 4</i> : The IPU waiting list is ridiculous, it's like six months' time to see a consultant. So people can't wait that amount of time, so then they come through crisis team, which then increases our numbers, increases our workload.	staff demand due to waiting list in other communities		
<i>support worker 3</i> : So we've gone out to see patients [clients] that have got mainly alcohol and drug issues, and nothing we can do, they need referring onto the specialist services.	providing one service at a time	partial response in the system	

<i>support worker 3</i> : they've got a baseball bat by the door (...), they've got metal bars on the ledge, or I've seen knives behind the curtains, then the assessment cannot be carried out.	loss of assessment in unpredictable cases		
<i>support worker 3</i> : you know the patient [client], you read the history, and you might have seen them last week, but on that day, things could have changed, something could have activated them to just break down even more.	unpredictable abrupt shifts in clients risk presentation	acute changes of risk	Evolving Risk Trajectory
<i>doctor 10</i> : Because again, most of the mental health conditions (...) are conditions which are relapsing and remedying. So they do get better, but again (...), they can have a relapse.	coming back to the crisis team		
<i>AMHP 1</i> : we ask the questions, why the person is feeling like that, (...), is it something that they've just thought about today or has something happened, has there been a loss in the family maybe. Maybe a relationship breakup or something. A person can't just get up in the morning and think okay, I'm going to kill myself. There has to be a reason (...)	relationship disturbance	risk impingements in long term	
<i>support worker 3</i> : Yeah, there was one recently where a lady was opened to us. I think we'd seen her a couple of days before, but the day before she died, she has been seen here by the outpatients Consultant. He'd closed her, and she took her own life the next day, (...) I think she'd got Parkinson's, so I guess that's what drove her. And it around the anniversary of her husband dying, so there's kind of alarm bells (...)	social integration issues		
<i>nurse 10</i> : we can deal with 16 year old girl who's having crisis with her exam	resilience deficiency		
<i>social worker 3</i> : what I am looking for is first of all or initially, to see what is going on in their lives, what has brought them to the point of crisis, (...) maybe some financial issues (...) first of all that brought that individual to the point where they act when they come to the crisis team	significant social or welfare stresses		
<i>doctor 5</i> : Because people think if someone tells about mental health problems, it means they are mad. (...) Because there is not much awareness of mental health problems, (...)	social exclusion	recovery handicaps	
<i>nurse 8</i> : I think there is stigma around people that go to a psychiatric hospital whether it is against their will, or they are choosing to go in themselves.	stigma affecting self-esteem		

After establishing the Dynamic Risk Model that informs about how the crisis team members think about the risk and how they conceptualise the fact that the risk is continually changing and evolving, it is natural to ask how they manage the risk. Since “Risk management is always a practice under some description (...) in larger systems of value and belief” (Power, 2007:25), understanding actors’ beliefs about the risk they encounter and how they conceptualize its dynamics, will be essential for interpreting their day-to-day efforts in containing risk.

To better understand the situated nature of what the crisis team members actually do to manage risk, we applied a practice theory lens (Schatzki et al., 2001; Nicolini, 2012; Reckwitz, 2002; Orlikowski, 2010). Indeed, Schatzki’s definition of practices as “embodied, materially mediated arrays of human activity centrally organized around shared practical understandings” (Schatzki, 2001:11) emphasizes the role of shared practical understandings that the crisis team members have about dynamic risk and the ways the dynamics becomes meaningful in their practices.

Consequently, we turned to coding and focused on risk practices, iterating again between data, codes, and emerging ideas. We again built first order themes, second-order categories and aggregated dimensions following Gioia et al. (2013). In particular, we noted openness to “any possible” risk indicators and importance of the experience and individual judgements of the involved professional. From this we concluded that initial scarcity, temporal unfolding, and possible diversity of the risk related information are key for the way the service works and drive related recursive situated routines of the professionals that together we termed the practice of Interpreting and Reinterpreting. Another leitmotif that emerged from the observed and reported activities was how the professionals synchronize their views and how they draw strength from combining their different perspectives, agree on risk assessment and take risk related decisions. This revealed the importance of collectivity in the context of emergent understanding. Collectivity manifested itself through the significance of various ways of consulting and confirming with colleagues that were justified through the perspectives of different professionals and through pulling different experiences and viewpoints together. We concluded that this aggregated dimension constitutes the practice of Corroborating. Another theme in actual doings of the team members that constituted a considerable proportion of their day-to-day work was related to a collection of routines that ensured responsiveness of the team.

These routines clustered into efforts aiming in a timely fashion to adjust the scale of response to the scale of risk, to organize response within the team's capacity, and finally to promote sustainability of the team's morale. All these situated routines were organized around the ability of the team to respond to risk and we termed this the practice of Securing Efficacy. The final theme that appeared as an aggregated dimension in our coding related to teams' efforts to stabilize the client beyond the time horizon of the crisis team services. The team members were engaging with the clients to improve their long term experiences after they leave the service by addressing a range of their recurring issues related to social situation, care and self esteem. We termed these engagements the practice of Counterbalancing.

Our coding structure related to risk practices is set out in Table 3. The Gioia table provides additional quotations for each theme.

Table (3): Coding structure for eliciting risk practices.

Examples	1 st order themes	2 nd order categories	Aggregated dimensions
<i>nurse 3</i> : [client's history] gives us a bit of background to work from really, and to be able to assess them [clients] and see if there is actually a pattern going on the way that sort of led to the situation that is the problem at the minute.	gathering client past and present mental health history	evaluating multiplicity of risk markers	(Re)Interpreting
<i>support worker 3</i> : this patient [client] drinks alcohol most days, he's dependent on cannabis (...), he's also attacked drug dealers, stole their drugs. <i>nurse 3</i> :we initially go out and see what risks they present if they are hostile, aggressive, if they are drug users, where they live.	examining drug, alcohol use information		
<i>doctor 4</i> : forensic history helps you to find out if there's any risks to others.	searching for client forensic history		
<i>AMHP 1</i> : we ask the questions, why the person is feeling like that, what has happened for them to feel like that, and how long they've been feeling like that. Is it something that they've just thought about today or has something happened, has there been a loss in the family maybe. Maybe a relationship breakup or something. A person can't just get up in the morning and think okay, I'm going to kill myself. There has to be a reason.	understanding relations around the client that may affect mental health		

<i>nurse 8</i> : we do ask the family their opinions and how they are finding the patient [client].			
<i>nurse 10</i> : tell-tale signs, that we noticed that people might actually just be lying to us, actually what they are telling me is not what their body language is saying, what their eyes are saying.	fleshing out “tell-tale signs”		
<i>AMHP 5</i> : but then you go next week, an elderly person, for example, or a vulnerable young person, you see some people hanging around in their house, you begin to ask, “Who are those people?” And then you start seeing that it’s people who come to sell drugs to them, or people who come to abuse them for their money. So the risk is changeable, isn’t it?	being observant and continually reassessing risk (ongoing home visits)	facilitating emergence of relevant information	
<i>AMHP 5</i> : when you go to do an assessment, you might be able to gather so much information today. But when you go next week, there are more things come to light.	revealing new risk markers		
<i>doctor 5</i> : everyone who is doing assessments they update the form. <i>nurse 9</i> : took a phone call off a mum and she was really worried about her daughter. I thought from the conversation with her mum she needs to go to hospital. Somebody went out to see her. (...) they did a mental health act, didn’t detain her and she took a big overdose.	updating/reinterpreting patient’s presentation	revisiting and reassessing information and risk markers	
<i>support worker 5</i> : I went out and we were going, yes, she’s fine, no problem, we’ll put a service around her which might include daily visits, a medical review, basically not involving an admission (...) A couple of days later she went off down to Beachy Head, and I don’t know if you know about Beachy Head, but basically it is a place where a lot of people go and try to kill themselves. So they have people at the pub, at the pub in Beachy Head they’ve got a telephone so people can ring people say I’m thinking about killing myself, and they do patrols as well. She had a Mental Health Act assessment down there and was admitted [to hospital].	identifying unstable patient condition		
<i>AMHP 4</i> : there’s more joint working and more cooperation and sharing and on the main things, talking about risk is what happens here. <i>support worker 2</i> : we’ve had a man (...) and he did come across as really risky, so we needed a bed. But we	relying on experience and perspectives across a multidisciplinary team	considering multiple interpretations	

went and discussed it with Dr [name] first, and then we took it further, and then the AMHPs were involved as well, and we sent them down to see this guy, and he ended up being admitted.			
<i>nurse 4</i> : she's presenting as very manic, very elated. So it has just been me and another member of staff that have been going to see her. And we've both been comparing what we see when we go out. Because we don't know if it's her, that's her personality or whether she is actually elated. So we've both been comparing, and now we've both said that we'd like the doctor to just go out and see for himself.	arranging joint assessments		
<i>psychologist 1</i> : we'll have a consultation, discussion, to understand from a multi-disciplinary perspective what we think the persons needs might be. Sometimes then it's still not clear so then I'll go out and assess directly with that clinician. And then we'll have more consultation and formulation.	seeking confirmation of made assessment		
<i>support worker 1</i> : I was worried all the time, have I made the right decision, have I done this, and that went on for a long time.	searching for an "objective" opinion		Corroborating
<i>support worker 2</i> : I went and spoke to him [the client's son-in-law], and he was tearful, and he was saying about what had happened [his wife took an overdose] (...) I could feel my eyes starting to go, but I thought, no, I can't cry, because it's not about me, it's about him, and he's got to rely on, and lean on people around him, so you can't be there crying. You have to toughen up.	taking oneself away from being too closely involved in client's risk assessment	seeking critical distance	
<i>nurse 8</i> : I am always going to the social workers and the AMHPs, talking to them asking for advice. Ask support workers what they think. We've got occupational therapists, I'll ask them what they think, ask the doctors so I'll ask everybody.	avoiding professional background bias		

<p><i>social worker 1</i>: we were due to do the Mental Health Act Assessment on that day, because I was asked to set it up. But it didn't go ahead, (...) it didn't result in a hospital admission, because the person was prepared to engage with home treatment as a least restrictive measure.</p> <p><i>doctor 5</i>: you have to admit a patient and sometimes a bed is not available.</p> <p><i>nurse 3</i>: he was more of a risk rather to himself, (...) he was a superficial self-harmer (...) he would always have to be seen in a secure environment (...) still seen by three or four people. And actually he sought help but wasn't particularly safe to be around; we could go to [community name] or he could come to the [crisis team location] or he would have to go A&E and be treated (...).</p>	<p>coordinated effort around the junctures, problems being supported:</p> <ul style="list-style-type: none">- detaining the client or not?- high risk patient vs lack of beds in hospital- high risk patient vs multiple opinions about patient treatment	consulting on pivotal junctures	
<p><i>assistant practitioner 2</i>: we'll say listen, he's risky let's just go and do a visit, capture the risk then we'll do an assessment at a later date, so that does happen.</p>	addressing dynamically changing client's risk	accommodating risk and its scale	Securing Efficacy
<p><i>nurse 9</i>: if they [clients] were really high risk you would ask the bed manager to look at an out of area bed. If they go on the bed waiting list [there is no available bed in a hospital] the crisis see them once a day, that's our procedure, maybe twice a day (...) you could perhaps put phone calls in as well (...)"</p>	managing clients in crisis who are waiting for a hospital bed		
<p><i>AMHP 2</i>: Then you are looking at the risk to the assessing team, with two doctors. Now, for example, the guy that we're going to assess doesn't like males, he is threatened by males, he has a history of abuse at the hands of males, so why is he going to want a male? So he tends to get more disturbed by males, so you are perhaps looking at female team.</p>	tailoring actions individually to clients		
<p><i>AMHP 1</i>: if there's two of you then one can say okay, I'm doing this, can you take the second assessment sort of thing, and take it in turns.</p> <p><i>AMHP 5</i>: we are able, between ourselves, to swap with each other and cover the shifts.</p>	managing team members flexibly	meeting team capacity in day-to-day work	
<p><i>doctor 4</i>: will try to do as much as I can, but also I'll involve my team members. So I can get more information in less time and we can make a decision quickly. If I'm doing</p>	sharing the load		

everything myself, it may take much more time. <i>social worker 1</i> : I've got professionals immediately available.			
<i>assistant practitioner 1</i> : the whole team used to have (...) our counsellor, which I used to find beneficial. <i>nurse 13</i> : our counsellor, has offered group supervision and support to people who've needed that after somebody has completed suicide. So that's not a requirement, but that's just something that the team has developed and [a counsellor name] offers to colleagues.	managing and supporting colleagues professionally and personally	relieving overload	
<i>Fieldnote 1</i> : Today the crisis team arranged a cake sale within the NHS Trust, in order to collect money for a Cancer Foundation, which gave them an opportunity to spend more time together. The crisis team's working open space which normally is a quiet place is filled with the loud and lively atmosphere now. People seem to enjoy their conversations.	socializing crisis team		
<i>nurse 8</i> : if somebody (...) needs some kind of support because they are a bit isolated (...), then we might make a [community name] befriending service referral.	building connections with communities outside of the crisis team		
<i>AMHP 5</i> : everybody needs to be respected, to be valued, whatever. So if people have limitations and they're distressed now and they're going through something (...) my role, or our role (...) is to support them.	supporting identity and self-worth		
<i>AMHP 2</i> : it could be death, it could be divorce, it could be whatever. It doesn't mean they have an acute mental health problem. It could be, at that time, they are so distressed it affects them so much. And they need help. You don't need to go straight into there, because you are considering their human rights, their liberty and the stigma. From everywhere, from every culture, mental health has this stigma.	destigmatizing	stimulating social relationships and reintegration	
<i>support worker 3</i> : If it's something that they need long term support, but not crisis, then I could refer them to [community name], increase qualifications, start education.	helping with employability and qualifications		
<i>nurse 11</i> : we refer a lot of people to advocacy who help with debts and benefit issues.	combating neglect and negligence	stabilizing and developing protective layers	Counterbalancing

<i>AMHP 1</i> : if somebody is struggling with washing and that sort of thing, I will sort out domiciliary care to come in and do it.			
<i>social worker 2</i> : he's in a high risk category, he lived alone, he was lonely, (...) he's got nothing, he just sits in this flat all day, so then I thought well I'll take him on and I'll refer him to [community name] for floating support so that they can start getting him out of his flat and then he wants to go back to work. [community name] can help him with that doing a CV, looking at employment.	reducing/eliminating risk impingements of acute crisis (e.g. loneliness or exploitation)		
<i>doctor 5</i> : I spoke to the social worker [about client's presentation in long term] to explore it further, and get in touch with the family, and these are the options, like looking for respite care. And in the long-term maybe look for a residential care home, depending on all these risks. Because even if she [the client] has carers going in, even if her family is involved, like her son is sleeping there every night with their mother, and sister is visiting every day, even though they are getting involved, there are many risks that are still not covered, or cannot be covered, you know, in the long-term.	maintaining client's risk in long term		

The key aspect of dynamic risk and its systematic conceptualisation through the Dynamic Risk Model is the crucial role of time. It enables to formalize risk urgency and understand risk evolution. Consequently, in our study of risk practices in the dynamic risk context, it became apparent that attention to time and temporality plays a crucial role. Therefore, when analysing risk practices, we drew from theoretical perspectives on time in social and organisational sciences.

There are two fundamental perspectives on time in social sciences that result from the objective and subjective realities (Jacques, 1982; Kern, 2003; Blyton et al., 2017). In the objective reality time is an absolute homogeneous physical dimension, independent of human being and their actions, and measured by the wall clock. The locus of explanation of temporal phenomena is an external entity. In contrast, the subjective view of time conceptualizes it as a socially constructed object, that is inhomogeneous and “defined by organizational members” (Clark 198:36) as a product of norms, beliefs and customs. Socially constructed time is measured in events and

meaningful events are defined by actors. Hence the locus of explanation of temporal phenomena is cultural meanings.

To study time in the practices of the crisis team we adopt the temporal structuring approach of Orlikowski and Yates (2002). It fills in the gap between the two subjective and objective extremes and provides “an alternative perspective on time in organizations that is centered on people’s recurrent practices that shape (and are shaped by) a set of temporal structures” (Orlikowski and Yates, 2002:685). The temporal structuring approach sees human activities as the locus of explanation of temporal phenomena. It accepts the fundamental duality that temporal structures, just like all social structures, are constituting and being constituted by human action. Temporal structuring is a way of understanding and studying time as an enacted phenomenon within organizations. It suggests that through their everyday actions, actors produce and reproduce a variety of temporal structures which in turn shape the temporal rhythm and form of their ongoing practices. Examining the ongoing work practices of the crisis team through the lens of temporal structuring provides a richer understanding of how, when, and why the crisis team members structured their activities over time, and with what consequences. In particular it enables understanding of how the risk practices are timed in order to respond to risk urgency and ensure the appropriate response on time in the dynamic risk context.

CHAPTER 4

ANALYSIS

Conceptualising risk encountered in Mental Health Services - towards a Dynamic Risk Model

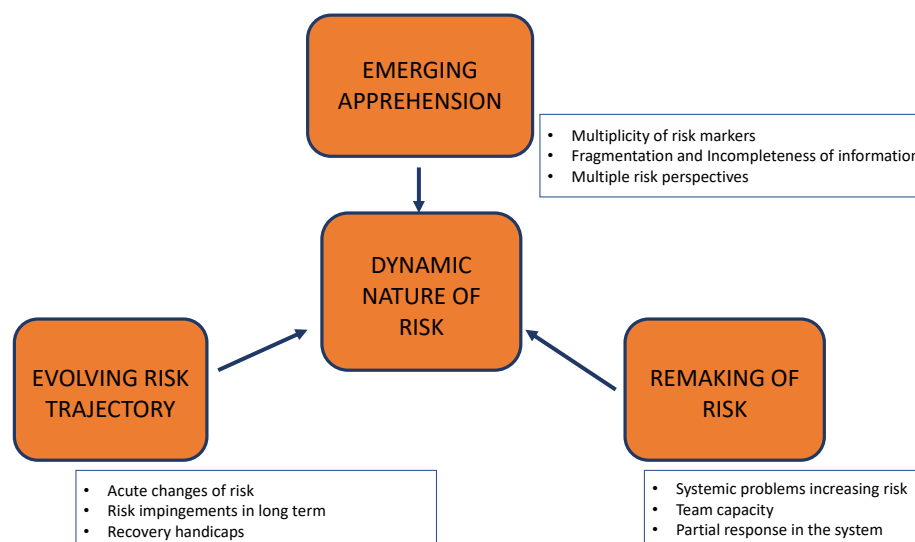
The Crisis Resolution Home Treatment Team (crisis team) manages acute and complex risks of their current clients and new referrals within its capacity and availability of resources. The risks in the service are characterised by urgency and are subject to both short- and long-term evolution while the required actions are characterised by immediacy. The crisis team is making decisions and undertaking actions based on available partial information that is ever changing and in circumstances that are unstable over time. Therefore, we aim to answer the question how do the crisis team professionals conceptualise this dynamic risk, what is its nature and how can it be described systematically?

We present and analyse our data collected in this complex setting by developing a Dynamic Risk Model that systematises the sources and characteristics of dynamics in risk. The Dynamic Risk Model consists of three dimensions: (1) Emerging Apprehension that addresses the question: what can be understood about the risk? (2) Remaking of Risk that addresses the question: what can be done about the risk with available resources? and (3) the Evolving Risk Trajectory that is concerned with how the risk may evolve over time. The three dimensions of the Dynamic Risk Model explain how the crisis team professionals see the sources of ambiguity, instability and change in the risk they encounter and how they form the dynamic environment of their work. The Dynamic Risk Model is presented below, in Figure 2, and summarised in Table 4 at the end of this chapter. The Dynamic Risk Model is further developed in the discussion in the section 6.1 and Figure 2 is discussed in detail there.

In chapter 5, the second part of the analysis, that follows after this one, we shall see that developing the Dynamic Risk Model will help understand how its three

dimensions shape the riskwork (situationally-specific risk-related practices, c.f. Horlick-Jones (2005: 293)) of the crisis team by influencing how, when and what the team does to manage the risk.

Figure (2): The three dimensions of a Dynamic Risk Model.



4.1. Dimesion 1: Emerging Apprehension

The first dimension of the Dynamic Risk Model relating to what can be understood about the risk is shown in the top box in Figure 2 labelled Emerging Apprehension. This dimension pertains to how relevant information about the risk is emerging. Risk is characterised by a very large number of risk markers of varying relevance, depending on context, obtained over time from varied sources. At any point of time, available information is fragmented, incomplete, and often inaccurate and while new pieces arrive, the available ones may become questionable. The wide range of possible risks, mechanisms creating them, possible untold stories, aspects of a different nature makes the risks subject to multiple perspectives. We shall see in our data how these characteristics of Emerging Apprehensions appear and how they make the risk in the service dynamic.

The majority of active clients managed by the service are suicidal and have experienced a recent deterioration of their mental health condition. Clients can be

referred to the service in various ways including their GPs, community mental health teams and self-referrals. Information in such referrals is very limited and due to the variety of referral sources, most of which have no staff with or little training in mental health, there is no common underlying standard or structure to rely on. Hence, when the team professionals take on a new person, they start with a blank space of information about the case and its associated risk. When little is known about a client who is new to the service, it is a major concern as the intensity and type of risk is masked:

“Risk is when the patient’s [client’s] unknown, not known to services (...).” (support worker 6)

First contact with the client is usually on the phone, made by the team member sitting currently at the duty desk. The phone contact with the client has to be done within 4 hours after receiving referral, reflecting the urgency imposed by the unknown. This is the starting point when the first understanding of the client’s problem can be obtained and the professional on the phone gets information about of “*what is actually going on with that client at that time*” (nurse 10). Because the amount and quality of information in referrals varies (from a phone call from a GP being concerned about their client’s risk presentation, through a brief letter with client’s problem description, to a more detailed client assessment), a phone conversation verifies the information already given. It also allows for a better initial understanding of the client’s risk presence and its intensity, and whether the case is within the remit of the service. It is crucial to confirm the correctness of client placement, but also to gain an initial understanding of the problem. Hence the risk apprehension may start presenting itself through *reading* the obtained referral, which represents a recent and past risk information, and through *talking* on the phone as a source of understanding of “now”. The shift coordinator (the person who answers the referral calls and is triaging clients), being aware that the client’s risk factors, as well as their context are never stable and are often reported inaccurately, checks the referral is in accordance with what the client talks about. Letting the clients talk and *listening* to what they want to say beyond verifying the referral enables the assessor to gain additional perspective in understanding the risk. Finally, *hearing* the client’s voice, its timbre, and their reaction on the phone when asked questions, is another important aspect through which risk apprehension is emerging. The crisis team does not use a formal questionnaire for this

brief phone call assessment, instead, as a nurse stated, there are “*standard things that we normally ask*” (nurse 10). Thus, through these four channels (reading, talking, listening, hearing) the first apprehension of risk and the client’s main problem that led to the crisis emerges. This will be used to decide on the next steps. A nurse summarises the aim of the phone contact with a new referral as “*getting the information we need and then booking an assessment*” (nurse 10). Through the referral and phone triage risk presents itself only very partially and the team members are aware this initial apprehension is superficial and characterised by significant uncertainty:

“we think, ‘this person is not risky’ and the next day you hear that something horrible has happened – either the person has committed suicide, or there was a hospital admission, or something. And then you think, ‘well, the triage wasn’t right.” (doctor 10)

After the initial risk understanding has been captured over the phone and the client has been opened to the service, a face to face meeting is arranged with two team members. One of them, who is always a nurse or a social worker, becomes the client’s lead professional. The meeting is typically a home visit, during which a more detailed risk understanding is sought. The client and the risks are assessed more thoroughly through the four channels mentioned above and also through a new one, which is *observing*. Two people will make this visit and the client, their body language and the environment in which they live will be subject to observation. Observing will influence the risk apprehension and the assessment. From this moment until the client will be closed all information will be updated via personal contact.

The risk apprehension is emergent as information becomes available over time and is being interpreted by the team members. A comprehensive risk assessment starts during the first visit and, through the four channels discussed above, is based on **multiplicity of risk markers** arising from different sources, like the client’s mental health history, forensic history, family history, social context, substance abuse, information in the referral, behaviour of the client, and therapy progress. These important risk markers indicate different things about the risk, in particular, they are associated with the frequent risk categories, such as suicide, aggression and violence, substance abuse, neglect or social decline. Identification of what is a risk marker and its meaning is based on mental health medical guidance (c.f. Northamptonshire Healthcare NHS Foundation Trust policy (2018)) and while associations with suicide or violence and aggression have been researched formally, the other categories are

mostly obtained from reflections of practitioners over their experience in the service, shared at workshops and other professional meetings (Morgan, 2007). Team professionals will be paying attention to all of the risk markers to gain understanding of the person and their risk. A nurse explains the multiplicity and meaning of different risk markers and what they reveal about risk:

“(...) because I think it's important to look at the history and to look at any markers within the family. ... Forensic history, that's a very important one because it would indicate whether you see the person in another environment like say the hospital, or were you safe to visit them at all? Did you need police involvement? Do they carry weapons, have they used weapons? Are they a risk to NHS staff in the past? (...) You have to go into their risk history from their perspective and also from the years of experience you may have in the job (...) I can pick up signals and cues from the voice, from what they're saying. The language they use, how they put the sentences together (...).” (nurse 13)

Information about risk is collected and the client is assessed every time contact with the client is made: on the phone, in their home during the first and every consecutive visit, or in the place of safety. The information is further exchanged, discussed and interpreted during formal meetings (handovers, team meetings, medical clinical reviews) and informal meetings (chats between staffs at open working space in the crisis team building). This constitutes the process in which a picture of clients' medical and social presentation is being revealed and contributes to the dynamic nature of the emergent risk apprehension. Part of emergent understanding of risk is to apprehend the 'risk of what', e.g. risk of client's condition deteriorating, risk of suicide, or risk of events triggering more acute crisis, such as risk of breaking relationships.

Team members differ in their background and training, as well as the nature of tasks they undertake. This influences the way in which they process, interpret and contribute **multiple risk perspectives** to understanding of the available risk information. For the social workers a holistic orientation towards clients' mental improvement and wellbeing, including focus on the social aspect of their lives (not only medical), is particularly important in risk apprehension and deficits in these aspects will be interpreted as risk markers.

“[I] try and intervene in all sorts of areas really of people's lives, [it is] not just about mental illness, getting better, end of story, because mental health is more than just treatment for psychosis or depression or whatever it might be. It's also about those other things, it's about purpose in life, about occupation, about relationships with others, et cetera. (...) to give themselves meaning, that they're not isolated.” (nurse 13)

During their consecutive visits, social workers will seek to gain an understanding of the person and their situation, to obtain information about client home condition, risk of neglect, abuse to the children in the household, drug use, alcohol use, domestic violence, ability to work, and relationships with family and friends. In other words, it is about emergent understanding of the person and her situated nature of risk. As pointed out by a social worker:

“(…) there tends to be more of a focus on the person in a community, so it’s a person in a context, not necessarily just with family, but also with the (…) their funding (…) their employability (...), some of those societal level (...), integrations into their life”. (social worker 4)

In parallel to this situated nature of risk understanding, doctors and nurses also bring a clinical assessment of the illness to the service. Looking at client’s medical presentation and current medical treatment is an important part of the process of uncovering risk. The emphasis on the medical model gives doctors and nurses confidence, as it’s related to their professional training. On the other hand, psychiatrists as well as nurses help social workers and support workers understand the client’s medical presentation. Support workers visit clients most frequently and perform continual reassessment. They update the information about client’s presentation, which changes every day. Each professional will be collecting risk markers around their client, but influenced by their educational background and role in the team, stressing and interpreting different aspects according to their background. Thinking about emergence of risk and understanding it emergently, rather than measuring it, then relies also on combining these varied multidisciplinary perspectives. When the risk markers are collected in the ongoing contact and treatment process the relevant information is revealed about client’s risk intensity. The markers are not given and observed just at one point in time, instead they are being revealed gradually, as the information about the client unfolds. Consequently, risk associated with the specific client, its intensity and type, can be apprehended only gradually as contact with the client is made during triage, the client is regularly seen during treatment, and the case is assessed and discussed by the team members. Listening to what a client says and how they portray themselves contributes to the emergent process of revealing risk markers in order to understand and assess the client’s risk level. Obtaining an additional perspective verifies what somebody else wrote before in the client’s

documentation. A social worker explains the importance of having a conversation with a client and double-checking existing information:

“I would have the history, but I would always double check with the client, because I want their perspective. Sometimes, not everything what is documented is accurate. I just think it is best to get that information from your client, from the service user, who is in front of you (...).” (social worker 3)

Relevant **information is fragmented and incomplete**, it will emerge gradually and may become meaningful only in the context of other markers; therefore, each time contact with client is made, or new markers are revealed via other means, the current assessment of risks needs to be revised. Moreover, not all information may be accurate, as in the example given by an assistant practitioner:

“his previous assessment had said he was mourning, loss of his mother, his mother had passed away, da, da, da, that was a previous assessment from say two months previous - his mother had passed away. When he was assessed the second time, it said social stresses around his mother drinking, being abusive to him, I said what’s going on here (...).” (assistant practitioner 2)

The emerging information may change the understanding of the client’s situation and their risk levels and make the available risk picture elusive. Moreover, because people in crisis are vulnerable and unstable, the risk levels may be changing gradually or abruptly, and the team must be alert to recognise such changes as soon as information or relevant markers emerge. A doctor explains that abrupt changes in client’s risk are to be expected:

“This is a dynamic service. The person I’ve seen just now before I came to see you, that person may change tomorrow because it is a crisis (doctor 10).

Risk apprehension will often change as more risk markers are being revealed or updated, as multiple and convolved risk markers are being interpreted by different team members, or as new events occur. The following excerpt highlights how a nurse’s risk understanding was emerging over time, supported by other professionals of the crisis team.

---Vignette 4---

10am - Peter [a nurse] and I have a meeting. We have met to talk about the team work. Peter brought a big sheet with him to show me, how he and other people work in the crisis team. The meeting is very informal, Peter is absolutely relaxed and happy to talk with me. He is very calm, explains everything in detail. We follow a story of a specific client.

The client has been referred to the crisis team by the Central Booking Service (CBS)³. Based on this referral Peter thought that this is a person with a risk of overdose who doesn't cope with his current life, who takes medications, and who was so far under the GP treatment. At this point his understanding was that this client was seen by the nurse practitioners from the GP surgery, he was given a medication but the risk of him ending his life increased so much (according to the referral information) that he was referred to the crisis team. Peter's first contact with the client was on the phone (day 1) and this conversation together with the referral information let him think that indeed there was risk of overdosing and that a file on the client should be opened to the crisis team. During the first home visit (day 2), which is called an initial assessment, Peter started collecting additional information. He asked questions about the client's current situation, his professional and personal life, past history and plans for the future (all details are in the table 4). The holistic assessment is based on asking, talking, letting the client talk, listening, and observing what is going on in the client house, how he reacts, what their body language says, and what can be concluded seeing the client's house. After the initial assessment Peter collected 4 important new pieces of information, which we term new risk markers (NRM). First, the conversation revealed that the crisis team client was hearing voices (NRM1), which didn't let him sleep and function normally. There was a risk that "those voices" could push the him to ending his life. Later during the home visit, the nurse noticed a pack of psychotic medicine (NRM2). It turned out that it belonged to the client's ex-wife. The client gave them to the nurse being aware what type of medicine it was and of possible consequences after taking them. This let Peter think that the risk of overdose couldn't be as high as it had been stated in the referral, as otherwise the client would have hidden the medicine, or would have already taken them. From then on Peter concluded that hearing voices rather than overdosing was the key risk factor. From the referral Peter knew that the client didn't work and didn't have any income. But the home visit revealed another important factor – the client's house has been sold, the client was uninsured, and there was a risk of becoming homeless in a short period of time (NRM3). It was likely that losing the property will only exacerbate the client's mental presentation. This new finding aggravated Peter's view on the risk of suicide. Peter knew that the client was taking some medication prescribed by his GP. However, the client's low mood, poor responsiveness, low motivation and hearing voices let him think that the medication didn't seem to be working (NRM 4). He concluded that a doctor has to assess the client and change his medication in order to stabilize him and decrease the risk of suicide. The following visit in the client's place (day 6; two days after the medical review, when the medication has been changed) revealed that the client looked more settled, his mood improved but he was still hearing voices. The client has been assessed as risky, but more stabilized. Peter's perception of the client's risk was changing with every contact and reassessment. *"It's ongoing assessment, things can change, it's fluid... risk moves up and down"* - he repeated a few times.

In this excerpt from the client's admission to the service and of his treatment the main characteristics of Emerging Apprehension are manifested. Relevant pieces of information are being revealed gradually over time (referral, phone call, initial visit and assessment, subsequent assessments) and some turns out inaccurate; the information contains several risk markers of diverse character (ranging from medical and mental condition to personal and financial circumstances) that together contribute to risk assessment during each consecutive contact; different professionals from the crisis team are required to contribute to assessment in order to obtain a more complete picture.

---end of vignette---

³ CBS – Central Booking Service – "is the first point of contact for referrals into many areas of the Trust (...), directs booking of patients [clients] initial appointments for many community services including: Mental Health (...)" (NHS Coventry and Warwickshire Partnership).

Sometimes the same information available about a client and the same risk markers result in different assessment of risk levels by different professionals contributing to the crisis team as illustrated by the following fieldnotes:

--- Fieldnote 2 ---

This is a clinical review meeting for clients open to the crisis team. At the meeting, there is a consultant psychiatrist, a clinician trainee, 3 nurses, a social worker, a support worker, a clinical support officer and a community representative of an early intervention team [EIT].

The case of a client [...] is being discussed. The client has been put by EIT on a bed waiting list for admission to the hospital. Dr [...] reads notes about the client that include current assessment and recent treatment. The social worker from the crisis team talks about increasing medicine doses for this client up to two times per day instead of once and letting the client stay in his home environment due to his mid-levels of risk. The EIT worker's perception of this client's risk is different. He thinks that the client may kill himself, and needs to be admitted to the hospital. Both, the social worker and the EIT worker have assessed the client a few days ago. Dr [...] is of the opinion that a better and more up to date understanding of client's risk is required before deciding on the next steps. He prefers to wait until another trainee doctor will share their opinion after visiting the client later that week. Everyone agreed.

---end of fieldnote---

In this case we observe two different interpretations of the client's risk presentation and further treatment. For the social worker from the crisis team the priority was to minimize client's current risky presentation by increasing his medication and to maintain him at home. The EIT representative was of the opinion that the risk levels were not acceptable and around the clock hospital treatment was required. In this situation a more up to date medical assessment has been requested by the consultant psychiatrist, illustrating perceived dynamics of the crisis episode, necessity of continual reassessment, and of combining multiple perspectives. Social workers are strongly focused not only on the medical perspective of the mental condition of their client, but also on the social aspect of their existence. They tend to prioritize the observation that keeping the client in their own environment as long as it is possible gives the highest chance for successful recovery in the long term. This explains why the social worker in the above fieldnote did not support sending the client to the hospital.

Clinical review meetings where all current clients open to the crisis team are being discussed, handovers, bed waiting list meetings, other regular meetings, as well as informal discussions between team members, facilitate exchange of views, interpretations and perspectives on the partial and complex information available

about clients. Consequently, the discussions contribute to risk understanding that necessarily changes as these discussions progress and the evolving combined views of the team professionals contribute to the dynamics of risk apprehension and its emergent nature.

Table 4 summarizes the treatment progress of the client introduced in vignette 4. It tracks emerging risk apprehension related to the client, includes information sources and their interpretation, as well as actions taken by the nurse involved and other members of the crisis team.

Table (4): Summary of a client treatment as time progresses.

When?	Who deals with the client and how?	What do we know?	Risk markers sources	Interpretation
day 1, afternoon	GP sent a referral to CBS and CBS contacted crisis team	59 years old person intends to end his life, client has suicidal thoughts, thoughts of overdosing, doesn't work, is neglected (is not washing, not shaving, not eating), not leaving his house, isolated, taking medication, but not taking it regularly, low in mood, in risk category for males (30-60 is a range for male suicides), with no relationship, ongoing low mood for last 6 months	<ul style="list-style-type: none"> • referral 	gathering information about client and checking if his condition meets criteria to be referred to the crisis team
day 2	Shift coordinator triages on the phone	person on the phone is triaging the client (determining whether the crisis team referral criteria are met), is getting information about client's current presentation (getting more information about suicidal thoughts, medication mentioned in the referral form, etc) in order to confirm referral information with client's present situation.	<ul style="list-style-type: none"> • referral • phone call 	gathering information about client and checking if his condition meets criteria crisis team; confirming information from the referral, ongoing assessment
day 3	one nurse conducts initial assessment:	<ul style="list-style-type: none"> • client description (what the client looks like), why client accessed services: client lives alone in separation, ex-wife moved out, she is in a new relationship but supports him; client has a daughter 	<ul style="list-style-type: none"> • referral • phone call • initial assessment 	<ul style="list-style-type: none"> • the ongoing emergence of information, • risk is assessed based on markers arising from different sources

		<p>who lives with the mother; client was 6 months in the USA to support his father (the client's mother died 19 years ago); on the return client crashed his car in an accident; is in a very low mood (medication prescribed by the GP doesn't seem to help him); no allergies; no physical exercise;</p> <ul style="list-style-type: none"> • client's family history: no mental health issues within the family (no suicides); born in the USA, father worked in the air force and lives in the USA; mother died, client left the USA when was 5 years old; left school when was 15 years old, was working as a trainee chef; has started last job 18th months ago but anxiety has started so had to leave this job; no concentration, no motivation • no sexual, physical, emotional abuse • employment status: not working, isn't receiving any benefits • no forensic history, no convictions with the police • no safeguarding issue • daily living: no cooking, no cleaning, loss of motivation, house is very neglected • not taking drugs, not drinking • personal hygiene very poor • mental state examination: poor eye contact, tearful, low mood, neglecting care, his mood fluctuates, is hearing voices (New Risk Marker 1- NRM1) 	<ul style="list-style-type: none"> • STORM⁴ assessment 	<ul style="list-style-type: none"> • New Risk Markers (NRM) changed risk understanding: <ul style="list-style-type: none"> -NRM1 – hearing voices as a high suicidal risk marker -NRM2 – passing the medicine on to the crisis team worker by the client shows that the risk of overdose (as stated in the referral form) is low -NRM3 – financial problems as a risk marker escalating client's mental problems -NRM4 – ineffective medication as a risk marker; reveals that the current medication doesn't work and that the client needs to get a different one Client might need an ongoing care and might be open to the 3-8 IPU⁵
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⁴ STORM (Skills Training On Risk Management) - skills based training in risk assessment and safety planning to frontline staff and members of the community (c.f. Mental Health Partnership).

⁵ 3-8IPU – “provides a community age independent service for individuals who are grouped in the 3-8 cluster – non psychotic. Cluster 3-8 includes moderate to severe problems including depressed mood, anxiety, OCD [obsessive compulsive disorder] or other disorder not including psychosis”. (Barnes, 2014:15)

		<ul style="list-style-type: none"> • capacity: understands what is asked for, aware of his suicidal thoughts, client has capacity of deciding about his treatment • cognition problems • regarding delusion and suicidal thoughts: suicidal thoughts of taking overdose • risk assessment (assessing client's current situation): risk from others - no, risk to self - yes, risk to others - no, risk of neglect - yes, risk to children - no--> this is here and now, what we've seen at the assessment, physical complications yes (back pain), protective factors: daughter, ex-wife, engaged with the team, no safeguarding required in this case • STORM assessment - confirms client's suicidal thoughts • during the assessment the nurse noticed anti-psychotic medicines in the client home; all the medication were immediately given to the nurse (this medicine belonged to the client ex-wife who was struggling in the past with mental health problems); the client doesn't want to take an overdose (NRM2) • money troubles, financial problems, house has been sold, client is uninsured, will have to leave the property soon; (NRM3) • client is on a medication prescribed by the GP, however assessment shows that the client is still in low mood, without motivation to live, mentally unstable (NRM4) <p>assigned to a care cluster:</p> <ul style="list-style-type: none"> • 5-non psychotic disorder, low in mood but not depressed 		
	Short term treatment plan put in place by a nurse	<p>treatment plan for the next week:</p> <ul style="list-style-type: none"> • 2, 3 visits per week (every other day) 		The care plan for the next few weeks is based on available information and

		<ul style="list-style-type: none"> • request for medical review and changing medication • contacting advocacy for ongoing support with financial problems 		risk markers which unfold processually.
	Long term treatment plan put in place by a nurse	<p>plan for long term client support:</p> <ul style="list-style-type: none"> • referring the client to MIND, or/and keeping the client open for a day hospital (depending on changing client's presentation, available resources); • sorting out financial problems 		The care plan in the long term is based on information and risk markers which unfold processually. It might change when new risk markers will be revealed.
day 3	team discussion at the clinical review meeting (a consultant psychiatrist, a clinician trainee, 2 nurses, 2 social workers, one AMHP, two support workers, a clinical support officer).	Fieldnote 3: Peter refers to the team his understanding about client risk (more detailed information is presented above). Dr [...] understanding and focus is on client inaccurate medication, whereas the social worker present at the meeting is looking at the client financial problems.	Ongoing reinterpretation of: <ul style="list-style-type: none"> • referral • phone call initial assessment • STORM assessment • team multiple risk perspectives 	<p>While different pieces of information and risk markers are being revealed, they are open to multiple interpretations; different team members pay specific attention to different aspects of the case:</p> <p>The doctor's focus was on the medical aspects of the client risk presentation, whereas the social worker's interest focused on the client's financial problems. The nurse (assessing the client) understanding about client risk was combined with both colleagues approaches.</p>
day 5	one medical doctor, one support worker - a medical review	The type of a medication, the dose and the frequency of administration was changed; assessment was updated; visits will be every other day	Ongoing reinterpretation of: <ul style="list-style-type: none"> • referral • phone call initial assessment • STORM assessment • team multiple risk perspectives 	Ongoing reassessment

			<ul style="list-style-type: none"> ongoing visits and client assessments information 	
day 7	a nurse	to be confirmed	ongoing assessment	
day 9	to be confirmed next visit	to be confirmed	ongoing assessment	
day 13	to be confirmed next visit	to be confirmed	ongoing assessment	
day 15	to be confirmed next visit	to be confirmed	ongoing assessment	
tbc	to be confirmed next visit	to be confirmed	ongoing assessment	

4.2. Dimension 2: Remaking of Risk

While the risk is continually and emergently apprehended by the team professionals, the actual context of what can be done about the risk is recursively reshaping it. On one hand there is the biological level of risk and its triggers changing over time, which have to be understood. On the other hand, the level of risk is not independent of the availability of resources, coordination with other services, and feasible actions; these context variables, which are also changing over time, can make the risk bigger or smaller. This aspect will be explained in more details in the current subsection.

In order to better understand the second component of a Dynamic Risk Model (Remaking of Risk is in the bottom-right box in Figure 2), we illustrate three key points in which “management resources” are shaping the intensity of the client’s risk in the acute mental health service, which are: systemic problems increasing risk, team capacity and partial response in the system.

The first aspect remaking the risk is **systemic problems**, such as not enough hospital beds or poor coordination with police or ambulance service. Clients in crisis remain open to the services until their mental presentation is settled and their risk (for example of suicide) will be either eliminated or at least decreased.

However, because risk constantly changes, it is not possible to foresee when and how many of the clients open to the crisis team will have to be admitted into a hospital. As explained by an AMHP, when risk increases, when “(...) *the admission is required in the interests of their [clients] health or safety, (...) for the protection of others (...)*” and when “(...) *there are no alternatives and [admitting into a hospital] is the best way of providing the care and treatment that the person needs*” (AMHP 3), there might be no available hospital bed and consequently the risk increases. In these instances, the safety of the person will depend on the crisis team being able to undertake additional sufficient actions in order to manage risk. And again, available options and feasible actions will depend on team capacity and resource availability. Below the nurse explains what actions might be needed when a client cannot be admitted into a hospital:

“Sometimes there are no beds which means we have them, [we have to] manage that person in the community, they may be actively suicidal. I have to then manage that we see them [clients] daily, there will be phone calls every single day, there is lot of back and forth between bed management and ourselves, one o’clock we have tele-conference with all crisis teams, the bed management, [name of team] who are the mental health team in [name of hospital] all working out, who’s got beds, whose has priority, my patient [client] is more risky than yours, I want them in now, its negotiating, behind closed doors there is a lot going on, you can’t just pick them up and put them in there, it is a lot of background we need to do as well, so make sure, that everything is legal and goes smoothly, we don’t want a patient [client] running off onto the streets.” (nurse 10)

Hospital bed shortages cause delays in admitting risky clients who consequently need to be maintained in the community by the crisis team. Such clients often require an allocation of significant personnel resources (who would e.g. pay several visits per day to administer drugs) and maintaining such clients drains the team’s capacity, as well as generating significant risks. A service manager says:

“To my knowledge, that’s never happened where somebody has actually taken their life and they’ve been on the bed waiting list. We have had occasions when we have had people that have taken overdose while being on the bed waiting list, but never completed suicide, but it is a risky business, because you’re saying somebody actually needs to be in a hospital, needs to be in a hospital bed, but we can’t provide one. We’re going to visit you once a day, well if that person hasn’t got family or friends who they could contact, it’s clinically it’s quite a risk to take”. (manager 2)

While maintaining clients who are waiting for hospital bed drains the team’s resources, there is no formal limit for the number of people who could be open to the services. The dynamic risk associated with other clients open to the services implies unpredictable scenarios with extra appointments suddenly needed.

“(...) things might change, things will move very quickly, I can see someone at 10 and left behind and at 11 on the phone and he is suicidal.” (nurse 10)

Meeting these sudden requirements depends on the availability of the crisis team recourses. Sometimes in certain critical situations, risks must be transferred to emergency services. Such decisions depend on urgency of risk and feasibility of crisis team intervention. While the emergency services will act quickly to try to prevent suicide, self-harm, or harm to others, they will not provide the same range and quality of care to a client in crisis as the crisis team. Hence, the crisis team may follow up on such clients, as explained by a nurse:

We are not a blue light response team, we are not like ambulance or police, we have to make that call and judgement there on the phone, on the phone I have got a suicidal patient [client], I might not be able to see him two days because we work on a diary, so we can't just go for them right now, unfortunately, which case I have to make that call of risk, risk to me is high, they will take an overdose, they have a knife and will cut themselves, they have got voices telling them that the next neighbor was doing this (...) So I will phone the police and the ambulance saying (...) we need immediate response, so they would go out and assess situation on behalf, hopefully the patient [client] will be taken to [a hospital], where will be assessed by mental health team over there who will then refer to us to follow up (...). If the patient [client] is not too bad, they can wait, it might be 2 - 3 days before we can see them, then we will go out and assess the situation. (nurse 10)

The crisis team members seek assistance from the local police not only when reporting urgent situations that exceed their instantaneous operational capacity. When the crisis team worker during their home visit sees that there is a high risk of self-harming, risk of harming a family member or when the client has to be taken urgently either to a hospital or to a place of safety against their will in order to be assessed, or when his assessment (or sectioning) has been already done, the police support is necessary. Those with suicidal thoughts, who are aggressive, who do not agree to be taken into a hospital, are unpredictable. Hence, police assistance is needed to safely deliver such clients requiring a quick treatment. However, the police are not always able to act promptly and the risk often increases rapidly while waiting for them. This also aggravates the risk of other clients that are not being seen because the crisis team member is waiting for the blue light service:

“I think the ambulances is a struggle, because the police don't support us that well. Sometimes we ask the police and they ask for too much paperwork. You do the paperwork and they sometimes still don't turn up on time, so you're waiting for the police. So that's a bit of a challenge. The ambulance sometimes, we've got one patient [client] in the community and then there's one patient [client] in a place of safety, and the ambulance is taking their time. You tell them that you're under pressure, you've got another assessment to do, can you give high priority, and quite often they take two to three hours

before you can get that person admitted. So that's a pressure, wasting your time sort of thing. So, I think it would be ideal if we had an ambulance or a police officer, one or two police officers who were dedicated to assist people with our job. And one ambulance that could perhaps give high priority when we say we need somebody on a section. This admission, if they could give high priority, that would save a lot of time." (AMHP 1)

As it is shown in the above quote, as with the police, the delay or lack of ambulance is also an important factor impacting the level of risk. Both services play a vital role in high risk situations and it is often too dangerous for the crisis team professional to stay and wait with the client in their flat, as they do not have the means or training to deal with physical assault, so they need to wait outside. The client instead of receiving an appropriate treatment in a hospital has to remain alone being in acute crisis and nobody knows what is happening while waiting for the ambulance or police.

" (...) I've waited for 4 hours for an ambulance sometimes" (AMHP 4).

The risk of the client will not stay constant; it will change, and will increase if an appropriate treatment is not delivered.

Team capacity is another key component of remaking of risk. When the clients' biological level of risk changes abruptly, availability of a member of the crisis team plays a vital role. Conducting an accurate and objective assessment based on the emerging understanding of risk without being affected by concerns about the client's or one's own safety is an ideal scenario, but does it really exist? A person struggling with their own crisis influences the mental health professional who is dealing with them. The fact that the client is risky and that this risk is elusive, changes continually, and causes circumstances that are unpredictable or not fully controllable when meeting and assessing the client, impacts the mental health professional who is in the same environment. The way in which the client behaves (if they are aggressive, emotionally unstable), and the fast pace of changes in their presentation, causes concerns and pressures that are likely to compromise the assessment. Dealing with clients in crisis and being concerned about their own and the client's risks everyday, struggling with shortage of resources (lack of beds in the hospitals, slow response of blue light services) wears emotional resources, creates sadness, anxiety and fear among some of the crisis team members.

"It's that constant pressure can actually make people not function very well and I think we have had a big period where people have gone off sick, who can't cope with the pressure and the stress and the fast pace of the team. So I think that's the sort of knock on effect and the risk."(manager 2)

Emotional drainage and pessimistic attitude are detrimental to accuracy and efficiency of the assessments undertaken by individual team members and consequently aggravate the risks. In this sense the risk being apprehended by the worker for their own safety or well-being, remakes the level of risk for the client. The fieldnote below highlights how a team member finds himself at risk of failure and risk of breakdown due to stress at work. Because a client's risk is ever changing and it is difficult to predict his reaction, the paramedic's attitude changes from neutral to negative. Gradually the fear dominates other emotions, and the paramedic only expects horrible things from a client in mental crisis.

--- Fieldnote 4---

"Today I'm visiting Street Triage services⁶ (called triage team), which consists of a paramedic, a community psychiatric nurse, and two policemen. My role is to observe the team's daily work, how they triage clients on the street and deal with difficulties. It's 12.30 and we're going to a car park nearby McDonald's in one of the regions of the city. The triage team was called by the local police who were informed of "a weird man" sitting on the internal car park drive. When we arrived, we spotted 4 policemen and two paramedics already present. A policeman reports that it is a black man around 40 years old, who was found sitting on the street, with no documents (there was only a formal letter confirming his asylum from Sudan). The paramedic from the ambulance checked the client for being under the influence of drugs, and the outcome was negative. They further report the client doesn't want to talk, and only repeats that he has to go to London (however his bus ticket is not valid). There is no record in the system about this person. Together with the triage team I am going to the police van where we find a calm man sitting at the back. The paramedic goes immediately to the client and is doing his medical examination. At the same time the nurse tries to ask questions and get some more information about his situation and possible problems. One policeman stays behind the client. The second policeman and I are standing in the van close to the front door. The nurse tries to make contact with the client, patiently repeating the same questions: where is he from, how did he get there, what happened to him etc. The client is very calm. The paramedic examines the client, confirming that there are no concerns about the client's physical health. As time passes, the client looks more tired, he glimpses at me and again he puts his head down. Suddenly his hands are shaking, he becomes more alert, his body is wobbling, and the tone of his voice is stronger. The more questions he's hearing now the more nervous he looks. The paramedic who is the closest to this person is trying to calm him down. Instead, the client raises his voice, looks more aggressive and starts to speak in Arabic (he constantly repeats one phrase which nobody can understand). Suddenly, he jumps of his seat and pushes the paramedic. He goes to the back of the van and tries to open the door. When he cannot get out he starts to jump in the police bus, hitting the walls with his fists, shouting at the paramedic who tries to talk to him now. The policeman decides to take the client to the ambulance where the safety belts will be put onto him. When the client is outside of the police van, he bolts and tries to escape. All the policemen catch him, take to the ambulance, and transport to the safety place where the client will be assessed and triaged to other services.

⁶ Street Triage' "is a generic term used to describe a range of services based on a number of key principles underpinning a joint mental health service and policing approach to crisis care. Street Triage aims to improve outcomes for those people in a mental health crises who come to the attention of the emergency services (...) having an exacerbation of the problems associated with a mental health problem (...). Street Triage services aim to ensure timely access to appropriate care". (Reveruzzi and Pilling, 2016: 13)

On our way back, the paramedic tells me how often these situations happen, how stressful this job is, as nobody knows what the client's reaction will be and how will they be behaving. "It's not only about patient's [client's] risk, it's about our risk too" he says.

--- end of fieldnote---

The unpredictability of a situation in a strange environment and the client's changing behaviour create a stressful workplace and high service demand among team members as illustrated in the following fieldnote:

---Fieldnote 5---

Mark, one of the support workers, very calm at the beginning of our meeting, is telling me a story about one of his clients and suddenly becomes very engaged in our conversation, flush on his cheeks are visible now.

A 20 years old client, without any past history of violence, very thin ("no meat on him"), open to the crisis team, who has been seen the day before, during the current home visit becomes angry. This client categorized by the team members as "of low risk", who so far was calm, open to treatment, "reasonable okay", is now crying, shouting, becoming very nervous and impatient. In his impetuosity this young man is tearing his bed into pieces and is lifting his bed up. Immediately, with a great strength is throwing the bedpost at Mark who is in the same room. Mark is hit in the back of his neck. After that, the same client takes another bedpost which "bounced back probably in total 10 feet, five feet that way, five feet that way" and hit Mark for the second time, but this time in his head. The story finishes with police coming and arresting the aggressive client and Mark's visit at the A&E ward.

In the end Mark says: "you can't 100% know your patients [clients] (...) you don't have control (...)"

---end of fieldnote---

Working for the mental health services, particularly for the crisis team is very demanding. The extensive caseload (approximately 200 clients were open to 40 crisis team professionals in July 2017) has a considerable proportion of unknown clients with unpredictable risks, or clients that are known to have very high risks, including those waiting for bed admission. This requires paying visits to new or risky clients at their homes, both scheduled and urgent, having phone conversations with them, and dealing with their ever changing risk. The continual reassessment of multi-layered risks, the emergent process of understanding somebody's mental problems and elusive risks means that the pace of the service is fast and sometimes a decision about a client's treatment has to be done quickly. This reshapes the risks, as it influences how the professionals will define, understand, and assess. It all together might also lead to the professional's own crisis. The riskworker might suffer because of depression, feeling overwhelmed, tired or sad, holding so much responsibility when assessing and encoding his client's problems so that they become less able to assess and manage the clients. Here a nurse comments about their own experience with depression.

“(…) I looked at my depression, you could have all my family around the bed and when I was at my lowest point that would’ve meant nothing to me, because I just could not cope anymore (…)” (nurse 10).

Another factor that contributes to the remaking of risk listed in the bottom-right box in Figure 2 is **partial response in the system** to mental health issues interwoven with other factors, such as drugs, alcohol or criminality. In case of the first scheduled visit after triage the risk apprehension is only very vague, and even during subsequent visits the emergent and dynamic nature of risk implies that the crisis team professionals do not know what will they encounter in client’s home. Going for an assessment to the client’s place means that unpredictable and unknown circumstances may influence the client and consequently the crisis team worker’s own risk intensity.

“It’s that you’re going into unknown territory, every person is different, and they all have different days. One day they might be good, and the working risk will reflect that, that things are well at the moment, but everything can change. You don’t know what you’re going into, so you’ve got to make an assessment before you even go in the house as to what you might face. Because it might be that they’re having a party, or the area might be a poor area, and you don’t know what’s going on in the street, so you’ve always got to weigh up before you even get out of the car”. (support worker 1)

There are often also risks associated with factors not directly resulting from the mental health condition of the client, but related to other issues, like criminality, alcohol, drug abuse and others. The mental crisis of the client is sometimes only one part of convoluted problems and when helping their clients, mental health professionals have little influence on these other factors. The crisis team can address only the mental health crisis, and also other services that deal with addictions for example, address only one problem at a time. No service addresses problems comprehensively given the range of possible risks. Criminal environments, alcohol and other substance abuse also have a profound influence on the risks of the crisis team members. Friends or other visitors from various backgrounds, including criminals, might be at the home, using drugs, or just hanging around, possessing weapons, and may behave aggressively not liking the crisis team witnessing them. Consequently, a person indicating risky mental presentation being under the influence of drugs or alcohol, will not be treated by the crisis team, but instead sent to other institutions to treat their addiction problem first.

The second dimension of a Dynamic Risk Model shows, that the level of risk is not independent of the circumstances of the service and surroundings that are either

dynamic or unknown or both. These circumstances can increase or decrease the risk. Risk, which is continuously evolving and changing, is affected by available resources, and the ability to use them efficiently. In the case of the mental health crisis team these resources are: staff members, their availability, condition and morale; availability of hospital beds; timely support of other services, above all the ambulance and the police. The actual availability of these resources is recursively reshaping the risk. Another point of consideration is the wider context and the risks that are not directly in the focus of the service, but are convolved with them. They are affecting the ability to use the resources efficiently and safely.

Both emerging apprehension and the remaking of risk unfold and change over time, but are explaining the sources of the risk dynamics here and now, in the short term. One could interpret this time perspective following Kim et al. (2019), as the long present. The future risk trajectory is the third component of our model and it focuses on the risk dynamics in the longer perspective.

4.3. Dimension 3: Evolving Risk Trajectory

“We look at the past that predicts the future to a degree”. (AMHP 6)

While the two dimensions of the Dynamic Risk Model presented so far, Emerging Apprehension and Remaking of Risk, focus on risk and its dynamics in the short term, the third dimension of the Dynamic Risk Model (displayed in the bottom-left box in Figure 2) is the Evolving Risk Trajectory, and it relates to risk dynamics in the long term. Whereas the role of the crisis team is centred around the short-term treatment for people in crisis, where “(...) there was an identified need for urgent intervention by mental health professionals (...)” (Barnes, 2014:1) thinking about the client’s risk in long term is inseparable part of the team work. Whatever the client’s risk is at the present, the crisis team is also concerned about the future risk prognosis.:

“Yeah, as I said, yeah continually thinking of them holistically, what are you going to do to make sure that that individual doesn’t fall into crisis again, to keep them stable in the future.”(social worker 4)

Clients’ risk in the long time horizon is associated with their mental health condition that follows its inherent dynamics. The long term risk trajectory is being driven by the

relapsing nature of clients' mental health, resulting in acute changes, while impingements and recovery handicaps make these relapses more likely and more severe. Acute changes of risk, risk impingements in long term as well as recovery handicaps are the key points constituting the third dimension of the dynamic risk.

Clients of the crisis team are suicidal and have experienced a recent deterioration of their mental health condition, where risk subjected to further **acute changes of risk** is making them unstable. A doctor explains the volatile relapsing acute change of mental health crisis:

“Because again, most of the mental health conditions that we come across, like depression, bi-polar affective disorders, schizophrenia, dementia, delirium, whatever, these are conditions which are relapsing and remedying. So, they do get better, but again, given the right triggers, they can have a relapse. When the relapse happens, crisis happens. They do come back to us.”(doctor 10)

Unpredictable abrupt shifts in clients mental health condition change their risk trajectory towards very high levels. Risk which is subject to such dynamics, is controllable while the client undergoes treatment in the service, however in the long term clients might be coming back to the crisis team. The doctor considers the relapsing nature of mental health problems to be expected and part of the characteristics of the condition the crisis team is addressing:

“But I think it is inevitable, that’s the nature of our job, that we do not discharge people to think that then we have discharged people for good, and they will never come back to the team”. (doctor 10)

Indeed, when crisis team clients are discharged from the service, they typically continue to live their life in similar conditions and circumstances as before and when they deal with their problems unsupported, they often encounter the same pressures that led them to the previous crisis:

“there’s a client whose about to be referred to the day hospital who I saw for a period and they were closed. They came back to us about two years later, similar problems”. (counsellor 1)

Crisis episodes are often related to harmful activities, like alcohol and substance abuse, and other addictions. They may also result from neglect, in particular failure to take medications regularly. People suffering from such issues return to the service unless the support is provided to deal with it.

“(…) we look on our database, we have seen her about, say, one and a half years ago. So, we know what happens and what are the signs. And we went in again, put in an intensive treatment. We had to convince her, work with her very closely to say that, “Look, your medication is important. If you don’t take your

medication you don't stay stable." And then she got better. Now we have discharged her back to the community team." (doctor 10)

On the other hand, clients under the crisis team treatment are particularly vulnerable and any adverse event can tip the scales and cause a relapse. A debt letter, school or university exam, family or relation problems, abuse from partner or parent - are examples of many possible reasons for sudden collapse.

"Crisis can be anything to anyone, anytime, someone could lose their mother and be very strong, and then something could happen to the cat and they will fall apart (...) it depends on that person (...)" (nurse 10)

Events or circumstances that cause a relapse will be different for different clients, but identifying them while the client is open to the service will inform the prognosis for future. Financial problems, being at risk of becoming homeless, or in a toxic relationship are frequent **risk impingements in the long run**. On the other hand, the detrimental effect of risk impingements depends on how robust the individual is to withstand adverse events. Those clients who struggle to see the sense and purpose in life, who do not maintain social relationships, and do not have a job, are especially vulnerable. A nurse considers prognosis for a client:

"I'd also consider whether somebody's isolated, lonely, those kinds of social factors as well. (...) I look for risks of social decline and risks of not intervening as well." (nurse 13)

Relationship disturbances (break up, death of a family member), social integration issues (loneliness, permanent illness impacting quality of life, Parkinson's disease), resilience deficiency in dealing with different situations (lack of job, stressful conditions at work), as well as financial problems or welfare issues, are examples of risk impingements which, if not identified, will in the long term bring a client back into crisis. Having an occupation, job, relationships with family or friends, other social links and activities are all factors that make an individual robust, and constitute protective layers, while lack of them makes the person vulnerable and prone to crisis.

The next vignette provides a story illustrating that being a client of mental health services might become a factor contributing to future mental health collapse. The risk impingements of mental health crisis and relapse may be complex and some clients in the long term could be better off using other services tailored to their problem. The following story of a young man shows how it is perceived by an AMHP

that a personality disorder diagnosis may reinforce challenging behaviours while a different community service could possibly help bring more positive factors to the foreground and reshape his life.

--- Vignette 5---

I found myself in an interview yesterday talking to one of the Approved Mental Health Practitioners (AMHP). I listen to a story of 19-year-old teenager who is spending whole days in his bedroom, playing computer games. He keeps saying that he will kill himself if he doesn't get what he is asking for. This client has been just opened to the crisis team, is going to have an initial assessment today in order to verify to what extent he really wants to commit suicide. The client history and the phone call conversation provide information that this boy experienced domestic violence, was abused emotionally, possibly physically as well. His mum has mental health issues, but not diagnosed, and the parents are divorced. There is a possibility that he will be diagnosed with personality disorder (PD) and will be treated by the crisis team. On the other hand the client is communicative, thoughtful, "intelligent bloke", who is aware of his behaviour and who shows remorse in his voice.

The AMHP explains "(...) and my belief is personality disorder, once you're in that system as a person with personality disorder, you're treated very differently (...) people with personality disorder are seen to be histrionic, or challenging to the service. They might be aggressive, they might be angry, they might be unable to manage those emotions, or they get multiple admissions to hospital because there is self-harming behaviour, threats to self-harm, threats to kill themselves, and it's all in terms of challenging the service (...). If there was a more robust system, I was thinking youth clubs, or agencies that specialise in young people. He is clearly an intelligent bloke, and articulate, but there is no way, he is on the step now, because he's going to have an assessment, and he's coming today, so obviously ... so perhaps it's my fatalism, thinking I'm going to be seeing him in 15 years, or maybe less than that, because the behaviours increase when you don't satiate them, so I do worry". (AMHP 2)

The above excerpt illustrates how the long term risk trajectory of the client is part of the risk perception. The AMHP is trying to understand the client's medical level of risk, is analysing his personal situation pointing out triggers of the client's poor mental presentation. Most importantly this professional sees beyond the client's current presentation here and now, she places the client risk on the long term trajectory, predicting in which circumstances it might go up and when he could be stable and function safely in society. For the crisis team worker labelling this young man with this specific mental health diagnosis, and opening him to the mental health services within the NHS might be considered as a risk factor for future crisis relapse. In contrast, she considers communities outside the crisis team, such as clubs for young people, as more favourable solutions that in the long term would reduce risk and move this client's risk trajectory lower.

--- end of Vignette ---

Just as risk impingements cause repetitive events with detrimental effects, there might be also **recovery handicaps**, that is circumstances that make improvement

difficult. While mental health becomes an increasingly important part of NHS and other public health services in many developed countries, and while society becomes more inclusive, discussing it openly and admitting to mental health problems still remains a taboo. The mere fact of being treated by mental health services may be seen as a stigma and affect the life of an individual:

“Now this lad come over from Taiwan and he was a mature student doing an Engineering PhD. (...) He just couldn’t hack it. He couldn’t do it, you know, cos of his illness. We even phoned his parents and tried to explain to them but they didn’t want that. It was taboo. His illness was taboo and the words ... I’ll always remember the words he said to me. He said, “If I go back home I’ll be in the gutter.” (support worker 6)

Sectioning is a particularly oppressive practice and likely to stigmatize the client, contribute to low self-esteem and have a negative impact on their long term recovery. The impact it would have on the future life and future risk trajectory will depend on the individual circumstances of the client. Young people are likely to be more affected as their personality is not fully developed yet and they are still need to set their life goals and try to achieve them, ideally without the burden of a stigma:

“Mostly to do with risk, really. Our judgement is done by risk. Students, for example, students have got their whole life ahead of them. We wouldn’t want to section them unless it’s absolutely necessary. We would want to support them because stigma is there. We would try not to, if we can help it. Because we are understanding, take everything into consideration. So Mental Health Act is quite an oppressive practice and we would only section somebody if it’s absolutely necessary.” (AMHP 1)

For some professionals sectioning has legal implications, as noticed by an AMHP, a solicitor after sectioning would not be able to continue their career. Undoubtedly this would deprive the client of their self-esteem and their livelihood and would make them very vulnerable in future:

“Well, we do look at the impact on what can happen for that person. Our idea is not to section somebody if we can help it (...). There was a solicitor a while back I had to assess. Because it was a solicitor we didn’t want it to ruin his career by putting him on a section, so we tried to work with the patient [client].” (AMHP 1)

4.4. Summary of the Dynamic Risk Model

Table 5 presents the three dimensions of the Dynamic Risk Model. Each of the dimensions is related to a question about risk that has a temporal character. The

emerging risk apprehension, circumstances remaking the risk, and evolving risk trajectory will all change over time due to their characteristics.

Table (5): Characteristics of the 3 dimensions of the dynamic risk.

Dynamic risk dimensions	Question we will ask:	Characteristics	What is changing?
Emerging Apprehension	What can be understood about the risk?	<ul style="list-style-type: none"> • Multiplicity of risk markers: Risk markers are diverse and are being obtained gradually over time from many different sources • Fragmentation and incompleteness of information: The available information about risk is incomplete. It can be acquired only emergently in a process that happens over time: Risk, its intensity and type, can be recognised only gradually as contact with client is made during triage, and the client is regularly seen during treatment. Not all information may be accurate. Subject to multiple perspectives: there are many facets and aspects of risk. Risk assessment requires combining interpretations of multidisciplinary team members. <p>example: risk is unknown because there is little information; when information becomes available, risk apprehension will start emerging; new pieces of information and new events will change the risk perception.</p>	risk perception: available information, understanding and interpretation of the available information is dynamic;
Remaking of Risk	What can be done about the risk with available resources?	<ul style="list-style-type: none"> • Systemic problems increasing risk: beds availability, police and ambulance coordination • Team capacity: what resources are available to maintain client at risk? stressful work, overstretched caseload imply shortage of resources • Partial response in the system to drug, alcohol, criminality <p>example: - there are no beds available, so the client cannot be taken to a hospital; - if the team is overstretched, there are too many clients to see and options of how to mitigate risk are limited, making risk more acute; therefore the risk management is affected: another client with high risk of suicide won't be seen today.</p>	Availability and motivation of riskworkers; availability of related services; levels of other risks that are related but not within the remit of the service

Evolving Risk Trajectory	How the risk may evolve over time?	<p>Risk is ever changing according to the position on the long-term trajectory of risk evolution. Risks are associated with certain underlying phenomena. Future risk trajectory is driven by:</p> <ul style="list-style-type: none"> • The relapsing nature of risk, • Risk impingements in long term • Recovery handicaps <p>example: if a client is socially neglected, doesn't have friends, is alone, then their long term risk evolution is likely to deteriorate</p>	Biological level of risk
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All three dimensions of the Dynamic Risk Model have temporal character. They inform how the crisis team professionals are conceptualising the dynamics of risk that they encounter. The dimensions of the Dynamic Risk Model allow to systematically understand ambiguity, change, and urgency inherent to the risk managed by the crisis team. This urgency is imposed onto the riskworkers who have to react: action on risk efficiently and on time to prevent risks from realizing.

In the following section we are going to analyse the risk practices of the team, what do the riskworkers do in their situationally-specific every day encounters with dynamic risk, how do they deal with risk dynamics, emergent character and ambiguity and how do they make decisions and deliver actions in the context of the Dynamic Risk Model.

CHAPTER 5

ANALYSIS

Riskwork in the Dynamic Risk Model

In the previous chapter we were concerned with the question: how do members of the crisis team perceive acute risk in mental health services? Our particular focus was that the risk they encounter changes from hour to hour, and from day to day, and cannot be determined accurately and confidently a priori or on first contact with their client. Such risks are unpredictable in the sense that they cannot be scrutinized through historical data by analytical methods. Instead, the ever changing risk is emerging and unfolding gradually while the dangers are immediate and dramatic. Hence, we aimed to answer the question: what is the nature of that risk and how can it be described systematically? To this end we elicited the Dynamic Risk Model from clients' dynamic risk encountered by the crisis team. It informs that dynamic risk is composed of three dimensions: the Emerging Apprehension, Remaking of Risk and Evolving Risk Trajectory.

In this chapter, we focus on the team's day-to-day riskwork that is, what the team does to mitigate this dynamic risk in real time, as it unfolds. We use the notion of riskwork as conceptualized by Horlick-Jones (2005), and comprising the whole of 'situationally-specific risk-related practices' that take place in encounters with risk at different levels and may involve a variety of forms and efforts (Hutter 2005; Hutter and Power 2005; Labelle and Rouleau 2016). The Dynamic Risk Model developed in the previous chapter reveals the three dimensions of risk characteristics that differ in their nature and that are changing in both short and long term. Hence, the question we pose in this chapter is: What are the practices through which the crisis team recognizes the risk in real time and responds to it? And in what way are these practices situationally-specific and shaped by the dynamic nature of risk? We identify four practices that constitute the team's comprehensive riskwork summarized in Table 6. These are (1) *Interpreting and Reinterpreting* that relates to the question how can the

team members figure out the current status of risk? (2) *Corroborating* that relates to how do the team members know they are doing the right thing? (3) *Securing Efficacy* that relates to how do the team members respond and remain responsive to risk? and finally (4) *Counterbalancing* that relates to how can the team members prevent relapse of crisis?

Table (6): Characteristics of the risk practices.

	(Re)Interpreting	Corroborating	Securing Efficacy	Counterbalancing
Question it relates to:	How can we figure out the current status of risk?	How do we know we are doing the right thing?	How do we respond and remain responsive to risk?	How can we prevent relapse of crisis?
Practice composed of:	<ul style="list-style-type: none"> • Evaluating multiplicity of risk markers • Facilitating emergence of relevant information • Revisiting and reinterpreting information and risk markers 	<ul style="list-style-type: none"> • Considering multiple interpretations • Seeking critical distance • Consulting on pivotal junctures 	<ul style="list-style-type: none"> • Accommodating risk and its scale • Meeting team capacity in day-to-day work • Relieving overload 	<ul style="list-style-type: none"> • Stimulating social relationships and reintegration • Stabilizing and developing protective layers
Practice catalysts: facilitators (F) and motivators (M):	<ul style="list-style-type: none"> • Subjective feelings (F) • Reading emotions (F) • Embodied sensory perception (F) • Basis for action in view of presumptive risk urgency (M) 	<ul style="list-style-type: none"> • Collectivity (F) • Trust (F) • Empowerment (M) • Risk sharing (M) 	<ul style="list-style-type: none"> • Compliance to risk dynamics (F) • Mindfulness towards colleagues (F) • Professional and personal support for the team members (M) • Sustaining morale (M) 	<ul style="list-style-type: none"> • Holistic approach (F) • Mindfulness towards clients (F) • Humanity (M) • Universality: this could be anyone (M)
Objective: What is this practice for?	Understanding what is the risk, how big is the risk and what causes the risk.	Confirming how and when to act.	Being responsive and sustaining responsiveness to risk.	Sustaining stability beyond the treatment time of the crisis team.

We identify and examine riskwork comprising the four practices enacted by the crisis team and conclude each section with an analytic summary. For each of the practices we pinpoint the question it relates to and the objective it is aimed at. These questions and objectives result from or are intensified by the dimensions of the dynamic risk. We also identify bundles of activities that constitute the key components

of the practice. In addition, we describe practice catalysts, that is to say the factors that either facilitate or motivate enacting the practice. A concise summary of these findings is in Table 6, whereas the supporting coding structure with categories and first order themes is presented in the methodology chapter 3 in Table 3.

In the dynamic risk context, the notion of time plays the key role in the day-to-day work of the service and we bring it to the foreground in each section to prepare ground for the discussion, where we elicit and analyze the time coordination between the practices and the risk.

5.1. The practice of Interpreting and Reinterpreting.

The first practice identified is that of initially interpreting and then continually reinterpreting the nature of risk. The risk associated with suicidal clients in acute crisis is characterized by little and vague understanding of the new client's situation. When information about the client is emerging gradually over time, from the referral, from the first contact, and then during treatment, it appears fragmented, incomplete, and often inaccurate or convoluted. Moreover, risk is characterized by multiplicity of risk markers, and is often reshaped by acute changes in the client's condition that may occur at any time. Such risk can neither be predicted in advance, nor understood and assessed on the spot, when meeting the client. As decision making and action can be only based on what is understood, this hinders accurate response that needs to be timely and tailored to specific circumstances of every individual client. As one of the AMHPs puts it:

"So risk by itself is meaningless really, it's the ability to assess the risk, and to respond to the risk in the appropriate way [that matters]." (AMHP 2)

The fundamental objective of the practice of Interpreting and Reinterpreting is to deal with this complication and allow the team to make an ongoing assessment about the nature of this elusive dynamic risk. The objective of this practice corresponds to understanding what is the risk, how big is the risk and what causes the risk. It is motivated by risk urgency: prevention of suicide and other harm that may happen shortly. The most acute cases and the clients whose condition deteriorates while in

service must be identified quickly and supported with adequate actions to prevent realization of their risks, above all, suicides. Therefore, the key question that the team members are constantly addressing regarding their client is “how can we figure out the current status of risk?”

Capturing the elusive and dynamic risk necessitates a complex practice in which time plays a central role, a practice that looks at multiplicity of sources, facilitates more information and allows for continual reassessment of the case. Uncovering and **evaluating the multiplicity of risk markers** is the initial step taken by the team in understanding the emerging apprehension of risk. The risk markers cover a wide range of indicators, such as client history, current presentation, family context, and forensic history, among others. Different risk markers indicate different things about the risk and team professionals are paying attention to many of them to try to interpret the case. For example, for the essential question of how suicidal a client is, the team members are looking for some characteristic risk markers:

“Has that person [client] had suicidal thoughts for a long time, how often? Have they considered any ways in which they may end their life? Have they done it before (...) So you might ask them is there any member of your family with a major mental illness? Has there ever been a suicide in your family and I would look at all of those indicators.” (nurse 13)

Risk markers are being collected gradually from different sources, such as medical records, referrals, conversations, whenever contact with client is made or whenever new information arrives. However, understanding risk of the clients involves more than just evaluating the risk markers, not to mention that the key characteristics are often hidden intentionally by the clients, or their relatives, or unintentionally by their complex stories and situations. When enacting the practice of Interpreting and Reinterpreting the client, the crisis team members rely on their rich experience. Knowing how to customize their actions and what to pay attention to in their situated assessment is one of their competences that help quickly navigate the maze. Here a social worker describes how approaching the client’s house may give clues that help recognize the situation:

“(...) you would notice perhaps how the front of the house is. Is the door left open? Is it unlocked? Is it secure? You know are the windows wide open, is it appropriate, you know, what's in the window, these sorts of things. In terms of perhaps building a picture of neglect for instance. Yes, is the door open, is the person able to keep themselves safe from people just entering, can you just enter the house, those sorts of things.” (AMHP 4)

The crisis team is thinking about understanding their client's elusive risk emergently and in real time. Interpreting and Reinterpreting takes place as time progresses, as information about client is gradually collected, and as they engage with the client and link with their way of thinking.

"You get to read people, you become like a human watcher." (nurse 10)

Typically, insight into the urgency of the case involves relations around the client and mechanics of the risk that are not directly observable. Recognizing them may involve delicate matters, such as trauma, insecurities, family and relationships, substance abuse, addictions or offence against the law. Therefore, understanding crisis is often about understanding relationality of the person, their situation and their feelings.

"Like there was one [case] yesterday that my instinct is, for example, that she has allegedly made threats to kill her family, she has shouted at them, she's been aggressive with them. She's been on medication, she looks like she's taking her medication, but the family are saying they don't want her there, because of this aggression, because of the threats. But also, what we know in terms of when we are looking at stuff, the brother owns the house, he wants her out of the house, his wife's pregnant so they're going to need a bedroom. This is a 47 years old Asian woman who's not likely to be married now, she works as a cleaner for two hours a day, and that's her life, and that's what she does. She doesn't seem to mind it at all, she's not wanting to get any further qualifications, and it's just her existence, but the older she's getting the more unattractive she is to have in your house. They recorded her as well, when she was making these threats, but when you look behind the recording it was done when her parents weren't there, and her parents would never have tolerated that. So, we don't know whether there's some family dynamic, some manipulation going on, and so they're requesting really, ultimately, an admission, or the son is. But the parents, who also live with the family, are saying that she is as she normally is, so it's a difficult one really. Threats to kill are quite serious on the face of it, but people interpret (...) people say all the time I could kill you, but it doesn't mean anything. So somehow in that intervention we've got to gather what it actually means." (AMHP 2)

However, understanding the client's situation is not straightforward because the service clients are usually withdrawn and vulnerable individuals. Engaging with the client, knowing how to make them feel at ease and how to initiate and facilitate a candid conversation that would move on to important matters quickly, is one of the tacit contextual abilities that the team members rely on:

"You might see something or an ornament and say, "Oh, you've been to so and so", and they'll say, "Yes", and they'll tell you the story about it and they open to you, I think, because you're interested in the person as well, not their illness. So, I think people like that because you just don't want to keep saying, "What's your thoughts like? What's your sleep like?" There is the whole person instead." (support worker 5)

As the support worker explains, questioning clients persistently would lead to only partial learning about the risk. **Facilitating emergence of relevant information** involves knowing how to build quickly a tailored relationship and trust with the client and the team members routinely engage in this in their daily work. The ability to understand emotions of people in mental health crisis is acquired with work experience through situated learning from peers. The team members are sometimes armed also with first-hand experience of personal or family mental health history, as one of the nurses reveals:

“I had family members as well who have been poorly, so my ex father in law had dementia, he went through inpatient service, so I worked for a bit that, my little boy was not very well, he has been often through to CAMHS [Children Adolescence Mental Health Services], I have suffered depression myself in the past, so I had personal experience what is like to be depressed, not very good coping strategies, but I learned how to manage it and through medication and taking therapies, got to where I needed to be (...) then I met my wife and (...) I have now got support in my life which is my wife, she gives me that kick and support I need, she is a mental health nurse as well, so we work together”. (nurse 12)

Subjective feelings that involve reading emotions, sensory perception and other tacit and contextual ways of engaging with clients and interpreting their mental state constitute the core of the practice that is essential in recognizing risk levels and urgency of the elusive risk. Gut feeling based on such elements as client’s body language or integrity is often the first signal of impending danger before it can be verbalized or confirmed otherwise. The team members engage with their clients, internalize the way they think and describe their feelings, to make best possible subjective assessments. They rely on impressions of perceived coherence and their own instinct to interpret the case, as one of the medical doctors on the team describes:

“Mental state examination sometimes is a lot of subjective feelings; it’s not always objective questioning. It’s a lot of subjective. So it’s the body language of the patient [client], the patient’s [client’s] way of commenting on other things.” (doctor 10)

In many cases these indirect observations and subjective judgments are at the heart of the Interpreting and Reinterpreting practice, in particular giving insight into immediacy, and contribute more to the assessment than what the client is willing to reveal or what their medical documentation is saying. Similarly, structured risk assessment through forms and evaluations is often secondary to the perception of urgency when things “do not seem right”. The following excerpt illustrates how a nurse is unmasking risk:

“(...) but you have told me this time you have got no thoughts or plans or intent to end your life in any way, but there are tell-tale signs (...) what they are telling me is not what their body language is saying (...) they have been low for weeks then suddenly they’ve got food in, the house is tidy (...) have spoken to their mum they haven’t spoken to in months (...) their will is in place, they are ready to leave this life with everything sorted out (...) that’s too much, too quick (...)” (nurse 10).

Timing is an inherent part of the Interpreting and Reinterpreting practice and is dictated by urgency and by the need of having the ability to take appropriate action. If the crisis team member has a doubt or a thought about a client, they cannot leave this doubt for later because “things can happen”. Doubts must be addressed, the client’s situation and risk reinterpreted and reassessed (**revisiting and reassessing information and risk markers**) to decide if action needs to be taken, or a tighter schedule of monitoring and treatment needs to be put in place.

“Sometimes people, they leave you as well, with a feeling of what they’re going to do; sometimes it’s unsaid. You can go on, you can have a visit, you can be quite chatty and then at the very end, you say, “I’ll give you a call when I go back and arrange your next visit.” “That’s if I’m going to be here the next time.” (support worker 5)

The concept of continual reassessment is well established among the team members. Because clients in crisis are vulnerable and unstable, the risk levels may be changing gradually or abruptly, and the team’s day-to-day work is aimed at being alert and recognizing such changes as soon as possible. Sudden changes in the client’s risk are to be expected and they may be triggered by the factors in the client’s environment, influenced by family members or other disturbing events in their complicated lives.

“That’s what I mean by risk continual assessment, because of the unpredictability of the people we work with. And sometimes it’s not the people we work with, it’s their family, you know.” [AMHP 5]

The members of the crisis team anticipate and interpret not only the sudden changes triggered by events that aggravate the mental health crisis, but also those due to the inherent dynamic character of the condition and the treatment. Timing of visits, conversations with the clients, and all other actions are key for Interpreting and Reinterpreting to be as accurate as possible. Since the risk markers and relational understanding of the client are being revealed gradually and change over time, the crisis team needs to anticipate the pace of this evolution and synchronize their actions with the perceived dynamics of the risk they address in order to facilitate timely decision making, information flow, update of the emergent perception of the client’s risk and any other actions desirable or necessary at the current stage. Each time the

current assessment of risks needs to be revised and dynamics monitored, as a nurse explains:

“Risk indicators, what is going on, suicidal thoughts, plans, intents, these all are indicators, in two weeks, every time when we see that person we ask the same set of questions, so in two weeks time, their sleeps has gone from no sleep at night to up to 2 hours, their appetites increased slightly, they’re still having thoughts of suicide, but they’ve got no plans, they might have oh you have had a shower, the house looks a little bit tidier, there is food in the fridge, there is little bits and pieces that are more positive, they are making steps towards, they’ve made a phone call, the advocacy has come in, their debts have come down.” (nurse 10)

The type and intensity of risk practices of the crisis team are being flexibly adjusted to the circumstances. An important aspect of this strategy is to adjust frequency and means of contact so that enough information is being obtained about the client and that this information is revised and reevaluated as frequently as required. Uncertainty about risk dynamics may result from many factors, such as insufficient information about the client and insufficient understanding of their situation or subjective feeling that “something is not right”. This inclusive framework dictates further, more frequent contact with the client, phone calls, additional home visits and other tailored responses to the situation.

Analytical summary: the practice of Interpreting and Reinterpreting

The objective of the practice of Interpreting and Reinterpreting is to figure out the current status of risk and its urgency, so that appropriate action can be taken and the elusive dynamic risk can be managed in real time. This amounts to understanding what is the risk, how big is the risk and what causes the risk.

The practice is based on the tacit contextual knowledge of the team members, on their knowledgeability of action (Orlikowski, 2002). The crisis team members engage with their clients, facilitate candid relations, follow their way of thinking and viewing their problem, use their embodied sensory perception, read emotions and make subjective assessments under the pressure of urgency of risks. This is because risk markers that are being collected, and that inform about risk more directly, are becoming available only gradually over time, are multiple, often missing, or inaccurate and in view of risk urgency cannot constitute the only ground for assessment.

The practice of Interpreting and Reinterpreting is enacted continually as the dynamic risk evolves over time or may change abruptly. The practice is timed as circumstances dictate so that appropriate flow of information is ensured. The actions

are synchronized with the perceived dynamics of the risk they address in order to facilitate timely decision making, information flow and update of the emergent perception of client's risk.

5.2. The practice of Corroborating.

The crux of managing dynamic risk is to take adequate action at the right time. However, how do the team members know when and in what way to act if the risk is elusive, dynamic, subject to abrupt changes, and can realize at any time? And how can the crisis team members have confidence in their actions and timing, when the client's life may be at stake? The practice of Corroborating corresponds to the question "how do we know we are doing the right thing?" Its main objective is confirming how and when to act, an issue that is omnipresent in the context of dynamic risk. The practice plays a particular role in the relationality between the professionals. Enacting this practice is pivotal for the team: Corroborating has an effect of empowering the individuals to take action, it induces risk sharing and removes blame if risk realizes.

One of the key situations when the Corroborating practice is essential is to support pivotal junctures. There are scenarios when risk goes up dramatically and action to mitigate it needs to be taken immediately. For example, such scenarios include when something goes wrong during a visit and the member of the crisis team, the client, or some other person is in direct danger; when a client has attempted suicide; or when the client appears so suicidal that they cannot be left alone. Such situations occur regularly, and the involved member of the crisis team witnesses the risk materializing and is sometimes in direct danger. Being close to risk, acting under emotional pressure or stress and in urgency, is a factor that additionally hinders making the best possible decisions. Given the gravity of possible outcomes and the anxiety this can induce, individuals own fears or past experiences may become integrated into their assessment of risk. In such moments **considering multiple interpretations** between different team members is vital, it provides an additional perspective obtained from someone who is not directly at risk and maintains critical distance. Below a social worker gives an example of how they seek advice from a colleague when in a

potentially dangerous situation. Note how the social worker trusts the advice given by a colleague and this gives them the confidence and empowers them to do what has been agreed.

If I am at any point unsure of the assessment, or how the assessment is going, or the risk, like say somebody is really high risk, I would be totally honest with that individual and would tell him: listen I need to seek some advice, so what I am going to do is to go to my car, I am going to ring a doctor from the team, or I am going to ring the duty worker just seek some advice what needs to happen next, etc. and then I would follow that. I would probably problem solve with my colleagues initially yes rather then go straight to the ambulance, because, if it is purely mental health related, it's wasting ambulance resources, they could be out doing something much more needed, whereas I have the options either of coming back or contacting somebody on the phone to seek for more advice. (social worker 3)

The crisis team deals with extreme risks and it is unavoidable that these risks will materialise occasionally. In such situations blame is a very delicate aspect and may detrimentally affect the team spirit, morale and engagement of the professionals. In today's highly bureaucratic health services avoiding blame culture and protecting the team from blame culture is one of the key aspects for sustainability of high-level service provision. Through the Corroboration practice, the team shares the risk and prevents occurrence of blame. Consulting and confirming with colleagues about what to do when risks become intense, not only empowers them to act, but also provides moral support and reassures that the right decisions and actions have been taken, as explained by a nurse and by an AMHP:

"I'm just talking to my colleagues about different patients [clients], (...) there have been nights where I have been a bit restless, (...) because of what they [clients] have said. (...); I will tell my colleagues about A, B, C, they go [and say]: "well you've done A, B, C there is no D. You have done everything you can, you can't do anything else, that you have done (...) [and it] gives me yeah you've done everything. (nurse 13)

"we share the risk. I don't deal with any patients [clients] in isolation." (AMHP 5)

Another example of a pivotal juncture, and one of the most important decisions that the crisis team need to make urgently in high risk cases, is whether to section a client. Sectioning a client is a commonly used phrase that means taking action to institutionalize a client against their will under the Mental Health Act 1983, when he or she is a danger to themselves or others. Here the practice of Corroboration is enacted in a more formalized way. In order to coerce the client into institutional custody, they need to be deemed 'unfit to make decisions for themselves' as outlined in the Mental Health Act. Specially trained social workers in the team, called AMHPs (Approved Mental Health Professionals), trained to implement the Mental Health Act, have

formal decision making power regarding grounds to section a client. AMHPs hold responsibility for organizing, coordinating and contributing to this decision. This is a pivotal role in the team, undertaken after consultation with two doctors (**consulting on pivotal junctures**). Hence, to make such a decision, an AMHP and two doctors need to connect and synchronize their knowledge and their perspectives on the case. In particular, if any other member of the crisis team believes the client should be detained, they need to ask an AMHP to look into the case:

“I can go to one of the social workers, one with AMHP, Approved Mental Health Practitioner, I feel the need of mental health act on that person, I feel this person needs to be brought to the hospital, so I can phone from the patient’s [client’s] home and bring him now, so it bypasses everyone, hopefully we can get a bed and bring the person straight away to the hospital, if they won’t come in, then we have to get a Mental Health Act set up and then they will be sectioned under the Mental Health Act and then detained and brought in that way (...).” (nurse 10)

“if I was really concerned, psychiatrists and then perhaps an AMHP to ask for, if I was that concerned that this person is going to take their life, I would also ask an AMHP to review under the Mental Health Act, so I would ask for a formal Mental Health Act assessment, and request that it is quite urgent etc.” (social worker 3)

Sectioning is a complex decision and of critical importance, and indeed several key aspects of Corroborating play an important role in the procedure. When the team members request an AMHP to evaluate high risk clients, they are **seeking critical distance** from the AMHP and the involved doctors. Here an AMHP explains their role and different perspectives in sectioning:

“You get the medical perspective from the doctors and your role as an AMHP is to make sure the assessment is balanced, that you bring in a social perspective, you get a feel for who the person is and what’s led to their distress, and what works and what doesn’t, so I suppose you’re more in touch with the humanistic side”. (social worker 1)

However, as noticed by the management there are differences between how nurses and social workers interpret the situations when the Mental Health Act should be applied. The nurses are primarily concerned with ‘here and now’, that is, with preventing the client from harming themselves, while the social workers are willing to accept a far greater risk:

“(...) there’s quite often discussions around when nurses take a call, and they may consider somebody needs a Mental Health Act assessment, they may need to be detained against their will, but our social workers feel that isn’t necessary and they don’t think the risk is quite as great and they make suggestions around not doing a Mental Health Act assessment, but just going out to see them in the community (...). Social workers I think, (...) they often feel that people have a right to make decisions, not necessarily take their lives, but they seem to feel that a much greater risk could be managed by the nurses (...).” (manager 1)

When discussing individual cases, these two standpoints need to be synchronized and the team is using their collective knowledge to make the best possible decisions. The rationale behind reluctance to detain clients is that it adds stigma and is likely to have a negative impact on their future life. This illustrates how in the practice of Corroborating the team members are reopening the case for Interpreting and Reinterpreting and how in their collective decision making, the team considers multiple interpretations of the dynamic risk. Precisely, in this pivotal juncture of sectioning a client, the riskworkers coordinate their view how the current risk levels should be balanced against the risk of stigma and loss of self-esteem, the long term consequences of sectioning that affect mental health recovery. An AMHP explains it also with relation to their orientation of value, such as the liberty of a client, and the right to decide for themselves:

“As a social worker and an AMHP, one of our primary responsibilities is to be aware of the risks of admitting people to hospital and the potential damaging effects of that on people. And the importance of looking at alternatives and being aware of what significant powers and restriction on somebody’s liberty that we are imposing on people when we section them. And therefore, we’ve got a very clear responsibility to only use that as a last resort if it’s absolutely necessary and in the person’s interest, and that it’s justifiable (...).” (AMHP 3)

The crisis team members are seeking critical distance in a variety of situations, not only under urgency of extreme risk pressures. The dynamic risk can become entangled with the individual seeking to apprehend it and the professionals become aware that being close to the client, being engaged in their story and their way of thinking affects the ability to assess the risk. Therefore, those who are further from the subject may see things differently from those who are close to it. Crisis team members are aware risk assessments are requiring critical distance in order not to be biased by personal or emotional perspectives ‘in the anxiety of the moment’, and they are seeking to obtain such a critical perspective from their colleagues not directly engaged in the particular case. Obtaining critical distance from colleagues helps reopening and reinterpreting the risk and reaching a more complete assessment. Therefore, a doctor will often ask another team member for their perspective:

“I certainly prefer a collaborative approach, and certainly in this team (...) it’s good to have an objective view point, and take yourself away from being directly involved in that situation, having a discussion with another team member who might give you suggestions that makes you reconsider things that aren’t directly influenced by the anxiety of that moment.” [doctor 9]

Consulting colleagues not engaged in the particular case and seeking their opinion is facilitated by collectivity and trust between the team members. It also allows offload the weight of a decision, finding reassurance that the action plans are appropriate; thus it empowers the team professionals to go ahead with an action or a decision.

“And I think as a medic, and because we’re not seeing every patient [client], you don’t have that intimate question with every patient [client] and you’ve not been subject to that dynamic from every patient [client], so when a member of staff wants to talk to you about a patient [client], you’re the person that they go to, to offload onto and to get the objective viewpoint.” (doctor 5)

In some problematic cases, when high levels of risk or difficulties with interpreting the client’s presentation are expected, joint client visits are arranged. Visits in twos facilitate multiple interpretations; synchronising knowledge, and confirming the appropriate action plan for the client.

Client’s family members may be a help or a handicap in team’s riskwork. A strong negative impact is not uncommon and it may take various forms, such as destabilizing the client, obstructing meetings with the crisis team, or threatening the team with complaints and legal consequences. In such cases the team needs to adapt its conduct strategy to ensure timely and appropriate care for the client. Discussing the issue and agreeing on a plan empowers the team members and arms them with a strategy to deliver their service. The following fieldnotes illustrate how the team collectively tries to adapt to a difficult relation with the client’s mother and confirms what needs to be done next.

---- Fieldnote 6----

This is a clinical review meeting for clients open to the crisis team. At the meeting, there is a consultant psychiatrist, a clinician trainee, 3 nurses, a social worker, a clinical support officer. One of the clients is being discussed at considerable length. The client (...) with a low mood, suicidal thoughts (he has thoughts of jumping off a bridge) couldn’t be seen by the crisis team, because his mother is causing problems. She didn’t let the team see the client stating that the visit was too late into the evening. A nurse who saw him previously, noted that the mother of the client disturbs each visit. The team couldn’t reach the client either by visiting in person, or by phone, and therefore the following visit couldn’t be arranged. The nurse asked the consultant psychiatrist what the next steps in his case are. The consultant decided to hear an opinion of a manager (the client’s mother said that she will make a formal complaint about the work of the crisis team). When the manager showed up, together with the consultant psychiatrist they decided to call the client’s mother and inform her about possible scenarios of her son’s treatment. At the same time the psychiatrist thought that the medical director should be informed about this case. The manager agreed.

---- end of fieldnote ----

Time structuring of the Corroboration practice is dictated by the urgency of risk and synchronized with its dynamics. Seeking critical distance when risks culminate unexpectedly happens instantly and on the spot. Supporting other pivotal junctures, like sectioning, is also arranged at the earliest convenience. Consulting colleagues about other individual cases takes place as per needs.

However, the Corroboration practice is also enacted within day-to-day regularly scheduled routines that are arranged in patterns of varying frequency. For example, it takes place as part of carrying out the client's schedule of regular treatment visits and updating their supporting notes and documentation. Each client has their lead professional, but different team members will play regular visits, as per availability. After each visit, and also whenever professionals discuss the client's case, a note regarding current assessment will be put on their file. This way different interpretations are being connected and synchronized, as one of the AMHPs explains:

"Today, seeing this young man who was on twice daily home treatment, very underweight, not eating, et cetera, I felt I was making my own assessment, but I was also mindful that colleagues had seen him yesterday and they'd made their assessment, which was different to mine. I was also aware of a conversation I'd had with Dr [name]. He'd looked at the notes and made his assessment of risk. So, I was kind of incorporating all of these different influences, but it felt like it was my assessment, I was seeing this man on my own, but I'd seen him, I'd spoken to his mother, spoken to Dr [name], spoken to [name of an AMHP] and [name of another social worker], who had seen this chap yesterday. I'd read his notes so I'd got perspectives from all sides (...)" (AMHP 3)

In addition, the crisis team holds a number of meeting series with a more rigid schedule that ensure regular enactment of the practice of Corroborating. Those more urgent clients of the day, whose risk changes from hour-to-hour, are discussed at the handovers that are held twice a day. Once a week there is a clinical review meeting, where representatives of all professions on the team will be present to discuss the client caseload. Each client will be discussed on weekly basis and the meeting facilitates reopening the case, reinterpreting it in view of what has happened and the unfolding understanding, exchanging different perspectives resulting from varied backgrounds and levels of engagement in the case, and finally agreeing on the current action plan for the client. The work of the clinical review meeting is characterized in the following fieldnote.

--- Fieldnote 7----

This is my 8th visit at the clinical review meeting. Every week I meet different people who all together discuss each client open to the services. Cases are being displayed on a big screen. These meetings are arranged formally, but are conducted in an informal way. Everyone is very welcome to give their

feedback about the client's presentation, everyone's emergent understanding about client risk is important to making conclusions and people expect to hear what others think about the case in question. Those meetings last between 2 and 4 hours. Dr [name] is always present and the rest of the team varies. People have a rota for coming to the clinical review meeting, in order to always have at least one person representing each professional group, however everyone is always very welcome to pop in at any time.

---end of the fieldnote---

One of the issues discussed regularly and at length at the clinical review meetings are clients who should be in hospital due to their mental state condition, but are maintained by the crisis team in the community due to hospital bed shortages. Such clients draw the team's attention at the meetings as they often require an allocation of significant personnel resources (e.g. pay several visits per day to administer drugs) and drain the team's capacity, as well as generating significant risks. The fieldnote below reports on such a discussion where the client has been put on the hospital bed waiting list by another service, namely an Early Intervention Team (EIT), and hence also a representative from the EIT participates at the meeting.

----Fieldnote 8 ----

This is a clinical review meeting for clients open to the crisis team and to other communities. At the meeting, there is a consultant psychiatrist, a clinician trainee, 3 nurses, a social worker, a support worker, a clinical support officer and a community representative of an Early Intervention Team [EIT]. A case of a client [...] is being discussed, who has been put by EIT on a bed waiting list for admission to a hospital. Dr [...] reads notes about the client and what was his recent treatment. The social worker from the crisis team talks about increasing medicine for this client up to two times per day instead of once, whereas the EIT worker keeps saying that the client is risky and needs to be admitted to a hospital. Dr [...] decides to wait for another trainee doctor's opinion (he will visit the client in his place this week) before deciding about next steps. He said that he has to make sure that current client's presentation is so risky that the hospital admission is needed. He added that the last assessment of the client was some time ago and he has to be reassessed. Everyone agreed.

----end of fieldnote----

This discussion contrasts the way the crisis team is approaching risk of the client with that of the EIT representative. The EIT staff member was firmly of the opinion that the risk levels were not acceptable and that around the clock hospital treatment was required. However, the medical doctor from the crisis team starts reading the notes about the client and the treatment, hence he reopens the case for reinterpreting and invites others to give their opinions. The social worker appears to think hospital is not required for this client. These two contradicting opinions cannot be synchronised. The doctor then acknowledges the dynamic nature of risk by noticing that the last assessment has been some time ago and the situation could have changed since.

Accounting for this he requests a fresh assessment, hence reopening the case again, for another interpretation that will be up to date.

Analytical summary: the practice of Corroborating

The main objective of the practice of Corroborating is to confirm with other professionals concerning how and when to act in order to manage dynamic risk, and to provide confidence the agreed decisions and actions are the right thing to do given the circumstances.

The practice is based on the collectivity of the crisis team and trust between its members who consult their colleagues about their perspectives on risk in both critical situations and regular risk assessments. When confronted with intense risk in situ, the professionals seek critical distance of their co-workers, who are not engaged in the particular case in question. Furthermore, alternative interpretations of co-workers may also result from differences in training, sensitivity or experience and are synchronized through the practice. When enacting the practice, the team members connect their views, interpretations and knowledges and synchronize them to agree on decisions and actions regarding risk. This sometimes amounts to reopening the client's case and reinterpreting it collectively.

The practice of Corroboration is critical to the team when dealing with pivotal junctures where risks are intense and urgent and consequences may be profound. It empowers the team members with confidence to take actions and make decisions, giving them assurance that they are doing the right thing. It also distributes responsibility for risk across the collective team, offloading the individuals and protecting them from blame.

Time structuring of the practice of Corroborating is synchronized with risk urgency. It is enacted immediately and, on the spot, when dealing with instant risks; performed in the course of treatment visits to clients that are arranged as per needs; and also, at regular team meetings that are scheduled specifically for the purpose of enacting this practice.

5.3. The practice of Securing Efficacy.

Managing risk that is dynamic and subject to abrupt changes requires developing the ability to continually respond and readjust. When a client's condition suddenly deteriorates, appropriate action needs to be taken immediately. When an assessment reveals new aspects that change the understanding of the client's risk, the team's response must be flexibly adjusted to be sufficient. However, who shall respond when the service is running at full capacity and all the team members have tasks scheduled for the following days? Who is willing to go the extra mile today? Tomorrow? Next week? The week after next? The practice of Securing Efficacy is about having the ability to be effective, it relates to the question "how do we respond and remain responsive to risk?" Its main objective is having and sustaining capacity for appropriate action.

The crisis team members perform their day-to-day riskwork in order to mitigate the dynamic risk in real time, as it unfolds. They **accommodate clients' risk and its scale** by interacting with the clients and adapt their doings to the particular case, considering the circumstances, and using their situated knowledge. Every activity is being tailored to the client and risk they encounter. No two home visits, no two phone calls, will be the same, and every plan for dealing with the client's risk will be individually constructed.

"The risk is different in each individual person, and you have to tailor what you do to the individual, not the group." (nurse 10)

It is the understanding of risk and its entanglement that dictates what response is appropriate and what will mitigate risk for the client. The team members are prepared to comply with the risk specifics and risk dynamics. Often when accounting for their interpretation of risk and their judgement of what action is required, they take nonstandard steps, as the nurse further explains:

"A couple of weeks ago I was working with a patient [client] and his wife left him so I went for a marriage breakup (counselling session) with him, two days later his father had passed away, so I went through the death of the father, then his wife came back and then I ended up going to the funeral with him, which is not in my job description, but then in the end I've been through a marriage breakup and a death of a family member with a patient [client] and I'm managing all of this on my own (with the

support of the doctors). But for me that's about keeping him safe. And, well, he collapsed on that day (...)" (nurse 10)

Appropriate response to risk means not only responding to what has been noted or interpreted, but also responding to lack of information. When a new client is admitted to the service, an initial assessment will be arranged. At this point little is understood about the risks and their intensity, and the team members do not know what will they encounter at the client's place. Therefore, two professionals will go together for the first assessment, as explained by an assistant practitioner:

"Probably ninety five percent of my visits I go alone and if I'm honest, I prefer going alone, I just think you get more of a rapport with somebody. If it's initial assessment we will always go with two because we don't know the risk, there'll always be two people." (assistant practitioner 2)

The crisis team constantly operates at its full capacity. There is no limit to how many clients are open to the service and the current organization of mental healthcare within the public system results in a permanent overload of cases. In the day-to-day riskwork, the crisis team follows an approximate schedule of phone calls, visits, assessments, meetings, discussions and follow-ups, but the fluctuating risk reshapes the timing of their work. The team members continuously adapt to the circumstances: prioritize between cases and actions, whom to see next, which action has priority, whom to postpone for another day. In doing so, they organize their schedules flexibly, and aim to target and mitigate the most acute risk, as explained by a doctor and an AMHP:

"Because people are so busy in this team, and they need to prioritise. There's so many patients [clients] to see; they need to know, why do I need to see this patient [client], and ultimately they want to know the risks, because that's the best thing that they can know to prioritise, to balance the pros and cons of seeing one person ahead of another." (doctor 9)

"(...) I did a Mental Health Act assessment on Monday and I'm required to complete an AMHP report, which is a fairly big document with some analysis as to decisions that you've made. That work led to (...) that assessment led to some other work in terms of me trying to make provision for this young man who needs occupation and training, but because I've been pulled in the other direction since then, I haven't been able to do that work." (AMHP 3)

When handling risks that scale rapidly and unexpectedly, sometimes a lot needs to be done quickly to respond appropriately. The practice of Securing Efficacy helps the crisis team to achieve this while **meeting its capacity**. The team members are ready to cover for colleagues who have to prioritize urgent risks over their scheduled jobs, they are willing to swap tasks, clients and other arrangements so that synchronizing actions and prioritizing risks becomes feasible.

“I share the load, I will go in, in the meeting in the morning and say: look, I can sort this, is there anyone who can make a phone call for this [other] person, can we go out and see this person, we’ll have a discussion as a team, and as a team we will manage both of them (...).” (nurse 10)

The sense of teamwork and flexibility is deeply rooted in the team’s day-to-day work and the team members realize it is the only way to deliver the service. Helping out with clients, swapping tasks and prioritizing help in situations of urgency is considered normal conduct rather than an occasional favor, as illustrated by the following vignette.

---Vignette 6---

The clinical review meeting which I attended today is run once a week. All the clients open to the crisis team are discussed by a multidisciplinary team one by one. Each case is displayed on a big central screen to facilitate discussion. Today there was a situation when a nurse who was not scheduled to attend this meeting (Mark), suddenly showed up, in order to discuss one of his clients. Doctor [...] immediately responded to Mark’s request. He found the client’s file, put it on the big screen and started to talk about him. Mark, who had seen this client the day before, was concerned about his high risk of suicide. He wanted to arrange a medical review as quickly as possible because it seemed to him the medication wasn’t working. He knew that firstly the client has to be medically stabilized in order to continue further treatment. Mark looked very engaged in this “intervention”. He was confident and demanded effective action. Dr [...] asked an admin about availability of medical doctors for the next day. At the same time, he asked a junior doctor to book a meeting for tomorrow with this client. As suggested by the rest of the team one support worker will go with the doctor as well to help with the medical clinical review. Mark, satisfied with the plan of action, started asking if any of the social workers could help him contact advocacy for this client as he has financial issues and is in debt. One of the social workers got up and they both left the meeting in order to talk more about the problem.

This above excerpt illustrates flexibility of the team members and how their willingness to make adjustments, in order to help mitigate urgent risk without delay, is an integral part of their conduct. Mark does not hesitate to interrupt the meeting and to request discussing his client. The medical doctor who leads the meeting switches to Mark’s client without any hassle or delay and follows the request to arrange a medical review of the client for the next day. The involved junior doctor and support worker agree immediately to prioritize and meet the client. Further, Mark seeks help of a social worker who specializes in advocacy and finds help immediately. This is the standard course of events in the team: clients with urgent risks are prioritized and there is team effort and synchronization of tasks to respond to this risk immediately and appropriately.

----end of vignette---

Being responsive and handling rapid scaling of risk through prompt tailored actions, requires engagement, and proximity to clients and their contexts. The emotional toll on the members of the crisis team is inevitable and it becomes worse if risk realizes. In the following fieldnote one of the nurses shares a story that happened when she was at the duty desk.

---Fieldnote 9---

Today I'm visiting the duty desk, the place where two nurses are answering calls from clients and taking other referrals. There are 4 desks in this office and a big screen in the middle of it. The screen displays names of all clients open to the service. I'm sitting at one of the free desks and when waiting for an interview with one of the nurses (Caren), I have a chance to observe how busy this office is. Caren is the shift coordinator today, deciding which referral will be accepted to the service. She is making assessments on the phone, without seeing the clients. She looks very confident in her work. Our interview is delayed, due to her many phone conversations.

Finally, she is taking a break and we are moving into another room which is a designated recovery place for the workers. It's the place where one can rest, with a quiet and peaceful atmosphere, with cosy chairs and blinds.

Caren takes a seat. She looks tired, very tired. Now I see a person with less confidence. With some doubts? She starts the conversation:

Caren: "When you're a shift coordinator you're meant to be coordinating the shift. You get loads of phone calls. There's also a to-do list which you have to follow through and you just get loads and loads of phone calls. Sometimes it is never ending and you can't say I've had enough, I don't want another phone call, they keep coming, they keep coming and you're assessing people without having seen them and sometimes I find that very stressful."

Pause

Caren continues: "you have to triage, you have to assess, (...), you just have to manage, but that is a really, really stressful job (...)"

Now I hear a story: "I took a phone call from a person, well it wasn't anybody that was open to us, they were open to the community and she [the client's mother] said that her son was not walking, wasn't talking and hadn't eaten for a couple of weeks and I said that she needed to call an ambulance, she was describing somebody who was physically unwell. He was open to a community team and they were going out the next day [to see the client]. (...) It turned out she did call the ambulance and they didn't take him in. There's a query whether he'd been drinking and he knew then that the team were coming out the next day. He went [the client] to talk with someone with whom he has never been talking before. He left and never came back and three days later, he was found dead. So, when we went to court she was really focused on me and blaming me for everything".

Pause

Caren: "The whole family, they said I killed him because of one phone call. He'd been open for years to the [community] team and they hadn't seen him, but it was me that was responsible. (...) They'd made a complaint it was investigated (...) the Coroner just let the family keep going at me and tell me I'd killed their son (...)"

Caren: "After all I felt completely panic stricken because I was on the desk and I thought I can't do it because it was just so scary and I think my first shift I cried, I just cried all my way through the shift, but I knew I had to do it or I'd never of come back to work" (...), it was my colleagues that supported me".

People within the crisis team are never left alone. A counsellor who works for the team is always accessible for everyone who needs to talk, without a prior booking.

---end of fieldnote---

Relieving overload of the crisis team service, maintaining its responsiveness, ability to react quickly, accurately and confidently to risks, depends on individual co-workers: they need to be engaged, feel empowered and act collectively. However, the story of the nurse exemplifies, that there are situations that can affect the confidence, motivation and performance of the team members, and how important it is in such situations to have a colleague counselor. A continual support from colleagues and conversations with them help to build again confidence, so important when managing other people's risk.

The demanding nature of the work, on both professional and personal level, overloaded schedule and ensuring around the clock coverage of the service are all factors that can be also damaging to morale of the co-workers. The tensions about client flow between the crisis team and other NHS services often increase the workload of the team which impacts the ability to keep good morale and remain responsive:

“(...) the IPU's [community mental health services for milder conditions] are changing, but there has been a lot of gaps that we have noticed in the system, lots of people have been discharged without any long term care, so people are relapsing a lot quicker, which means bringing in to our services (...)” (social worker 3)

“It can have a knock-on effect for things like sickness morale, people getting burnt out, the risk is that as there's more demand on the services, that people then start cutting corners or become very blasé.” (manager 2)

The service remains a robust team in these demanding conditions, maintaining a strong sense of unity. Members of the team understand the need of mutual support as the best way to maintain composure - there is a collective sense of action, that they agree on, and responsibility, that they share in the team.

“We are strong team, we are close team, we all work together, so we all support each other, professionally and personally, we are all nurses again there, can support our colleagues when they have got a problem, never leave the front door without coming in (...)” (nurse 10)

The team members are aware that they will find support in their colleagues and managers and share the emotional burden that they are struggling with. Looking for support and supporting others is part of day-to-day work for the whole team, including the managers. Being aware that everyone on the team is vulnerable under constant pressure, the co-workers are mindful towards their colleagues and are supportive towards each other as this is the only way the service can remain sustainable.

“(...) so sometimes I need to come in here and say to one of my colleagues, it is not good, I am not

coping today, I am really struggling with it, just having someone to sound off to within the team (...) management is really supportive, management knows what is going on, management who can help me do that (...)” (nurse 12)

The management understands indispensability of support and teamwork and the pressures the service is putting on the team and is flexible to help the nurses, social and support workers recover from stressful situations:

“ (...) if I need time off very quickly they are aware what is going on, so they can act on it, and then you aren’t having to explain stuff to them, so it’s just keeping them informed, little huddles occasionally, go have a coffee with a manager, just catch up upon things, just touch base, how things are going here, any problems, things like that (...)” (nurse 10)

To maintain the morale of the team and run a sustainable service, the management takes an individual approach to every team member to release pressures and case overload when necessary:

“Sometimes they’ll approach me and we’ll talk through the issue, sometimes it can be a practical thing that you do to make their workload a bit easier or timekeeping or give them a bit more freedom with time. For example, today somebody is upset. I approached them, gave them an opportunity to come here (into the staff room) and talk, identify what the problem is and make adjustments to their working day, sometimes it is just that, or the day after, giving them protected time because they’re so pressured. Sometimes it can be a personal issue so look at modifications there as well, do they need to be at work, do they need to be off, all that sort of thing really general wellbeing.” (manager 3)

Analytical summary: The practice of Securing Efficacy

The main objective of the practice of Securing Efficacy is to be responsive to risk and sustain this responsiveness. Responding to urgent risks that might scale up rapidly relies on compliance to risk dynamics and character. The team members tailor their actions according to their situated understanding of the risk and the client and carry these actions out without delay or hesitation. This is achieved by flexibility of the team members who are continually prioritizing risks and synchronizing tasks between themselves.

The team sustains responsiveness in demanding conditions of the service by proactively engaging in activities and routines that help avoiding burnout and poor morale. These include personal and professional support between the team members of all levels, counseling service for the team members and flexible working arrangements. Enacting these routines is based on mindfulness towards colleagues and the understanding that mutual support and teamwork is indispensable.

Timing of the risk response is key for efficacy because in crisis only timely action can mitigate risks. The team members synchronize their actions with risk dynamics by prioritizing some risks over the others and synchronize actions between themselves to deliver required response at the right time.

5.4. The practice of Counterbalancing

The mental breakdown that the crisis team deals with is often one of several relapses of an underlying mental health condition that may relate to various factors. Clients of the team very often struggle with numerous difficulties and their lives are out of balance. Debt, neglect, isolation, lack of self-esteem, substance abuse, and other problems that are sources of negative emotions and depressing incidents, are common. At the same time, usually little good is happening in client's lives and there is a shortage of positive stimuli. These factors are projected to be affecting the client in the future and to have a further detrimental impact on their mental health and in particular on sustained mental health recovery in the long term.

The objective of the practice of Counterbalancing is to eliminate, as much as possible, the negative factors affecting the client and instead put positive determinants in place to achieve stability and sustain it beyond the treatment time of the crisis team. Consequently, this practice is related to the question "How can we prevent the relapse of crisis?"

While the most pressing task of the crisis team is to mitigate immediate risks of acute mental crisis, the professionals are also aware of the importance of long term stability and its implications for clients future life and safety. The team members identify themselves with their clients, their problems and issues, and for all the right reasons, and humanistic incentives, they are deeply concerned with the lasting effects of treatment.

"I'll try and put myself in that person's shoes because it could happen to anybody and it has, that's what led me to this type of work; I had three mates who took their own life so that could be anybody so it is a bit close to me like that you know. I think that could be my son, that could be my daughter you know, that could be me so I try and put myself in their shoes" (assistant practitioner 2)

“Yeah, we need to think about once that person’s crisis is over and they’re more stable in their mental health, how are they going to be maintaining that level of stability, what can we do as a service, as social workers to actually ensure that that person doesn’t get into crisis again.” (social worker 4)

Deteriorating mental health of the service clients is often aggravated by isolation and degrading social integration. An important step in setting the long term trajectory of risk on the right track is **stimulating social relationship and reintegration** of the clients, addressing such isolation by identifying appropriate social engagements that will play the role of stabilisation stimuli. This amounts to reworking the connections and connectivity between the individual at risk and their social context. Community partnerships are a follow-up treatment option through which the clients build connections with other people, focus on skills and engage in a positive experience. The partnerships would also help develop a sense of self-worth in the social context by providing opportunities for enhancing employability and therefore help long term stabilisation:

“Is there any other services that we could be perhaps putting in for them or referring them to, such as day care or (...) helping them with their employability, other services such as [community name], getting them involved on employability courses, computer courses, college courses, adult education, anything like that that would help them reintegrate perhaps back into society.” (social worker 4)

“It’s important that (...) they’ve got constructive occupation to give themselves meaning, that they’re not isolated (...)” (AMHP 3)

Having a computer diploma, for example, offers new opportunities for work, income, and socialisation. Individuals who have support and access to such opportunities can alter their own identity perceptions and sense of worth, which reconfigure how risk is enmeshed into their life. When the clients are able to develop important relationships and meet their goals, they are gradually restoring their self-esteem and sense of life. These crucially important aspects of existence, when strengthened, counterbalance and help to cope with other dimensions of life where the clients may still have struggles. Hence, placing clients in an appropriate community is an important factor in sustaining stability of risk. The team collaborates with a broad group of organizations aiming to prevent their clients from falling into crisis again.

Processes such as improving social reintegration and building relationships, restoring the sense of worth and identity perception, may all be hindered by the stigma of being a mental health client. Such stigma is particularly strong in clients who have been put into a hospital against their will. This type of treatment, and the resulting

permanent note on client's medical record is likely to cause shame and sadness precluding mental health recovery. Having this in mind AMHPs, who initiate and lead the process of sectioning, would only consent to section a client if it is absolutely necessary. While detaining a client might be crucial for managing their high level of risk in the short term, the AMHPs understand that Mental Health Act is an "oppressive method" (AMHP 1) and the long term consequences of detaining are always taken into account when making such decisions. An AMHP explains how they would consider that being detained abuses dignity of a client, affects self-respect and may be harmful in the long run:

"You do think about the patient's [client's] future before you will detain him." (AMHP 5)

"So, positive risk about somebody's independence, to be able to have the choice, their wishes, their dignity, to be respected, you know, all that. So just because they have mental health issues or distress at that time it doesn't mean all that goes out of the window." (AMHP 5)

Clients in crisis, struggling with a long term mental condition, are often passive and lacking advice on how to obtain the entitled benefits and services. They may not have the motivation and composure to apply for housing and other benefits, take care of their finances, deal with their debts, or ask for support from other, less acute, mental health and community services. They are also likely to overlook their basic health care needs and neglect health issues. This lack of basic care and support frequently creates direct crisis triggers through distress or suffering. The crisis team members will therefore organize advocacy for their clients to make sure their rights are met, that they are obtaining necessary health services and to stabilize and protect them from the misery of neglect.

"it's important that we establish that their rights are being met in terms of the benefits they receive, that they've got housing, that their health needs are met, and all that kind of stuff". (AMHP 3)

During their consecutive visits, the team members gain a holistic perspective on the client and an understanding of their personal and social situation. They will typically become aware of any pathological circumstances around their client, such as exploitation, abuse, or any other persistent and reoccurring issues that the client may suffer from. Such circumstances cause immediate threats and also lead to long term misery that prevents recovery and prompts relapse of crisis. **Stabilizing and**

developing protective layers from such issues is fundamental to sustained clients recovery.

“if we feel that a patient [client] that we’re dealing with is vulnerable, is being exploited financially, sexually or physically abused, whatever it might be, then we will take the lead in investigating and ensuring initially immediate safety but also working out a plan as to how to protect them in future.” (AMHP 3)

Some of the clients might not have the mental strength to deal with their daily chores. They cannot maintain their home and let washing, litter and dirt accumulate. Helping them with keeping their home in order is important for their mental condition and is part of the long term treatment and support put in place. The crisis team would arrange for domiciliary help to come and assist as this enables long term recovery and the same the client’s risk will be maintained in the long term.

The team members will often tailor the approach to recognizing and providing what the client might need in order to improve their quality of life. Sometimes being able to engage in basic activities, like cooking, is very important and provide the important everyday joy, as noticed by an AMHP:

“(…) I’ve seen somebody and I feel strongly about what they need, and I’m committed to following that through, then I’m driven by that regardless of what other tensions there might be. So there’s a man, for example, that I’ve been dealing with who ... He’s moved into a flat of his own and it was decided that we needed to close his case, but I knew that he didn’t have a cooker, a basic piece of equipment. He’s somebody who loves to cook and needed a cooker, and so I’ve managed to get ... Even though he’s not even open to the team anymore, I’ve managed to get a grant. I’ve lent him my own ... a spare hotplate that I’d got to keep him going in the meantime, and he’s having a cooker fitted in the next week or two”. (AMHP 6)

The teams mindful and holistic approach towards the clients is aimed at helping them regain a balanced spectrum of emotions and a meaningful life.

Analytical summary: The practice of Counterbalancing

The main objective of the practice of Counterbalancing is sustaining client’s stability beyond the treatment time of the crisis team. This is pursued by rebalancing positive and negative influences in the client’s life. Firstly, the team professionals focus on understanding and eliminating factors prohibiting long term improvement, such as exploitation, isolation or neglect, that have a systematic detrimental effect on the client’s emotions. Secondly, the crisis team aims to counterbalance the negative

experiences and emotions by stimulating the client's social relationships and reintegration, helping them regaining self-esteem, and avoiding stigma. These elements will support and strengthen the integrity of the clients when faced with various struggles that they may encounter in the long term.

Counterbalancing is aimed to have a long-lasting effect on the client over time. Eliminating detrimental factors and supporting social reintegration should help maintain a healthy dynamic in the client's mental condition.

5.5. Interlacing of the four practices.

The crisis team enacts these four practices that constitute its riskwork aimed to mitigate the dynamic risk of their clients in real time, as it unfolds. As presented in the previous sections, the practices shape the way the team designs, organizes and executes its various duties and activities. This section demonstrates how the practices combine and complement each other in the specific tasks undertaken by the team.

The next vignette illustrates how the practices of Interpreting and Reinterpreting, Corroborating and Securing Efficacy go hand in hand when dealing with pivotal junctures and carrying out key tasks, such as sectioning a client.

---Vignette 7---

Today, I came to observe the team's open working space where AMHPs, social workers, nurses, assistant practitioners and support workers are sitting together. One of the AMHPs is glancing at me and nodding for letting me have a look at his work. Matthew is showing me a document - report from Mental Health Act assessment he did the day before. It is a very detailed summary of the client's current mental presentation and explanation why the client has to be admitted into a hospital. It is the most important type of documentation which AMHPs produce. The report goes with the client and it is mandatory to complete it within seven days after the assessment. Matthew explains that it takes hours to complete it and that it is an urgent work which has to be prioritized. A few minutes later, the medical leader comes to Matthew and talks to him about another client whom he assessed this morning. It is an anxious lady living on her own. She is currently on medication waiting for a day hospital. During the morning visit it turned out that she stopped taking her medication regularly and refused further treatment. The lady was masking her real emotions and thoughts until now, assuring everyone she was feeling better. However, the loss of her two husbands and a son was pushing her to ending her life by taking an overdose. A doctor who was conducting the assessment, could not finish it due to unresponsiveness of the client.

Both the doctor and the AMHP discuss who will go with Matthew to the client and when Dr [name] is leaving and Mathew is telling me that the clashes between things that "need to be done now" happen very often and that the team has to be flexible and adjust to current needs.

The above excerpt shows several practices being enacted by the two professionals involved in sectioning clients. The practice of Interpreting and Reinterpreting manifests itself in that the doctor who has visited one of the clients earlier this morning has reassessed the client and her risks, and in view of sudden changes in her behaviour, concluded that the process of sectioning should be initiated. The doctor based his reinterpretation of the client's risk on partial and incomplete information, as the client was not responsive, and also it turned out she was masking her true feelings and emotions. The practice of Corroborating is being enacted in that the doctor requests that the AMPH leads the sectioning of the client, and hence implicitly requests a confirmation of his perception of the client's urgent risk and inability to make decisions for herself. The client will be assessed by the AMPH and two medical doctors based on their multiple interpretations and synchronised knowledge. The practice of Securing Efficacy is enacted in that the medical doctor immediately takes steps of appropriate magnitude in view of risk urgency. He instantly asks the AMPH for help and suggests sectioning. The AMPH, who is busy with an urgent task of completing documentation for an earlier case of sectioning another client, prioritizes the new case with active risks over the paperwork. The professionals also start synchronising the team's activities by considering who will join the AMPH to visit the client. It should be also mentioned that the practice of Counterbalancing is being enacted in the process of sectioning, through the extremely thoughtful decision taken by the sectioning trio, where the impact of sectioning on the client's future is carefully taken into account.

---end of Vignette---

The next example demonstrates how disengagement from the service triggers appropriate action that demonstrates the team's complementary practices. Appropriate response to risk means not only responding to what has been noted or interpreted, but also responding to lack of information. Disengagement from the service is one of the occurrences that require prompt action as it marks a potential increase in risks. Checking on clients who do not answer phone calls, miss their prearranged meetings at the medical center or home is essential and the team members need to urgently allocate resources and adapt their actions accordingly:

“If we had just left messages on this lady’s phone three times, after the third try, I would be really concerned, ok, what has happened to this lady, we need to go out, we need to do perhaps a cold call, to have some face to face contact and find out (...)”. (social worker 3)

The cold call mentioned by the social worker is a home visit without prior notice, usually done in twos. Cold call is an activity that combines several practices. The practice of Securing Efficacy manifests itself through the cold call being arranged instantly when disengagement of a client has been recognized and then two co-workers prioritize it over their other tasks to pay the client a visit. The practice of Interpreting and Reinterpreting is being enacted in that current information about client’s condition is being sought urgently, and specifically in the form of face to face contact, so that the two team members can have a conversation with the client and also watch their behavior, read emotions, and see their environment, such as the state of their home. The practice of Corroborating is expressed through the team members going in twos so that they can discuss their interpretations and consult decisions or actions if what they find at the client’s place indicates high levels of risk.

These examples show that the situated knowledge of doing, of how to enact the four practices, shapes and dictates when and how to undertake the many specific activities of the team and how these should be organized in terms of prioritizing, synchronizing and cooperating between the team members.

CHAPTER 6

DISCUSSION

6.1. Conceptualising dynamic risk - The Dynamic Risk Model

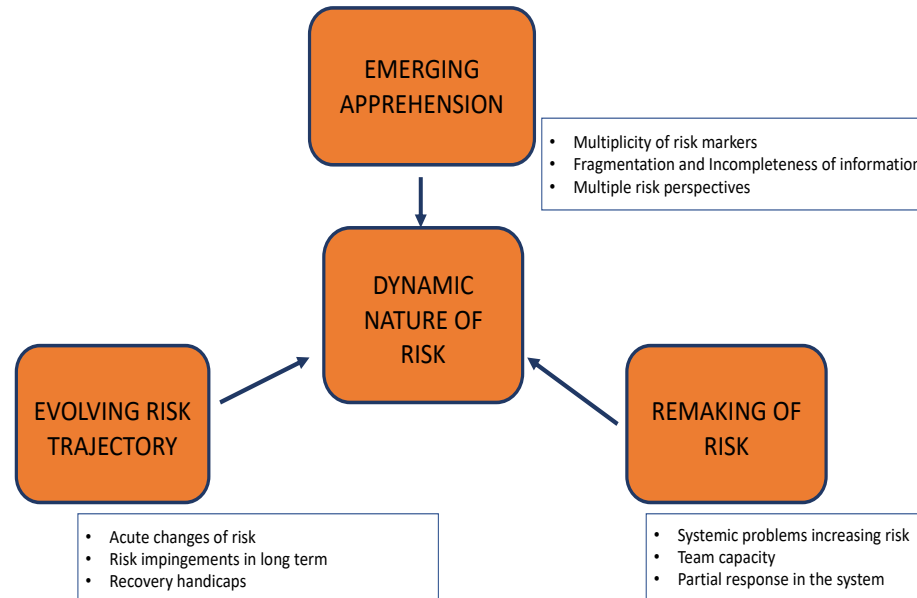
While the topic of risk is increasingly prominent in organisational and more generally social sciences research, the current literature is dominated by a view that risk is static and thus predictable calculable probability of harm or hazard that can be accurately analysed by experts, and for which recommendations and protocols to manage risk can be determined a priori, before the process of realizing risks begins.

It is tempting to think that risk is indeed so simple, static and calculable, but in reality, it is not. In the recent discussion (Hardy and Maguire, 2019:504) argue that “risk is Janus-faced: powerful and seductive, but also complex and potentially deceptive”. Indeed, in the mental health service we study, there is virtually no information about a new client referred to the crisis team and their risks are neither calculable, nor will they ever be. Yet, dramatic risks may materialize from the very first moment the client is assessed by the team. Prespecified scripts and protocols do not cover cases described by fragmented, incomplete information that may be inaccurate, may change from hour to hour or day to day, or may be open to conflicting interpretations from crisis team professionals.

In the analysis chapter 4 we demonstrated that the dynamics of risk has several sources, is multifaceted and complex. Our research setting of an acute mental health crisis service is rich and saturated, heavily loaded with intense risk characterised by immediacy. In our research setting the risks are viewed from the micro perspective. Indeed, the riskworkers deal with clients face-to-face and are concerned with every individual person, aiming to understand their individual risks. In this setting we develop a Dynamic Risk Model that explains how the crisis team members conceptualise risk encountered in the service. The model accounts for three generic dimensions of risk dynamics that evolve over time: Emerging Apprehension, Remaking of Risk, and Evolving Risk. Each of the dimensions split into several

contributing factors that are also generic (Figure 2), accounting for the multi-layered nature and complexity of the dynamic risk.

Figure (2): The three dimensions of a Dynamic Risk Model.



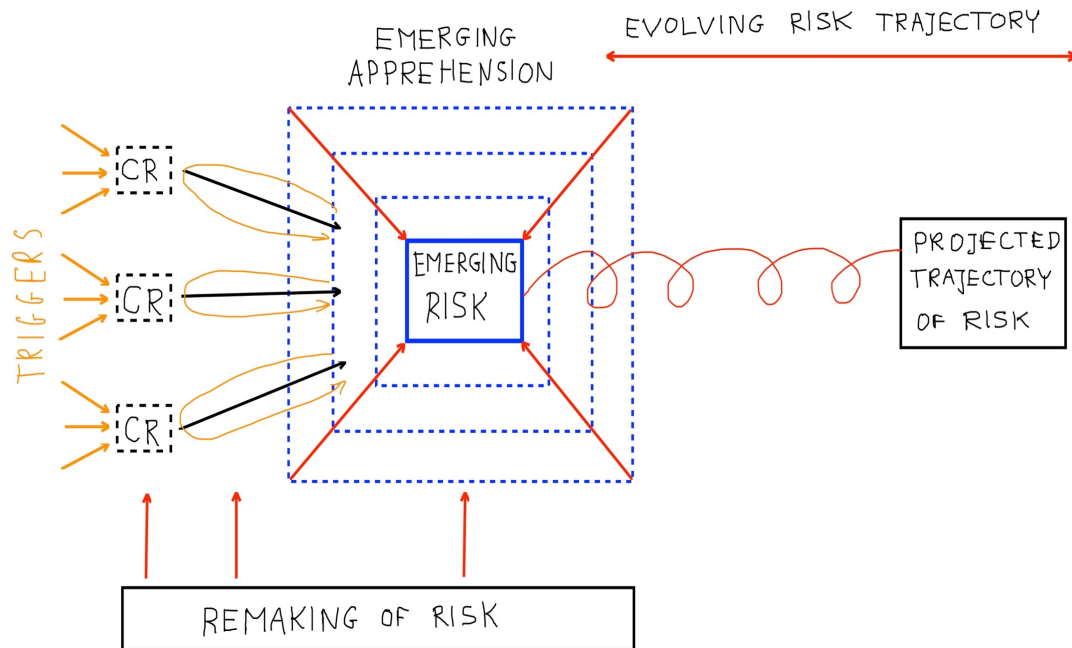
The first dimension of risk dynamics, Emerging Apprehension, relating to what can be understood about the risk, is implied by how the relevant information about risk is emerging over time and how that contributes to its inherent ambiguity. In the analysis chapter we identified three factors that contributed to risk uncertainty and resulted in risk apprehension being emergent over time. The first factor is multiplicity of risk markers. Risk markers are bits of data about the client that are associated with a wide range of possible risk categories. There is multiplicity of risk markers and they become available gradually over time through different routes and from different sources, their strength and relevance vary. The second factor of Emerging Apprehension is that at any point in time the available information is incomplete and fragmented. Some of it may also be incorrect and new facts that become available about a client may contradict what appears as known and confirmed. Clients' risks in the context of the service are multifaceted, with complex and convoluted underlying stories, and therefore on top of the ambiguity of information, it is subject to multiple interpretations. The picture of risk, described by these characteristics, can form only gradually, subject to dynamic changes and updates and risk apprehension can be only emerging over time constituting the first dimension of its dynamics.

The second dimension of risk dynamics, Remaking of Risk, relates to what can be done about the risk with available resources. It is implied by how the resources and local circumstances under which the service operates are set up and how are they changing over time, meaning that the same threats and dangers may become more or less acute depending on context. Firstly, the riskworkers are limited in their actions by their capacity and morale. If appropriate resources cannot be allocated to a specific case, the risk will not be appropriately addressed and will increase. Secondly, the service does not operate in isolation and relies on other entities in the system. Systemic problems relate to coordination with other services on which the crisis team depends and on their accessibility, such as availability of hospital beds, ambulance services or police. Delays and other issues in coordinating with these services may result in risks increasing abruptly. Finally, the service does not deal with the entirety of risk problems. In the context of the crisis team's other risks, such as criminality or drug dependence may be intertwined with the client's mental health crisis. This implies that some risks faced by the riskworkers are beyond their remit and may change and develop in unpredictable ways. Remaking of Risk shows how the risks become dynamic depending on circumstances of the service and surrounding events that are either unknown, or changing, or both.

The third dimension of risk dynamics, Evolving Risk Trajectory, relates to how the underlying risk phenomenon may evolve over time in the long term. It accounts for sudden acute changes in risk and changes in the intensity of risk that may occur in the future and that relate to risk associated with client relapses. It also accounts for environmental factors that have a detrimental effect on the long term development of risk dynamics. In our analysis we identified two types of environmental factors that can have a detrimental effect on the risk trajectory. Namely, they can take the form of risk impingements that through repetitive impulses push risk trajectory upward, towards higher levels of risk, where acute shifts and relapses of crisis are more likely; or they can take the form of recovery handicaps, which are factors of lasting influence that prevent the risk trajectory from recovering and move to the lower risk areas. Evolving Risk Trajectory contributes to a long term perspective of how the dynamics of risk may evolve, and shows how the characteristics of risk depend on the nature of the underlying phenomenon that generates risk, as well as on the environmental factors.

In Figure 3 we illustrate through the three dimensions of the Dynamic Risk Model how the riskworkers conceptualise dynamic risk and how the model allows us to systematically describe risk that evolves over time. The three dimensions of our Dynamic Risk Model are illustrated in Figure 3 and we interpret them as follows:

Figure (3): The three dimensions of the Dynamic Risk Model and their interactions.



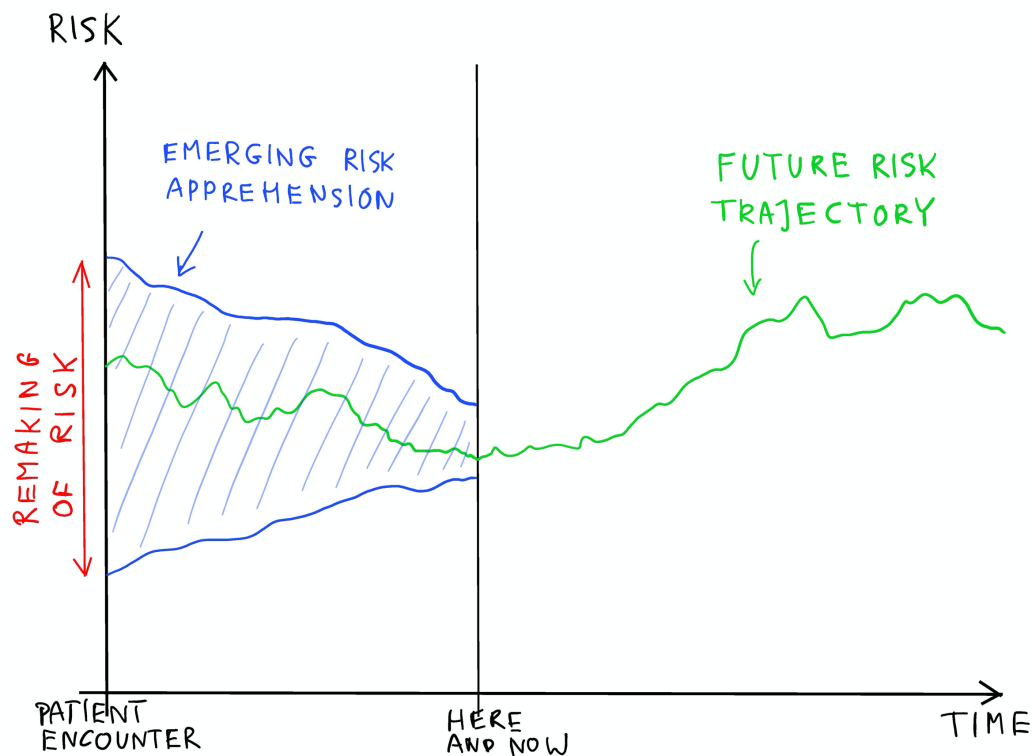
At the time of client encounter, there is little apprehension of type and intensity of risk. This is illustrated by the largest dashed blue rectangle. The width of the rectangle represents the range of different risks that may occur. The height of the rectangle represents uncertainty about the intensity of those risks. As information about the client unfolds from incomplete and fragmented sources, and risk markers are being revealed, a range of current risks (CR) becomes known. Combining multiple perspectives on these current risks contributes (through black arrows) to the emerging apprehension of risk that becomes more informative about levels and types of risk, and therefore to narrowing down of the dashed blue rectangles towards emerging risk, as time progresses. During this process current risks are also dynamic and changing, subject to treatment or triggers. These changes contribute to the emerging apprehension through the orange feedback loops.

Systemic issues (bed availability, coordination with other services), team capacity, and limited feasible response, can move the client's risk up or down. This is illustrated by the red vertical arrows that influence the risk levels and point from remaking of risk towards current risks and emerging apprehension.

Evolving risk trajectory concerns the dynamics of risk in the long term, beyond the time the client will be open to the service. Its dynamics will be subject to acute changes driven by various events, which is indicated by the red spiral-shaped line. The projected trajectory of risk will depend on the presence of risk impingements and/or recovery handicaps.

In the following Figure 4 we augment this model by illustrating how the conceptualization of dynamic risk and risk ambiguity are evolving along the horizontal time axis.

Figure (4): Evolution of dynamic risk as time progresses.



The graph illustrates the way in which the three dimensions of the Dynamic Risk Model contribute to risk dynamics and how it evolves in time. Time is on the horizontal axis with client encounter marked at zero, where the axes intersect. On the

vertical axis there is risk intensity. At the time of client encounter, there is little apprehension of type and intensity of risk. This is illustrated by the blue lines being wide apart at time of client encounter. As information about risk unfolds gradually, risk markers are being revealed, and multiple perspectives based on fragmented incomplete information are being combined, the emerging apprehension becomes more informative about levels and types of risk, which is illustrated by the narrowing gap between the blue lines, as time progresses.

Risk is then remade by the context in which it appears. The availability of resources is changing over time and the team capacity is varying, affecting the responsiveness of the riskworkers, and feasible actions are fluctuating. The coordination with other services may vary over time, and other risk factors not within the remit of the crisis team may affect the clients. All these factors will move the levels of the client's risk up or down. This is illustrated by the red double-sided vertical arrow that changes the vertical location of the whole graph with respect to the scale of risk intensity.

The green line that extends in time beyond "here and now" is the evolving risk trajectory. Its dynamics illustrates both sudden and long term changes in risk and is driven by crisis triggers, risk impingements, recovery handicaps. This model presents how the riskworkers conceptualise the dynamics of risk and factors that contribute to this dynamics.

While the literature is dominated by a static picture of risk, several aspects of dynamic risk have been recognised and studied. An important strand of literature develops dynamic risk from the risk conceptualisation proposed by Hilgartner (1992), Boholm and Corvellec (2011). This conceptualisation asserts that there are at least three elements necessary in any definition of risk, namely a risk object needs to be identified that threatens a valued object at risk. In this context there are two established ways in the literature to develop the concept of risk dynamics. The first approach, rooted in Lupton (2006) and introduced in Boholm and Corvellec (2016) is through valuations that need to be established and are subject to change. It is crucial to notice that in this approach valuations are negotiated and finally obtained by riskworkers involved in recognizing risks. Consequently, the source of risk dynamics is in the riskwork and practices of riskworkers. In Boholm and Corvellec (2016) risk is dynamic because the valuations are dynamic throughout the process of negotiating

them. The second approach, developed in Maguire and Hardy (2013) who study possibly harmful chemicals, introduced risk dynamics through evolving belief whether the link between the risk object and the valued object at risk exists or not, or equivalently if the risk object really threatens the valued object at risk. Similarly, in this approach to recognising risk dynamics, it is key to realize that the dynamics that is conceptualised here results from the practices of riskworkers. It is the riskworkers who undertake the task of reviewing and scrutinising scientific documentation regarding the possible risks of chemicals, and a result of this process the objects become risky or safe.

However, our research advances the previous literature by showing that there are other sources of risk dynamics that go beyond the risk conceptualisation of Hilgartner (1992), Boholm and Corvellec (2011). In our research setting all the key elements of the Boholm-Corvellec conceptualisation are static: mental health crisis as the risk object, threatens valued object such as life / health / dignity of the client or others. However, in our conceptualisation the risk is dynamic because of the following reasons: (1) the multitude of ways that the threat may be constructed and the level of the threat are not known and emerge only gradually over time from fragmented and incomplete information (Emergent Apprehension); (2) available resources, feasible response to address the risk, and the wider context of coordination with other related services, are changing over time and affecting the levels of risk (Remaking of Risk); (3) the underlying phenomenon that causes the risk, in our case the client's mental health condition and their social context, is evolving (Evolving Risk Trajectory). This is an important finding because the three dimensions contributing to risk dynamics are generic and we expect they will be also present in other settings where dynamic risk is managed at the micro level.

It is also important to notice that before our research the literature addressing the micro perspective of risk associated the dynamics of risk with the actions of the risk actors, such as (a) establishing or changing valuations; (b) establishing or negating existence of threat. However, our study advances the previous literature by showing that there are sources of risk dynamics that are external to the actors. The three dimensions that contribute to the dynamics (Emerging Apprehension, Remaking of Risk, Evolving Risk Trajectory) exist independently of what the actors choose to do. This allows for a better understanding of risk urgency and the role of time in

conceptualising dynamic risk. In risk encounters urgency comes from risk actors being under time pressure because they are unable to control the dynamics of risk. Therefore, urgency is imposed onto the actors by risk dynamics. In this context it is fundamental to conceptualise risk dynamics as independent of the risk actors rather than induced by them through their actions.

Another strand of the literature focuses on organizing risk in real time, and relates to the dynamic risk model through considering risks that materialize unexpectedly and unpredictably, and where predetermined plans and protocols are not effective because risks are not self-evident and deviate from expectations (Maguire and Hardy, 2016). This is where the prevailing approach to risk organising, based on the dominant discourse of calculable risk subject to systematic analysis from historical data, shows its shortcomings. Maguire and Hardy (2016:90) propose that in such cases real time organising of risk is more effective if “it problematizes existing expert risk knowledge of locally situated risk assessors-cum-managers-cum-bearers and challenges the hierarchy of risk identities”; while Horlick-Jones (2005) observes empirically that in such scenarios risks are being managed not strictly according to the plans and protocols but situationally-specific practices are applied instead. How then can we better understand the risk practices in such settings and possibly have a more systematic input into their design and improvement?

Understanding risk in these dynamic settings through our Dynamic Risk Model is important. Power claims that “Risk management is always a practice under some description or other, a description that embodies ideas about purpose and which embeds practices in larger systems of value and belief” (Power, 2007:25). Therefore, risk practices of individual actors are framed by their belief about the risk they encounter, namely their conceptualisation of the dynamic risk they face. This conceptualisation, systematically described by the dimensions of the Dynamic Risk Model, shows that risk dynamics is external to the risk actors and therefore imposes urgency onto them. The model not only explains the sources and nature of risk dynamics, but also informs about its temporal evolution. In particular it informs that risk develops simultaneously on different time scales. As observed in Sandberg and Tsoukas (2011) (c.f. also Langley et al, 2013, p. 4), not accounting for time in theoretical considerations, implies that “temporal structure of social practices and the uncertainty and urgencies that are inherently involved in them are passed over” and

consequently “the practices that make knowledge actionable – what to do, at what point of time, in what context – are not included in the timeless propositional statements”. Hence, adopting the Dynamic Risk Model that accounts for time, risk dynamics, immediacy and unpredictability, is a key step in an attempt to understand the organisational risk management process. We do this in the second part of the thesis.

At the macro scale Beck’s *Risk Society* (1992) describes risk as a dynamic phenomenon. Beck describes risk and its evolution at the level of whole societies and observes that as these societies transform, new global risks emerge that affect whole populations. The perceptions and interpretations of these new risks are often inaccurate as they cannot be understood through historical data or other reliable scientific methods. As Beck observes these perceptions often differ between lay and professional subpopulations. Beck focuses on the systematically increasing role that these risks play in the society and intensification of the entirety of risks. In contrast to the dynamic view of risk offered by Beck, our Dynamic Risk Model gives insight into how individual riskworkers perceive and conceptualize individual risks that are dynamic. Understanding risk at the individual level, how it is perceived in everyday routines by professionals on the team, is key to understanding the nature of human organising. It opens up the possibility of systematically studying the risk practices of actors involved in managing risk in dynamic contexts characterized by ambiguity and immediacy, of which the crisis team is an extreme case. How do the individual professionals coordinate actions to facilitate emergent apprehension of risk? How do they combine fragmented sources of information and share their perspectives on risk? How do they decide when to act to intervene right on time, in view of incomplete information, and how do they justify taking or not taking actions? How do they recognise and address recovery handicaps and risk impingements? We investigate these risk practices of the crisis team in the next section and aim to answer these questions that are so relevant for organizational practice.

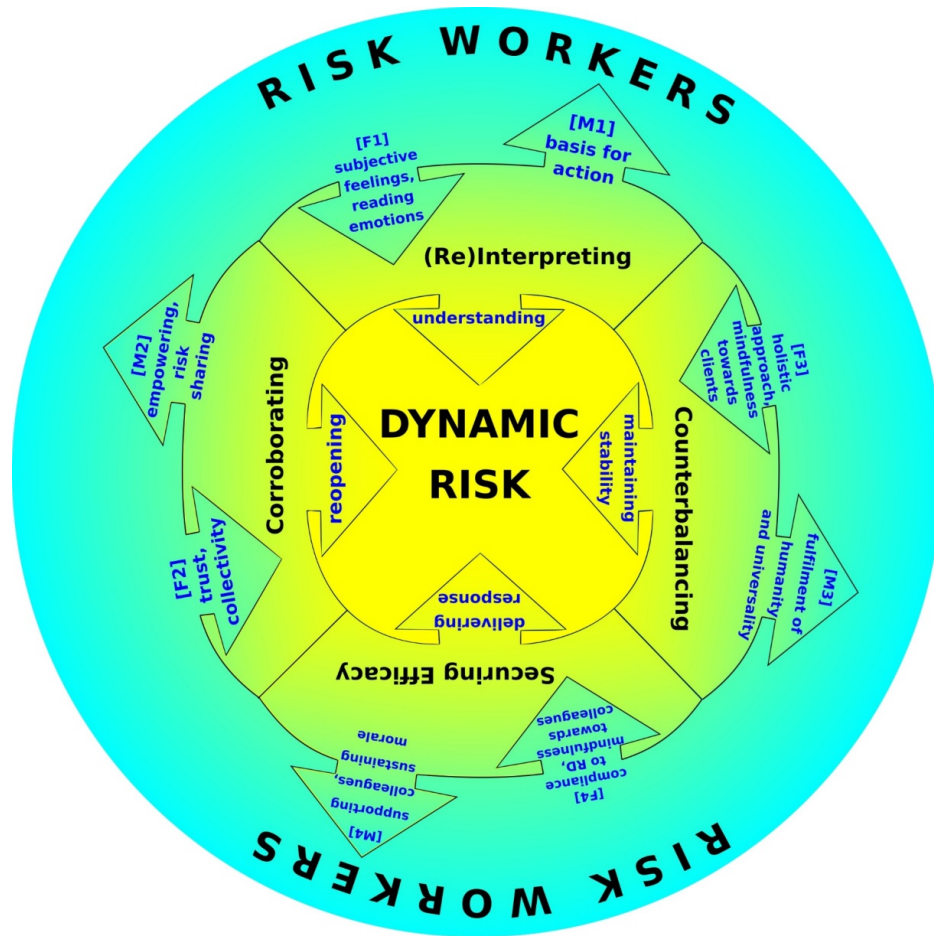
6.2. A riskwork model of managing dynamic risk.

Recall that dynamic risk encountered by the crisis team is characterised through the Dynamic Risk Model identified in the previous chapter 4 and section 6.1. The model proposes that dynamic risk is composed of three dimensions: the Emerging Apprehension, Remaking of Risk and Evolving Risk Trajectory that in different ways contribute to the emerging and ever changing risk.

The aim of the preceding analysis chapter 5 was to understand the day-to-day comprehensive riskwork of the crisis team; that is, what the team can do to mitigate this dynamic risk in real time. To this end we viewed the daily work of the team through the practice lens, since as Orlikowski (2010:37) observes, “a practice perspective, because it entails a theoretically grounded understanding of the recursive interaction among people, activities, artefacts and contexts, is particularly well positioned to address organisational phenomena that are posited to be relational, dynamic and emergent.” We discovered that the team’s riskwork in the dynamic risk context comprises four situationally-specific risk related practices that take place at specific moments and at different levels of encounters with risk. These complex practices enable the team to recognize the dynamic risk and deliver a tailored response in time. The practices involve a variety of forms and efforts that are prompted and shaped by the characteristics of dynamic risk.

In this section, we bring together the concepts developed in the analysis, and formulate a model, summarized in Figure 5, theorizing how managing dynamic risk is being accomplished through riskwork composed of the four practices.

Figure (5): A model of managing dynamic risk through riskwork composed of four practices.



In our model, dynamic risk, shown in the middle of Figure 5, is surrounded by the four practices enacted by the team: Interpreting and Reinterpreting, Corroborating, Securing Efficacy and Counterbalancing. This is to illustrate that managing dynamic risk is taking place through the practices that are jointly aimed at recognising and containing it. It also indicates that the practices that are situationally-specific and take place at particular moments of riskwork, are interdependent, interact with each other, and are often co-enacted. The positioning of the riskworkers aims to indicate that they enact the practices as a team in a joint and coordinated effort. Furthermore, the model shows the four practices of the riskworkers, together with the main effects and interactions that occur through enacting these practices. It demonstrates how managing dynamic risk is being accomplished as a recursive and sustainable process. Firstly, the model illustrates the relation between each of the practices and the dynamic risk, which is indicated by the arrow pointing from the practice towards the dynamic risk in the

middle of the diagram. Secondly, for each practice, the model shows its supporting catalysts, illustrated by ingoing and outgoing arrows. There are two types of catalysts that stimulate enacting the practices: motivators and facilitators. Motivators are desirable or beneficial outcomes of the practice and hence they are illustrated by outgoing arrows marked M1 to M4. Facilitators are the attributes that are instrumental for enacting the practice. They are illustrated by ingoing arrows marked F1 to F4.

We now elaborate on this model, focusing first on the role of Interpreting and Reinterpreting in managing dynamic risk and how it resonates with its emergent character. Second, we detail Corroborating and its capacity to empower riskworkers to decide how and when to act in the urgent dynamic context. Third, we discuss the practice of Securing Efficacy and how it facilitates being responsive and sustaining responsiveness. Finally, we expand on the practice of Counterbalancing and how it is the means to maintaining stability beyond the treatment time of the crisis team.

As shown in our analysis, timing is crucial when managing dynamic risk, and indeed, the four practices are deeply time sensitive. Their pace needs to match the risk urgency and their sequencing needs to respond to what circumstances dictate. We discuss the time coordination of the four risk practices in the last subsection of the present discussion.

Interpreting and Reinterpreting

The context of our research setting is loaded with urgent and serious risks as the primary reason the clients enter the service is to seek help with their mental health crisis. However, at the time of client encounter, there is little understanding of the actual type and intensity of the risk, and consequently there is little basis for deciding what is the appropriate action and how to manage the risk in real time. We identified the practice of Interpreting and Reinterpreting that is fundamental to managing risk and it underpins the other types of riskwork of the actors. As demonstrated in our analysis, the practice of Interpreting and Reinterpreting is aimed at recognising what is the risk, how big is the risk and what causes the risk. *Understanding* these characteristics of risk is the key outcome of the practice. The riskworkers are motivated to enact the practice, because any actions, including decisions, can only be based on what is understood, and therefore the practice provides them with necessary

basis for action. Similarly, the riskworkers recognise the levels of risk urgency through Interpreting and Reinterpreting and therefore the practice dictates the timing and the pace of response.

The risks encountered in the service are elusive and complex. They are convolved with client's history, context and relations that are typically not disclosed and not available for systematic inspection. Available information is fragmented and often inaccurate. Consequently, risks can be understood only gradually over time and considerable proportion of daily riskwork is devoted to this process. It forms the practice of Interpreting and Reinterpreting. Accordingly, three elements are clearly identifiable in our analysis of the practice. Firstly, the riskworkers engage in *evaluating the multiplicity of risk markers* that reflect the wide and open ended scope of possible risks and contributing factors. Secondly, they also *facilitate emergence of relevant information* through the way they approach clients, relate with them, and learn the relationality of the client with their family, and more generally, their environment. Finally, being aware that understanding the risk of their clients is an ongoing, open ended process, the riskworkers are continually *revisiting and reinterpreting the information and risk markers* in order to update their assessments. Enacting the practice relies heavily on knowledgeability of action (Orlikowski, 2002) that is embedded in the way the practice is enacted: what the riskworkers pay attention to, how they relate and communicate with the client, how they feel about the risk that they are dealing with, or how they choose situated ways of recognizing the levels of risk. This knowledgeability of action is acquired by the riskworkers over time as their sensitivity grows with both professional and personal experience. In the setting of the study, with elusive risk and presumptive risk urgency, Interpreting and Reinterpreting vitally relies on components such as *reading emotions, subjective feelings, and embodied sensory perception*. These components are facilitators put to work by knowledgeable riskworkers when enacting the practice and they catalyse risk recognition and understanding.

While the risks in our research setting are real and severe, including the risk of a suicide, and relate to serious harm to the service client or to others, understanding them through the practice of Interpreting and Reinterpreting relies on judgements, opinions, subjective views and feelings of the involved actors who aim to recognize and assess risk. As such, the practice relates to previous research developed in risk

literature that involve “constructionist” accounts of risk and focus on risk identification or changes in risk perception. In particular, an important strand of research builds on the risk conceptualization of Boholm and Corvellec (2011) (that extends Hilgartner, 1992), where a risk object threatens a valued object at risk. Typically, the literature in this context considers risk identification as an exercise aiming to produce an outcome which is based on codified well established scientific knowledge. For example, in the context of possibly harmful chemicals as risk objects, Maguire and Hardy (2013) (see also Maguire and Hardy, 2016), identify a dynamic phenomenon that objects are continuously in the process of becoming risky or safe and observe that these particular meanings are being attached to objects through organising processes that construct risks, namely, normalizing and problematizing. Since in our study of the practice of Interpreting and Reinterpreting the risks associated with clients are dynamic and consequently also in continuous change, it is important to understand similarities and distinctions between context and findings of both studies. The key difference is that in Maguire and Hardy (2013) normalizing and problematizing apply to results of normal science and codified norms that are basis for action and according to which risks of particular chemicals are identified and chemicals are classified before the legislated deadline of seven years (Maguire and Hardy, 2013:240).

In relation to the findings of Maguire and Hardy (2013) the practice of Interpreting and Reinterpreting contributes a new perspective on risks that have two important attributes. Firstly, unlike the risks of chemicals, they can realize in real time. Secondly, at the micro perspective of individual clients, these risks are neither subject to scientific scrutiny, nor can be measured or characterised in repeated experiments. This new perspective accounts for additional aspects, such as ambiguity and multiplicity of possible risks; their elusive character and actual changes in the dynamics of the real underlying risk. Our analysis in this context reveals the role of contextual situated knowledge in enacting the practice routinely as day-to-day riskwork, and of the relational aspect of the interactions between riskworkers and clients. Most importantly, our analysis also reveals the role of risk urgency in enacting the practice. Risk urgency results from the fact that risks can materialize any time, their levels are elusive and any delay in making decisions or taking actions may have dramatic consequences. It implies time pressure and the need to manage risk in real time, by making best possible decisions and taking best possible actions that need to

be based on current risk understanding that is updated on daily and sometimes on hourly basis. Risk urgency dictates the pacing and continual enacting of Interpreting and Reinterpreting, as well as its linkage with other practices: we shall see in the sequel how the riskworkers prioritize Interpreting and Reinterpreting of different cases through the practice of Securing Efficacy and how they seek confirmation from their peers in the specific situation through the practice of Corroborating. Interpreting and Reinterpreting provides basis for action in real time, rather than at a pre-specified future deadline. Through enacting the practice, the riskworkers are provided with an up to date understanding of the case and a course of action that is considered optimal at any point of time. However, since it relies on ongoing, incomplete and emerging assessments (in contrast to accepted knowledge and codified norms), it is linked with the practice of Corroborating discussed in the sequel.

The riskwork of risk identification of individual risks has been also studied by Boholm and Corvellec (2016), where they focus on the process of valuation related to railway planning. Their key finding is that in their context of study risk objects threaten the fundamental values embedded in objects at risk, but these values are often invisible in conventional risk identification process. It is also worth noticing that, similarly to the rest of the literature, the valuation practices considered by Boholm and Corvellec (2016) take place during the planning phase, that is prior to the building phase where these risks can realise. These characteristics are in contrast to our context where Interpreting and Reinterpreting occurs in real time and the importance of values that may be at risk is typically evident as these are the values of life, health, safety, or dignity. However, in our study it is the multitude of possible combinations of what these risks are, how they may appear, their mechanics, and levels, combined with their elusive character that makes each individual case complicated and forces the riskworkers to make decisions in ambiguous circumstances. These decisions often balance between different risks that threaten competing values, such as the value of safety versus the value of dignity and we shall return to this when discussing the practice of Corroborating.

Thus, before our contribution, the literature considered the work of risk interpretation in the form of a threat identification task, or valuation task, that the riskworkers aimed to complete within a prespecified time window or towards a prespecified deadline. But our research advances the previous literature by showing

how through the practice of Interpreting and Reinterpreting the riskworkers obtain continual and up to date assessment of the risk case, despite its emerging character, incomplete information and continuous dynamic evolution. The practice provides the basis for action in real time that allows riskworkers to make prompt decisions and deliver responses to risk if circumstances so dictate.

Corroborating

The riskworkers in our research setting encounter emergent and ever changing risk that is continually assessed based on fragmented, possibly inaccurate risk markers. The risk is characterised by urgency as serious harm may realize in real time. This results in very difficult circumstances under which timely decisions must be made and timely actions must be taken. As demonstrated in our analysis, the practice of Corroborating is aimed at confirming how and when to act in order to manage dynamic risk. When the riskworkers enact the practice of Corroborating, they are *reopening* the risk case in that they are consulting with colleagues, inviting their opinions, questions and suggestions. Their different perspectives and multiple interpretations are being considered, connected and synchronised. *Multiple interpretations* reflect the different backgrounds of the professionals, their distinct professional and life experiences that shape the lens through which they view the case. Differences in perspectives also result from varying levels of engagement with individual clients. The riskworkers who are engaged in a case and are under direct pressures of risk urgency, actively *seek critical distance* from their colleagues to synchronise with a neutral viewpoint that is not loaded with emotions.

The practice of Corroborating relies on the practice of Interpreting and Reinterpreting that is enacted collectively when *reopening* client's case for consultation. However, we argue that the role of Corroborating is far greater in the day to day riskwork than just collective Interpreting and we contribute the understanding of this practice in more detail. Crucially, Corroborating *empowers* the riskworkers to make decisions and act despite risk being elusive and dynamic. Synchronising views and agreeing on what needs to happen next yields assurance the riskworkers proceed with managing risk in the best possible way given the context, circumstances and the inferred level of urgency. Indeed, this results in empowerment because "individuals'

power needs are met when they (...) believe they can adequately cope with events, situations, and/or the people they confront” (Conger and Kanungo, 1988:473). Through Corroborating the riskworkers *share the risk* and responsibility and protect themselves from blame. This allows for decisions to be made and actions to be taken smoothly, confidently and without hesitation. The practice of Corroborating relies on collectivity of the team members, and trust across the involved professions, hierarchies and backgrounds of the riskworkers. Empowering through Corroborating is particularly important at pivotal junctures when risks are intense or change abruptly, and decisions made by the riskworkers may have profound consequences. We demonstrated that sectioning a client is an example of such a pivotal juncture and in this case, Corroborating is enacted in a very structured and formalized manner. However, Corroborating takes many different forms in other contexts. Regularly scheduled group meetings, face to face prearranged discussions, urgent consultations over the phone, and spontaneous informal chats in the shared office spaces are some of the possible forms this practice may take.

The practice of Corroborating that relies on different perceptions of and views on risk is in contrast to the predominant strand of literature that in case of organizing risk in real time (that is, when it realizes) focuses on how actors respond to risk by the means of a ‘control and contain’ strategy with “clearly defined rules, detailed and well documented operating procedures, and a clear-cut chain-of-command authority” (Hardy and Maguire, 2016:88, after Hood, 2005). However, in case of quantifiable risks, it is recognised in literature that there is not always a unique way of measuring them and that different measurements may result in different assessments (e.g. Kunreuther and Slovic, 1996). Similarly, for the constructionist accounts of risk multiple interpretations of risks are also natural as social phenomena are inherently ambiguous (Tansey and O’Riordan, 1999) and the actors are “magnifying one danger, obscuring another threat, selecting others for minimal attention” (Dake, 1992:33) using their “worldviews” as lenses. Risk literature that did consider multiple interpretations has seen them as a difficulty that leads to various issues, and for example focused on resolving tensions between different views and different groups of riskworkers (Labelle and Rouleau, 2016); has highlighted how different perceptions of risk undermine risk management based on shared agreement of what constitutes objective risk (McDonald et al, 2005); or in the macro scale, has shown how

differences in risk views, especially between lay people and professionals, leads to riskification of the society (Beck, 1992). Our research which identifies and provides understanding of the practice of Corroborating advances the literature by contributing a new insight into how actors benefit from multiple interpretations and perspectives in the context of dynamic risk that is multifaceted and emerging. In particular, our analysis shows that the risk actors are not only aware of their different perspectives, but also accept them as valid and valuable sources that should be incorporated to yield a more complete and insightful risk assessment in the context of urgent elusive risks. The different perspectives or “worldviews” result from situated engagement with clients, different backgrounds and inherent multiplicity of possible interpretations. The risk actors are not only open to the views of their colleagues, but they actively pursue contrasting and synchronising their opinions through established routines characterised by varied levels of formalization. It is through synchronising their perspectives that the riskworkers have confidence in their decisions and feel empowered to act under the pressure of urgency. Our research indicates that attention to corroborating and possibly other collaborative practices helps improve theory of managing risks. Another instance where understanding the practice of Corroborating sheds a new light on existing literature is the problem of proximity to risk and the impact of emotions on riskwork of healthcare professionals. Fischer and McGivern (2016) observe that heated emotions can escalate and overwhelm risk management systems. Our research advances the previous literature by showing the role of the practice of Corroboration in this context: riskworkers who are emotionally affected by risk and case proximity seek critical distance from their colleagues who are distant from risk and calibrate their assessments to confirm the course of action.

Risk assessment and risk management processes studied in the literature are typically highly mediated and are predominantly textual affairs (Hilgartner, 1992). For example, Maguire and Hardy (2013:251), notice that “decisions are made and actions are taken on the basis of texts that actors have accessed, read, interpreted, cited, critiqued, etc.” Therefore, the dynamic risk context of our study is considerably different. Here decisions need to be taken quickly in view of risk intensity and urgency, based only elusive risk picture and a quick discussion with colleagues, rather than on systematic, time consuming, reviewing of written documentation. To act timely and confidently in these circumstances, the riskworkers need appropriate footing. Our

research advances the previous literature by explaining how such footing is acquired through enacting the practice of Corroborating, that in particular consists of combining multiple perspectives, seeking critical distance and consulting on pivotal junctures. In a recent literature, day-to-day riskwork that results in “production of reassurance and confidence” has been studied by Jorgensen and Jordan (2016). They study the practices of constructing, drawing upon and revisiting risk maps in an inter-organisational project in the petroleum industry. Risk maps represent risks with a matrix format, indicating the probability of occurrence and potential impact. They note that “regularly delivered risk maps create some kind of mutual belief in each other’s thorough risk reviewing” (Jorgensen and Jordan, 2016:59). Thus, in their inter-organisational context, the focus was on confirming whether different actors have reviewed risks, rather than on confirming the conclusions of these assessments.

Risk and blame are inseparable and in particular the implications of blame and blame culture on organizations has been studied by organizational scientists in various contexts, for example through the strategies and practices that riskworkers implement to protect themselves from blame. In the context of healthcare services, the identified practices were mostly detrimental to the core service, for example taking the form of box ticking (McGivern and Ferlie, 2007), doctors focusing on producing evidence of good practice more than on treatment itself (McGivern and Fischer, 2012), practicing medicine defensively (McGivern and Fischer, 2010), or doctors refusing to implement incident reporting schemes (Waring, 2005; Waring, 2007). However, our research advances the previous literature by showing how the practice of Corroboration helps the riskworkers share the risk, reassures them in their decisions, protects them from blame and consequently empowers active and confident risk response.

Securing Efficacy

In view of dynamic risk that continually changes on daily or even hourly basis and of risks that can realize at any moment, it is essential that riskworkers are responsive. Timing of their actions and decisions, being able to deliver them when pressed by urgency, is key to containing risk. This includes timing of Interpreting and Reinterpreting or Corroborating the practices discussed above, as well as other operational activities of the team. Indeed, the professionals in our research organise

around the objective of being responsive and remaining responsive to risk by enacting the practice of Securing Efficacy. In the analysis chapter we contribute by showing that three distinct components can be identified in this practice.

Firstly, the riskworkers are *accommodating the risk and its scale*. They tailor and scale their actions to the perceived risk and synchronise with its urgency by prioritizing risks, clients and tasks to address the most urgent ones. Accordingly, they reschedule their own tasks flexibly or negotiate assistance with their colleagues. This is facilitated by their *compliance to risk dynamics* which means that the professionals act without hesitation, do not delay their actions, and when asked for assistance by colleagues, do not question the necessity of the request. The risk urgency, as recognised by them, or by their team mates, it is what dictates their priorities. This reinforces the perception that every riskworker can and should ask for assistance if they struggle with their schedule or with a particular action.

Secondly, the team members are *meeting team capacity in day-to-day work* by synchronising between themselves, swapping tasks, or covering for colleagues. They demonstrate and cultivate flexibility and willingness to adjust as circumstances dictate and as colleagues request. The riskworkers not only allow for last minute rearrangements, but also recognize that such flexibility is indispensable for delivering adequate response and for managing the dynamic risk of their clients. Due to the nature of the service, acute changes in risk levels will inevitably occur in some clients, or critical risk characteristics will be occasionally overlooked in the elusive risk context. To prevent risks from realizing in such unavoidable situations, the team will need to make immediate rearrangements and adjustments in order to deliver the required risk response. Understanding the team's readiness to do so emphasizes the role of and sensitivity to time of the day-to-day riskwork, an aspect that has been so far overlooked in the literature.

The riskworkers also synchronise with other services, including the blue light services, if they cannot cope in a particular situation on their own. By enacting the third component of the practice, *relieving overload*, the riskworkers at all levels proactively engage in activities and routines that help avoiding burnout and provide organisational and emotional support to team members in the demanding conditions of the service. There is a universal understanding that engaging with clients and their intense risks may wear the riskworkers out emotionally and that mutual support is

essential. The team members do not hesitate to ask for support and consider providing support to their colleagues as part of everyday work. Specifically, in this service, the routines include specialised counselling services, flexible working arrangements, free-spirited supportive conversations and atmosphere, all of which is facilitated by *mindfulness towards colleagues*.

The literature on responding to risk forms a substantial part of the vast risk management literature (c.f. Hood et al, 2001). As noted by Hardy & Maguire (2016), this substantial literature can be categorized into prospective organizing of risk (that is before it can realize), retrospective organization of risk (after an adverse event has happened), and organizing of risk in real time (that is, when it realizes) which is most relevant in the context of dynamic risk. Currently in literature, it is well understood how actors respond to risk in real time by the means of a ‘control and contain’ strategy with “clearly defined rules, detailed and well documented operating procedures, and a clear-cut chain-of-command authority” (Hardy and Maguire, 2016:88, after Hood, 2005), a strategy which is applicable to risks that evolve according to predicted scenarios. However, there is much less understanding what the riskworkers actually do to be responsive in case of open ended risks that deviate from predicted scenarios, or are not characterised by credible predictions. Our research improves this understanding by showing how riskworkers match the pacing of their practices to risk urgency, prioritize between tasks, synchronise their delivery with colleagues, and accordingly structure their practices temporally. This resonates with the observation of Chreim et al. (2019), who note that, in a related mental health service context, professionals perform roles that are interchangeable to ensure that services are not disrupted due to staff absence. Our findings also reveal that the practices of the riskworkers are not solely focused on risk per se. A significant portion of their attention and day-to-day riskwork concerns their colleagues and the evolving context that are part of the risk managing apparatus. So riskwork is not only about acting directly towards the risk, but also consists of wider interactions across the many actors that enable the risk to be targeted efficiently.

In terms of *relieving overload*, supporting morale and responsiveness in the long term, there are studies that indeed confirm the emotional burden of practising healthcare, in mental health services in particular. This is not surprising since already Douglas (1992) suggests that risk is tied to emotions, affect and moral values.

Specifically, Fischer and McGivern (2016) focus on the emotional dimension of riskwork. In the context of a specialised mental health service, the democratic therapeutic community (DTC), they demonstrate that clinical riskwork in mental health is a very intimate and affect-laden form of risk management. In the DTC tensions between clients and staff arise when following risk incidents regulators impose a change from ethics-oriented to rules-based management (c.f. also Fischer and Ferlie, 2013). This undermines the trust between the staff and clients of the DTC resulting in “staff feelings of anger, resentment and betrayal by increasingly ‘untrustworthy’ patients [clients]” (Fischer and McGivern, 2016:245). Our contribution and the understanding of the practice of Securing Efficacy shows the significant emotional stress of the riskworkers in the mental healthcare setting and sheds light on how they manage it in the long term through enacting the practice that comprises supporting colleagues and sustaining morale.

Counterbalancing

Riskwork of managing dynamic risk is primarily focused on recognising and preventing risks that are or might be realizing in real time. However, the risk encountered in the service is complex and evolving at different time scales at the same time. It is described by the Dynamic Risk Model elicited in Chapter 4, with the three dimensions that contribute to the dynamics: the Emerging Apprehension, Remaking of Risk and Evolving Risk Trajectory. The practices that we discussed so far, that is Interpreting and Reinterpreting, Corroborating and Securing Efficacy are predominantly related to the first two dimensions of dynamic risk, the Emerging Apprehension and Remaking of Risk. The third dimension of dynamic risk, Evolving Risk Trajectory, relates to the long term mental health condition of the client and to the important question that the crisis team considers alongside addressing immediate urgencies: how can we prevent the relapse of crisis?

The main objective of the practice of Counterbalancing is sustaining client’s stability beyond the treatment time of the crisis team. When clients are in the service and the riskworkers Interpret and Reinterpret their case, they gradually develop an understanding of clients’ situation, relations, difficulties and struggles, and are able to identify possible factors that put clients’ life and emotions out of balance, contribute

to the crisis and are likely to trigger a relapse in future. The practice of Counterbalancing is about putting in place positive and minimizing negative influences in client's life. There are two elements to achieving this: firstly, the riskworkers are *stabilizing the client and developing protective layers* by eliminating factors prohibiting long term improvement, such as exploitation, isolation or neglect, that have a systematic detrimental effect on the client's emotions. Secondly, the crisis team aims to counterbalance the negative factors by *stimulating client's social relationships and reintegration*. This aids the clients to regain self-esteem, avoiding stigma, and provides a better environment to live a meaningful life. The riskworkers are determined to improve the clients' life and are motivated by *fulfilment of humanity and universality*. Helping other people, those who are suffering from a mental crisis especially, is an important motivator for working as a professional on the crisis team and the riskworkers tend to make an extra effort to ensure a long term positive influence on their clients. Consequently, they facilitate strengthening the integrity of their clients by their *holistic approach and mindfulness*.

Before our research the literature that considered evolving risks, reported them as time homogeneous phenomena with risk actors engaged in their respective time homogeneous roles. Our study advances the existing literature by showing that in the dynamic risk context the riskworkers are dealing with multiple time scales at which risks evolve. They not only deal with the fact that risks are elusive, and may change in real time, but they also address a long term evolution of risk at a time scale that reaches far into future. To address this long term evolution, the riskworkers focus on questions about how and why risks of individual clients develop, grow or decrease over time, and engage in improving these influencing factors. Hence, the riskworkers treat the risk as a process (Langley et al., 2013) that develops over time.

While the details of the Counterbalancing practice, and its components, are specific to the setting of the crisis team, we identified in our analysis that among others it entails balancing between safety and stigma and for example careful decisions are made when sectioning a client is considered. This connects to the recent study of Labelle and Rouleau (2016) where the setting is related to ours. There, day-to-day riskwork in a mental health hospital is considered in a setting where particular attention is given to client autonomy and where riskwork is accomplished by multiple actors, including clients who, unlike in our setting, are formally involved in the risk

management process. The authors note that by being involved in riskwork, the clients feel empowered, and also that “feeling safe and actually being safe can be made compatible with feeling and being considered as an active partner in risk management decisions” (p. 226). The distinction between this study and ours is that in a hospital ward setting, where all the clients and personnel are together in a shared environment, the riskwork relates to the whole community, to regulating the ward and things happening there, to setting common rules, procedures and measures. Therefore, the perspective becomes more macro and there is less scope for considering risks of individual clients. In contrast to Labelle and Rouleau, in our context the riskworkers deal with clients individually, focusing on each client’s isolated case, individual history, dynamics and evolution of their condition and context. This allows us to contribute how the riskworkers recognize that risk dynamics evolves on different time scales and how they address the long term risk evolution separately from the immediate risk and safety, by enacting a distinct practice with clear long term goals of sustainability.

Time coordination of risk practices for managing dynamic risk

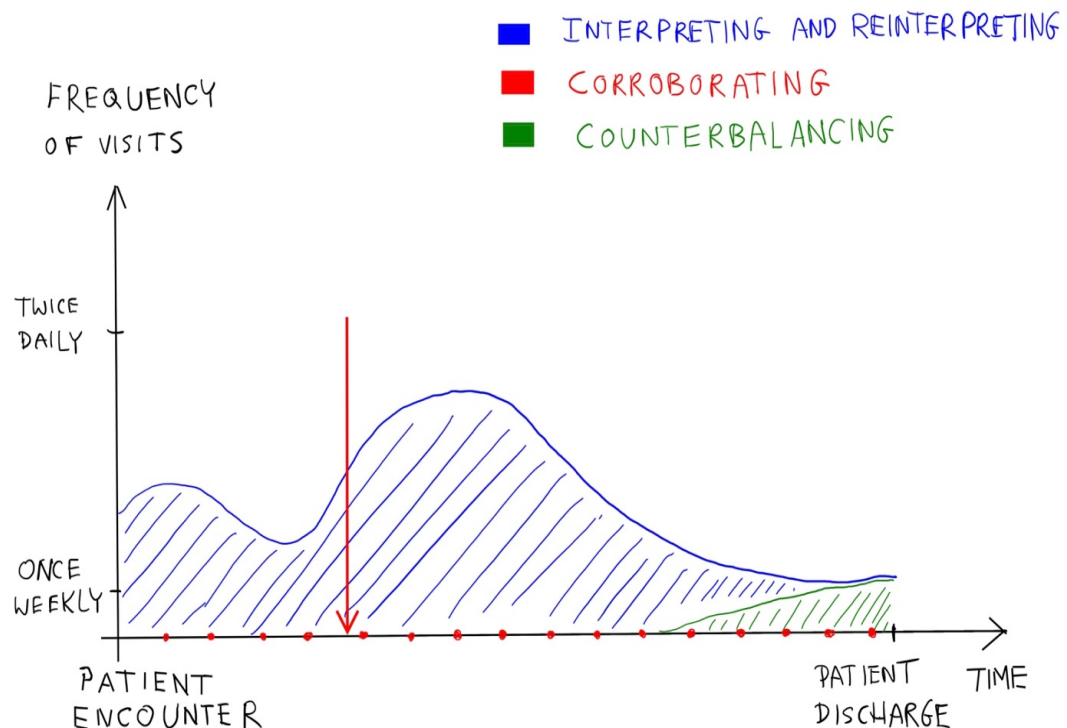
When facing dynamic risk that is urgent, emergent and ever changing, time is central to the riskwork and to individual risk practices. Risk can be contained if it is recognized in time for the necessary response to be put in place. As argued by Sandberg and Tsoukas (2011), the particulars of practice that make knowledge actionable, and dictate what to do, at what point of time and in what context, are only captured in time sensitive considerations. Sandberg & Tsoukas (2011:344) further observe that “practice is irreducibly temporal, not only in the sense of taking place in time but, more crucially, as immediate anticipations in actual carrying out of action”. Indeed, as demonstrated in our analysis, anticipations dictate timing of practices. When riskworkers anticipate that risks may increase, they increase the frequency of meetings with their client, adjusting the temporal structuring of Interpreting and Reinterpreting. When they anticipate a particular visit might turn to be emergency rather than routine, they ask a colleague for company, fixing in advance the timing of Corroboration.

However, despite time being so critical to risk practices, the recent turn to work in the risk literature has until now devoted limited attention to temporality. As Power (2016:20), puts it in the introduction to the influential riskwork volume: “(...) there are certainly gaps in this volume both methodological and substantive. For example, the temporality (Langley et al., 2013) of riskwork processes is at best implicit (...)” We take the opportunity to elicit temporality more carefully from the time sensitive riskwork context of our research setting.

To study time in the practices of the Mental Health crisis team we adopt the temporal structuring approach of Orlikowski and Yates (2002). Temporal structuring is a way of understanding and studying time as an enacted phenomenon within organizations. It asserts that time is experienced in organizational life through timing and pacing of processes that characterize everyday engagement of organizational actors in the world. Orlikowski and Yates (2002) suggest that studying time in organizations requires studying time in use, that is, examining what organizational members actually do in practice, and how in so doing they shape the temporal structures that in turn shape them.

In the analysis chapter, we put particular attention to how the riskwork and the four risk practices in particular are organized in time. This allows us to develop a systematic understanding of the temporal structuring of these practices. It is convenient to discuss our findings with help of a graph (Figure 6) that covers a timespan of a single client (a constructed example that represents a possible scenario) being treated within the service, from admission to discharge, as indicated on the horizontal time axis. The graph presents three practices: Interpreting and Reinterpreting (blue), Corroborating (red) and Counterbalancing (green) that are in effect when dealing with this client. Securing Efficacy and its role in temporal organization of the practices is then discussed in the sequel.

Figure (6): Temporal structuring of practices for an example client – scenario 1.



When clients are referred to the service there is a sense of urgency in that the typical client will be unsafe without quick help and without the crisis team undertaking promptly adequate action. This sense of urgency regarding a new referral dictates a wall clock rule that contact needs to be made with the client within four hours. Enacting the Interpreting and Reinterpreting practice starts from the very beginning when the client is admitted to the service. After that, face to face home visits or meetings at the crisis service premises are planned and arranged with frequency dictated by circumstances, as per needs. The frequency of these visits may vary from one per week to twice daily and it indicates how intensely the practice of Interpreting and Reinterpreting is being enacted. The blue line in Figure 6 shows varying frequency of the home visits during client's treatment. After recognizing client's situation in the first days, there is initial decrease in frequency of visits. However, shortly thereafter the client's presentation has deteriorated and dictated much more frequent visits to ensure timely information flow facilitating Interpreting and Reinterpreting. This high frequency of visits continued for some time, until the client's condition improved. Then the frequency was gradually reduced until discharge. During this time, there might have been also phone calls, consultations with family and access to other sources

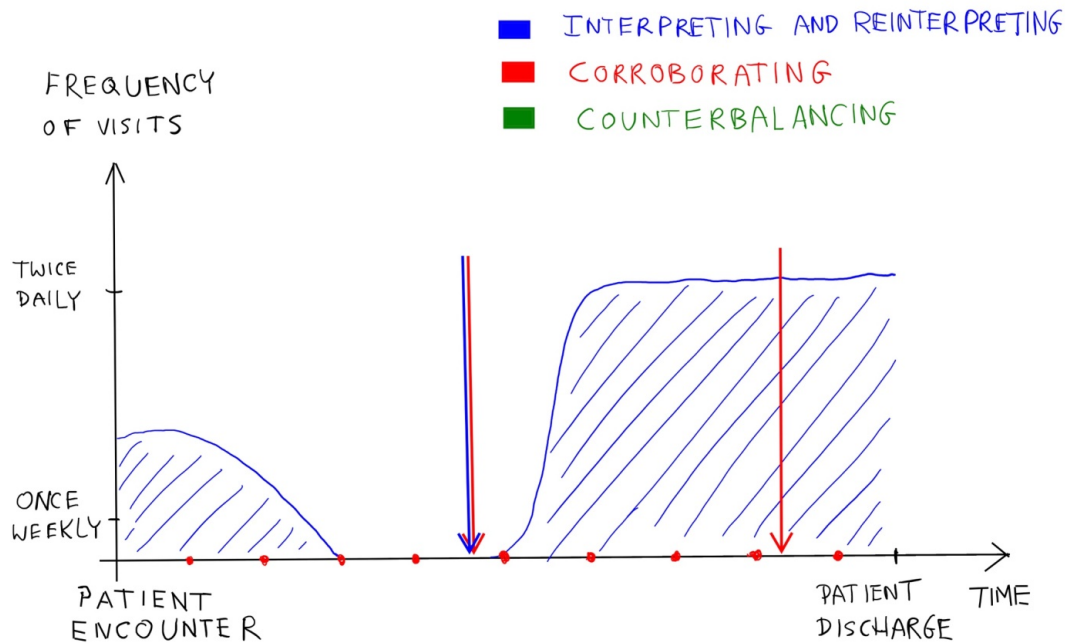
of information that were subject to Interpreting and Reinterpreting. The practice of Corroborating regarding this client is marked in red. It has been enacted at regular scheduled meetings, such as the weekly clinical review meeting, marked with red dots on the time axis. There is also a pivotal juncture, indicated by the red arrow, an event indicating high risk levels, and at that point of time unplanned enacting of Corroboration took place: the client's case was urgently discussed between team members. One can see that the home visits and Interpreting and Reinterpreting have also intensified following this pivotal juncture. Counterbalancing, marked green, started when the client stabilized, with an outlook that they will be discharged soon. This is not to forget that the details of what Counterbalancing entails depend on what has been understood through Interpreting and Reinterpreting during the whole course of treatment.

There are two cyclic elements in Figure 6. First, cyclic but with varying frequency depending on risk presentation, is the scheduling of home visits and consequently enacting of Interpreting and Reinterpreting (blue line). Second, the cyclic clinical review meetings and enacting of Corroborating (red dots), which is set up so that every client can be discussed at least once per week, adequately to the timing needs of the whole service. Their timing and pace are synchronized with the perceived dynamics of the risk they address (individual risk of the client, or combined risk cases in the whole service) in order to facilitate timely decision making, information flow and update on the emergent perception of client's risk. This arrangement is known in the literature as entrainment, that is "the adjustment of the pace or cycle of one activity to match or synchronize with that of another" (Ancona and Chong, 1996:251). Corroborating on a pivotal juncture (red arrow) can also be viewed as entrainment: it happens immediately in view of escalating risk, and therefore its pace is adjusted to the current dynamics of risk which requires instantaneous reaction.

These two cyclic activities, home visits and clinical review meetings, that enable Interpreting and Reinterpreting and Corroborating, respectively, are characterized by *open-ended temporal orientations*, that is, are carried out continually in time without a fixed end in view (Dubinskas, 1988). This is in contrast to Corroborating at a pivotal juncture, which is characterized by *closed temporal orientation*, that is, it is short-term and focused on "the immediate present and the proximate future" (Dubinskas, 1988). When an element of practice is enacted that is

characterized by a closed temporal orientation, it is marked by an arrow to indicate its anchoring at a particular timepoint.

Figure (7): Temporal structuring of practices for an example client – scenario 2.



The next plot, Figure 7, presents an example of an alternative scenario. After admitting to the service and several meetings with riskworkers, the client disengaged from the service. This stopped the necessary information flow, disrupted enacting of Interpreting and Reinterpreting and precluded adjusting risk practices to risk dynamics (making entrainment of Interpreting and Reinterpreting not feasible and timely accurate response to risk not possible). Consequently, following a discussion at a clinical review meeting (Corroboration - fourth red dot on the time axis), an unannounced home visit of two riskworkers (cold call) has been arranged. The cold call is indicated by the double red and blue arrow. The two riskworkers assessed the client during the home visit (Interpreting and Reinterpreting – blue arrow), as well as connecting and synchronizing their assessments (Corroborating – red arrow, pivotal juncture), concluding very high level of risk. Following that, twice daily visits have been recognized necessary and scheduled accordingly (entrainment of Interpreting and Reinterpreting – synchronizing with risk levels). After another three weeks, at one of the clinical review meetings (Corroborating – red dot) the riskworkers concluded that

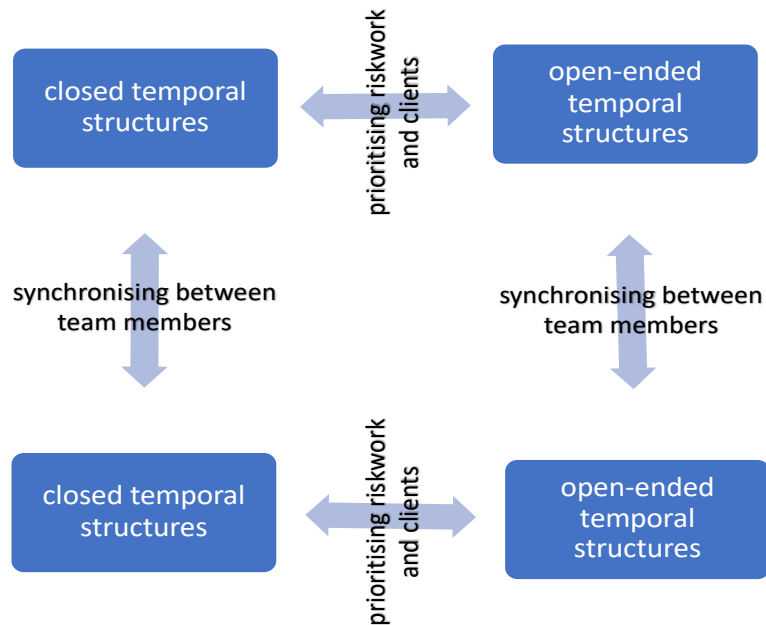
sectioning should be considered. An AMHP and two doctors examined the client (Corroborating – red arrow, pivotal juncture) and sectioned him. The twice daily visits continued, while the client was on a bed waiting list. When a place in a hospital became available the client was discharged from the service. Again, the cold call and the sectioning are indicated by arrows as they are characterized by the closed temporal orientation, while other enacted activities are cyclic and characterized by the open-ended temporal orientation.

It follows from our analysis and from the above example cases illustrating temporal structuring of practices that the actors tailor timing of their riskwork and risk responses in real time as circumstances dictate. They deliver timely risk interventions aimed at achieving a specific purpose and characterized by closed temporal orientations to address emerging issues where appropriate, or readjust frequency of their cyclic riskwork characterized by open-ended temporal orientation.

The riskworkers accomplish their tasks and deliver the required action at the right time through collective time coordination that is contained in the practice of Securing Efficacy: the riskworkers are continuously prioritizing between tasks and cases, and synchronizing tasks between themselves.

Figure 8 illustrates how Securing Efficacy is enacted by collective time coordination of riskwork practices in the crisis team. The horizontal direction demonstrates how the riskworkers prioritize urgent and immediate risks that can be addressed by one-off interventions (e.g. a cold call), which is riskwork characterized by closed temporal structures, over less urgent prescheduled cyclic riskwork (e.g. prearranged home visit) characterized by open ended temporal structures. The vertical direction manifests that the team members synchronize between themselves, executing specific tasks within both closed and open-ended temporal structures, depending on availability, expertise and background. Thus, through the practice of Securing Efficacy the team members not only match tasks to time availability, but also couple different types of problems with riskworkers who are best endowed to solve them.

Figure (8): Securing Efficacy: Collective time coordination of riskwork practices.



To summarize the findings that relate to the role of time in managing dynamic risk, we note that before our research, the literature identified different types of riskwork that were broadly classified into 'frameworks and designs', 'negotiating risk objects and values' and 'conflict emotion and practice' (Power, 2016), however none of the works considered the context of dynamic risk, where urgency and time played the central role. But our research advances the previous literature by showing how in the dynamic risk context the riskworkers structure their riskwork into four risk practices for which time is central. The riskworkers synchronize the pace of the practices with intensity of risks and coordinate enacting the practices and individual tasks between themselves. The practices enable them to (a) recognise the risk as it emerges, (b) deliver tailored response timely, confidently and efficiently, and (c) take measures in anticipation of risks' future dynamic evolution.

Furthermore, before our research, the literature identified different types of riskwork and considered them individually, or as coexisting and at best overlapping. But our research advances the previous literature by showing how in the context of dynamic risk, riskwork is composed of four practices that are linked together, interdependent and are enacted following nested, but individually suited, temporality

structures. Our riskwork model of managing dynamic risk explains the roles of the four practices, how they underpin each other, and how they combine into one mechanism for managing dynamic risk.

CHAPTER 7

Conclusions and Implications

7.1. Strength and limitations of the study

There are several ways in which our study may be limited and we now discuss these aspects. Firstly, due to the nature of our access, we were not been able to observe the crisis team members meeting with clients. This is clearly a limiting factor as these meetings are at the core of the service provided by the team and are the primary source of information about the risk in each individual case. As described in the previous sections, the skill and situated knowledge of how to interact with clients, encourage conversation, understand their body language, read emotions and capture other subtle signs of incoherence and possible risks constitutes the knowledgeability of action which is crucial for example for the practice of Interpreting and Reinterpreting. To compensate for this shortcoming, we have made every effort to obtain accounts of meeting with client from different sources, and triangulate these. We have discussed meeting clients with all of our interviewees, obtaining multiple account from each of the involved professions, and we have payed particular attention of how meeting with clients was reported at different types of team meetings and consultations. We have also followed a careful process of in-dept data collection and reflection through developing and revisiting field notes and discussing our data, findings and ideas with supervisors, as described in the methods section. Hence, we have made every effort to neutralize this shortcoming of the data collection process.

Secondly, our research was based on a single case study of the CRHT team and this has consequences for how general our findings are, especially regarding the risk practices described by the model of managing dynamic risk. So, how does the CRHT team differ from other settings where dynamic risk is encountered and managed? Certainly, the team dynamics was strong and the team appeared to be functioning well. The presence of good relationships in the team makes it difficult to research the absence of these sort of relationships. Similarly, there was no overt conflict in the team,

or maybe, if there was conflict, there was also will and capacity to resolve it in early stages so that it did not capture the attention of researchers, and did not require intervention of team leaders. This may be considered atypical as mental health services are very demanding of their staff, causing high levels of burnout and emotional exhaustion (Prosser et al, 1996) and have a documented record of conflict (Fisher and Ferlie, 2013) and emotional overflows (Fischer and McGivern, 2016). It is clear that our findings could be tested in subsequent research on different teams and in different settings. However, in Section 7.3 we use our model of managing dynamic risk developed in Section 6.2 to propose a discussion of how various team dysfunctionalities could affect this riskwork.

Another aspect of our study that influences the collected data and consequently the inferred conclusions is that we primarily observed and focused on actors dealing with risks that were unfolding in real time. This seemingly limits the acquired perspective on the concept of dynamic risk and on development of the Dynamic Risk Model to the single mode of real time risk organising, as opposed to encompassing the whole spectrum of prospective, real time and retrospective modes, as recommended by Hardy et al., (2020). Indeed, the clients of the CRHT team are experiencing an acute mental health crisis, which is an adverse damaging event in itself, and we have interviewed and observed the CRHT team members as they were making efforts to manage the continually developing crisis cases and trying to mitigate the variety of ambiguous, but typically severe, consequences in every individual case. In justification of the validity of this approach to this strategy of data collection as means to developing the Dynamic Risk Model, the following two comments are due. Firstly, as it is often the case in many organisations (Hardy et al., 2020), the three modes of risk organizing are not clearly separated. Many of the risks the crisis team is actively managing in real time can be interpreted as proxy of more consequential, and often unpredictable, risks that thereby are being managed prospectively. For example, the real time risk of not taking medicine is a proxy of the future risk of mental health deterioration, which in turn is a proxy of the risk of suicide or another unpredictable harmful outcome. Similarly, the risk of the client not applying for due benefits is a proxy of neglect and deprivation and which in turn is a proxy of crisis relapse. Hence the two modes of risk organising are indeed blended when managing the mental health crisis, and this is largely so due to the dynamic nature of the encountered risk.

Secondly, it is the real time mode that leads to lived-in experience of dynamic risk, with its ambiguities, time pressures and implied need for decisions and actions. Trying to capture the concept of dynamic risk through examining the retrospective mode of risk organizing would be reminiscent of the unsuccessful attempts to understand and prevent accidents through post incident investigations, as hindsight does not equal foresight and researchers who “are anchored to outcome knowledge run the risk of not capturing the complexities and uncertainties” (Henriksen and Kaplan, 2003:ii46) faced by the frontline risk workers.

7.2. Theoretical implications

The presence of risk and risk related issues has always been strong and is continuously intensifying in the life of individuals and organisations. Hence, the notion of risk is increasingly attracting the attention of researchers in fields ranging from philosophy and sociology to finance and statistics, with managerial and organisational sciences in the middle of this wide spectrum, resulting in many conceptualisations and definitions of risk.

When encountering risk, we intuitively think about it in terms of intensity and urgency as well as attempting to determine how matters may develop, and how to evaluate the potential of risk increasing. This approach begins to introduce time into our considerations of risk and typically implies the need to take action promptly in order to prevent future risks from being realized. This approach also reveals the importance of thinking about risk in dynamic terms. Indeed, from the data in our research setting we immediately see that risk actors are particularly concerned about time and in particular about dynamic changes in risks they encounter.

Yet, available conceptualisations and definitions of risk proposed by researchers in various fields tend not to explicitly account for time, dynamics, or urgency. This means that an important aspect of risk was missing from the literature, because time and urgency dictate what actors do, when, and why, which are the core questions in organisational sciences.

We declared to use the lens of process theory (Langley, 1999) and focus on events that mark shifts in risk over time in order to elicit how the risk actors conceptualize dynamic risk, at the micro level of individual client, as an ever evolving

phenomenon. Our research contributes to the conceptualisation and understanding of dynamic risk by introducing the Dynamic Risk Model. The model identifies three dimensions that contribute to risk dynamics and systematically help to explain its evolution over time:

- (1) Emerging Apprehension that addresses the question: what can be understood about the risk? It accounts for the multitude of ways that threats may be constructed and that the levels of the threats are not known and emerge only gradually over time;
- (2) Remaking of Risk that addresses the question of: what can be done about the risk with available resources? It accounts for available resources and feasible responses to address the risk that are changing over time;
- (3) Evolving Risk Trajectory that is concerned with: how the risk may evolve in the long term? It accounts for the fact that the underlying phenomenon that causes the risk is evolving. In our case it is the client's mental health condition and their social context.

While the Dynamic Risk Model has been developed in our research setting of acute mental health services at the micro level of dealing with individual clients, we identified broad patterns of how risk dimensions are conceptualised and found the three generalized dimensions. We conjecture that these dimensions are generic and the Dynamic Risk Model will be useful for explaining responses to risk in a number of other contexts.

Another important characteristic of the Dynamic Risk Model is that the three dimensions that contribute to the risk dynamics (Emerging Apprehension, Remaking of Risk, Evolving Risk Trajectory) account for three separate phenomena and consequently evolve on different time scales. They also exist independently of what the actors choose to do. This allows us to better understand time and urgency which is imposed onto the actors by risk dynamics. It opens the possibility to investigate how risk actors manage dynamic risk and in particular the role of temporality in their riskwork. We have done this in the second part of the thesis.

As promised in the beginning, in the context of the Dynamic Risk Model we studied day-to-day riskwork of the crisis team through the practice theory lens (Schatzki et al., 2001; Nicolini, 2012; Reckwitz, 2002; Orlikowski, 2010) and with

particular attention to the role of time via the temporal structuring approach of Orlikowski and Yates (2002). Our contribution is in line with the turn to work studies in risk management (e.g. Power, 2016) and is particularly relevant in this intense dynamic risk setting. Studying what actors actually do every day through their risk practices in order to recognise and manage risk becomes even more relevant if we consider that the risk they encounter is dynamic. Indeed, from the micro perspective of individual risks that are unique and not subject to scientific studies based on repetitive experiments, these risks are dynamic because their apprehension is elusive and only emerging, because they are remade by surrounding circumstances and because the risk itself is changing through the underlying evolving phenomenon that generates it.

We contribute an understanding of riskwork composed of distinct risk practices in this dynamic context. We show that the risk practices of the crisis team are complex and cover a multitude of aspects. Phillips and Lawrence (2012:227) observe that “one of the powerful effects of adopting a ‘work lens’ is a shift from the outcomes of action to the actors involved in the action itself”. However, we establish that these individual practices not only result in recognising risks and delivering response, but also yield outcomes for the riskworkers and facilitate enacting each other. Hence, the individual risk practices support and underpin the operational capacity of the riskworkers. We have identified, for example, that Corroborating empowers the riskworkers to make decisions and take action, which is critical in the difficult-to-navigate elusive and dynamic risk context. Securing Efficacy is another example of a practice that results in riskworkers being and remaining responsive. Hence the practices not only serve the direct purpose of managing risk, but they also depend on each other, and as a result provide the team with organisational entities necessary for delivering riskwork and keeping the service sustainable. Building on Knorr-Cetina (1981), Power (2016) observes that the emphasis of riskwork should be on forms of interactions understood as ‘interlocking of intentionalities’ (Power, 2016:7). Indeed, intentionalities and the resulting interactions between actors play the key role in the four practices that we identify. The intentionality fuelling Interpreting and Reinterpreting is understanding risk, and while the practice is most of the time enacted by individual riskworkers meeting their clients, its outcome, that accumulates and evolves over time, is an effect of joint efforts of all the team professionals involved sequentially in assessing a

particular client. Interactions between the risk actors are essential for Corroborating which is driven by shared intentionality of synchronising interpretations, confirming best decisions and actions. Risk actors enact Corroborating jointly, at prescheduled cyclic meetings, as well as during ad hoc discussions and consultations with the interpersonal values such as trust and collectivity playing vital roles. Securing Efficacy is a practice fuelled by the shared desire to be and remain responsive to risk, to deliver the response in a timely fashion and at appropriate scale. It relies on different types of interactions between risk actors who, in line with their shared intentionality, jointly prioritize risks and coordinate their schedules, as well as cooperating to relieve overload on individual team members. The humanistic intentionality to improve the client's life in the long term underpins Counterbalancing and the interactions it generates, when the riskworkers match tasks with their area of expertise or coordinate to avoid or minimise stigma at pivotal junctures.

Furthermore, the analysis of the risk practices in our research setting and the resulting model of riskwork composed of the four practices, brings to the foreground the role of time and how the practices enable the riskworkers to achieve their time sensitive goals: recognise the risk as it emerges; deliver tailored response in a timely fashion, confidently and efficiently; and take measures in anticipation of the future dynamic evolution of the risks.

Our research also offers a new perspective on multiple interpretations in the context of dynamic risk that is emerging, elusive and urgent. The riskworkers enact the practice of Corroboration to actively seek multiple interpretations and aim to connect and synchronise them in order to gain confidence about their risk assessments that then empowers the actors to make decisions and take actions. This advances the previous literature that considered multiple interpretations of risk as conflicting views and a hurdle that needs addressing.

We also advance the previous literature by showing that interpreting risk is continual in time and never ending, as opposed to a task that must be completed and finished by a deadline. Through the practice of Interpreting and Reinterpreting the riskworkers obtain continual and up to date assessment of the risk case, despite its emerging character, incomplete information and continuous dynamic evolution. The practice provides the basis for action that allows the actors to make prompt decisions and take necessary steps in real time.

We contribute a new insight to the understanding of how organisational actors may protect themselves from blame. Before our research the literature considered various blame-protecting strategies and practices that riskworkers may implement to be detrimental to the core service. However, we show how the practice of Corroboration helps the riskworkers share the risk, reassures them in their decisions, protects them from blame and consequently empowers an active and confident risk response.

We trust that these insights into riskwork and risk practices in the dynamic risk context will prove useful for other settings where circumstances are imposed onto the risk actors and are subject to constant change, possibly on different timescales. Fire-fighting, mountaineering expeditions, and many other high risk services or endeavours would benefit from a better understanding of possible risk practices and roles. We presume our riskwork model could be verified and maybe further developed in the many dynamic risk contexts.

7.3. Practical implications

An important question for every theoretical contribution, and for our research as well is what are the practical implications of the work. Hammersley, 1992:6, discourages far reaching conclusions in this direction by saying: “relevance of ethnography to practice is most likely to be general and indirect, rather than providing solutions to immediate practical problems”.

Nevertheless, we believe insights from our research may be useful in practice. The Dynamic Risk Model identifies the three generic dimensions that contribute to the dynamics and evolve at different time scales. This alone may be useful in structuring our thinking of a new risk, new phenomenon that needs addressing and help design an appropriate risk response.

For example, at the very moment of finalizing this dissertation, there is an outbreak of a new coronavirus causing pneumonia-like symptoms. The virus, first identified in Wuhan, China, appears to be highly contagious and resulting in a high death rate among those infected. There is a major concern the outbreak may turn into a global pandemic. Having the disturbing opportunity to witness how data and

information regarding the coronavirus outbreak is gradually emerging, we note that the associated risk can be conceptualised using the three dimensions of the Dynamic Risk Model. Indeed, our concept of Emerging Apprehension helps to explain how key risk markers can emerge gradually, being inaccurate or fragmented: it was believed at the beginning of the outbreak that the virus could be only transmitted to humans from an animal. However, human to human transitions have been later confirmed, causing significant modifications to evaluations of risk. Then, it was believed that only patients who suffer from symptoms can infect others (maybe because this was the case for SARS and gene sequencing has confirmed similarity of the virus to SARS). However, this evaluation and risk evaluation required modification when further information revealed that non-symptomatic people could be infectious and that the incubation period was longer than previously estimated for this type of disease (ranging from 5 to over 14 days). Hence the main characteristics of the virus are only gradually emerging and elusive. Remaking of risk also contributes significantly to the intensity of risk associated with the virus outbreak. Systemic problems have been exposed and contributed to the risk when the Wuhan government held an annual banquet for forty thousand families, despite the fact that the escalating rapidly. Moreover, while the transportation ban was put in place in Wuhan and other strongly affected cities, international flights are still both arriving to and departing from Wuhan at the time of writing. The capacity to handle the outbreak is also subject to changes and has been affected by WHO's decision not to declare a state of Public Health Emergency of International Concern. As further information becomes known, the nature of the risk must be re-evaluated. There are at least two important factors contributing to the Evolving Risk Trajectory. These are the ability to quickly obtain a vaccine for the virus and the capability of the virus to mutate. An additional factor that may influence the long term dynamics is the applicability of already available medication. Efficiency of available HIV (the Human Immunodeficiency Viruses) and Ebola drugs is currently under investigation.

As for our second contribution, the riskwork model of managing dynamic risk, it also seems to be potentially useful in several ways. We have discussed the limitations to which this model is subject and these limitations mainly relate to our study being based on a single well-functioning team. In view of this discussion, the first important practical implication of the model is that it illustrates how risk actors in well-

functioning teams work. A specific conclusion from the model is that management of dynamic risk turns out not to be a task undertaken by an individual, or a task that can be executed by individuals working independently. Managing dynamic risk turns out to be a collective process. Two of the identified riskwork practices, Corroborating and Securing Efficacy, are collective at their core, while the other two, Interpreting and Reinterpreting, as well as Counterbalancing are being enacted by different individuals with varied viewpoints and backgrounds only to be coordinated through Corroborating and Securing Efficacy. Importantly, we trust that the riskwork model allows to predict and theorise which practices would be missing, or which would suffer in teams that are not functioning well. For example, blame culture would severely undermine Corroborating which is facilitated by trust and collectivity. Lack of Corroboration would in turn take away empowerment for taking actions. Analogously, conflict or lack of support towards colleagues would undermine Securing Efficacy which is necessary sustained responsiveness to dynamic risk. We trust that viewing teams through the lens that our model of managing dynamic risk is providing, will be helpful in removing barriers to their collaborative functioning and improving their performance.

APPENDICES:

Appendix A: Participant Information Leaflet



PARTICIPANT INFORMATION LEAFLET

Study Title: Challenges of managing complex risk in the context of healthcare system

Investigator(s): Agnieszka Latuszynska

Introduction

You are invited to take part in a study. Before you decide, you need to understand why the study is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

(Part 1 tells you the purpose of the study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study)

Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

PART 1

What is the study about?

The aim of the project is to understand how different professional groups perceive and manage risk in a complex organization, like healthcare.

Do I have to take part?

It is entirely up to you to decide. We will describe the study and go through this information sheet, which we will give you to keep. If you choose to participate, we will ask you to sign a consent form to confirm that you have agreed to take part. You will be free to withdraw at any time, without giving a reason and this will not affect you or your circumstances in any way.

What will happen to me if I take part?

Participation in this project will involve being interviewed by the above named researcher on the theme of distribution and management of risks. The interview will be audio recorded. You will be free to request that the audio recording be halted at any stage before or during the interview. In the case when you agree to be interviewed, but not to be audio recorded, the interviewer will only take notes.

The time and location of interviews will be mutually agreed between you and the researcher. Interviews will be arranged so that they will not impact your work or patients' care.

The interview is expected to take up to one hour.

Your interviews may be followed up by additional, short face-to-face meeting or phone call, where clarification and elaboration of analysis is sought.

What are the possible disadvantages, side effects, risks, and/or discomforts of taking part in this study?

It is not expected that the participant will experience any of the above being involved in this project.

What are the possible benefits of taking part in this study?

Participant involvement in this project will help to understand how risks related to mental health are distributed and managed in the system, and how different professional groups perceive them. Taking part in this study will also help to provide feedback on management of risk processes.

Expenses and payments

This study does not provide any reimbursements for the participation in this project.

What will happen when the study ends?

When the study will end all information will be held and processed for the following purposes: to be analysed by the researcher for the purposes of completing their PhD research and, where relevant, for the writing of associated academic journal articles or monographs.

Will my taking part be kept confidential?

Yes. We will follow strict ethical and legal practice and all information about you will be handled in confidence. Further details are included in Part 2.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm that you might suffer will be addressed. Detailed information is given in Part 2.

This concludes Part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

Who is organising and funding the study?

The research is being developed within a broader umbrella of CLAHRC (Collaboration for Leadership in Applied Health Research and Care West Midlands) related research on risk management in healthcare.

What will happen if I don't want to carry on being part of the study?

Participation in this study is entirely voluntary. Refusal to participate will not affect you in any way. If you decide to take part in the study, you will need to sign a consent form, which states that you have given your consent to participate.

If you agree to participate, you may nevertheless withdraw from the study at any time without affecting you in any way.

You have the right to withdraw from the study completely and decline any further contact by study staff after you withdraw.

What if there is a problem?

This study is covered by the University of Warwick's insurance and indemnity cover. If you have an issue, please contact the Chief Investigator of the study:

Eivor Oborn
Patricia Reay

Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services
University House
University of Warwick
Coventry
CV4 8UW
Tel: [REDACTED]
Email: [REDACTED]

Will my taking part be kept confidential?

Data will be anonymised from the start, with no names or specific positions recorded as part of the interview material. Your consent form will be stored in a locked office at the University of Warwick, and transcripts of interview data will be anonymised before being printed and stored in the same place. The transcripts will also be stored electronically on the lead researcher's password-locked laptop. All material may be destroyed after 10 years from the completion of the research. You can request a copy of the publication from the researcher named above.

What will happen to the results of the study?

3

16/01/2017 & VERSION 2

The material from this study will be used in the doctoral dissertation and may be published. It will also support Mental Health services by providing executive summary to interested stakeholders that will inform their management of risk processes.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the University of Warwick's Biomedical and Scientific Research Ethics Committee (BSREC): **Insert your BSREC number here (given to you when your study is approved) and include the date on your approval letter from BSREC.**

What if I want more information about the study?

If you have any questions about any aspect of the study, or your participation in it, not answered by this participant information leaflet, please contact:

Eivor Oborn [REDACTED], Patricia Reay [REDACTED]

Thank you for taking the time to read this participant information leaflet.

Appendix B: Consent Form



CONSENT FORM

Study Number:

Participant Identification Number:

Title of Project: Challenges of managing complex risk in the context of healthcare system

Name of Researcher(s): Agnieszka Latuszynska - doctoral researcher

Prof. Eivor Oborn and Prof. Patricia Reay – supervisors

Please initial appropriate boxes

- | | |
|--|--------------------------|
| 1. I confirm that I have read and understand the information sheet dated [16/01/2017] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. | <input type="checkbox"/> |
| 3. I understand that my information will be held and processed in particular for the following purposes: to be analysed by the researcher for the purpose of completing their PhD research and, where relevant, for the writing of associated academic journal articles or monographs. | <input type="checkbox"/> |
| 4. I agree to take part in the above study and | |
| a. I am willing to be interviewed; | <input type="checkbox"/> |
| b. I am willing for the researcher to undertake observation of work activities. | <input type="checkbox"/> |
| 5. I agree to have my interview audio recorded. | <input type="checkbox"/> |
| 6. I agree to be contacted regarding a short face-to-face follow up meeting or phone call, where clarification and elaboration of analysis is sought. | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Researcher
taking consent

Date

Signature

16/01/2017 & VERSION 2

Appendix C: Interview Protocol.

Interview Topic Guide/Schedule:

A snowballing approach (Atkinson and Flint, 2001) will be used to identify key informants. In addition, a couple of preliminary scoping interviews will be held with site leaders to identify initial group of knowledgeable informants. In the main phase approximately 50 interviews will be conducted over the period of 6-9 month.

The interview questions, to be refined during the scoping period, will be according to the following outline:

Theme 1: Risk

- What are your key responsibilities?
- What sorts of risks do you (or other stakeholders you work with) face in your work?
- Who defines risk?
- How do you balance (and manage) these risks?

Theme 2: Accountability

- To whom are you accountable for managing risk?
- What makes you feel you are responsible for the risk?
- In what capacity does your approach to managing risk reflect your professional values? Are the others' values also reflected in your approach to managing risk?

Theme 3: Value

- What are the values that your service provides (and for whose benefit are these values)?
- What are the values created by the service/institution that you appreciate?
- How do you create value in your work and for whom?

Theme 4: Interactions between risk and value

- How does risk influence your work?
- How does managing of risk influence your ability to create value? Are there any conflicts between risk management and creating value?

Theme 5: Consequences of managing risks

- What are other consequences of managed risks from your standpoint?

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