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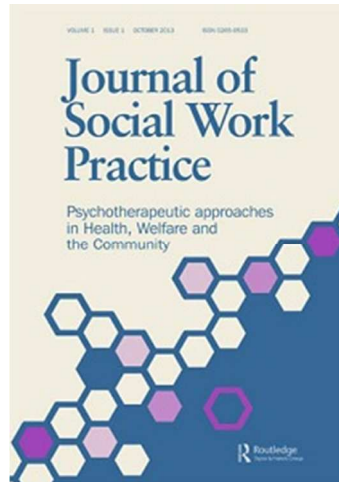
Hardy, Mark orcid.org/0000-0003-4639-4917 (2017) In defense of actuarialism : Interrogating the logic of risk in social work practice. *Journal of social work practice*. pp. 395-410. ISSN 0265-0533

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In defence of actuarialism: interrogating the logic of risk in social work practice

Journal:	<i>Journal of Social Work Practice</i>
Manuscript ID	CJSW-2017-0085
Manuscript Type:	Original Article
Keywords:	risk, actuarialism, social work, decision making

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In defence of actuarialism: interrogating the logic of risk in social work practice

Abstract

This article presents findings from a study of risk-based decision making which challenges aspects of the well-established consensus regarding the role that actuarially generated knowledge plays in risk based decision making in social work. Firstly, it suggests that there is little direct relationship between the process of risk assessment and its outcome. Secondly, it highlights that subjective practitioner judgement plays a role in elevating risk levels beyond those which actuarial calculations warrant. Finally, although risk aversion is evident, this cannot be reductively attributed to actuarial knowledge generation strategies. Instead, it is a function of practice in an environment in which fear of blame is a very real concern. I conclude with discussion of the implications of these findings for ongoing debates regarding forms of knowledge in practice.

Introduction

Risk has been an overt concern in social work for approaching thirty years and arguably represents a significant departure from familiar social work concerns. An emphasis on risk pushes social work away from inclusive, emancipatory approaches towards exclusionary, controlling practices which do not necessarily cohere with traditional values. Social work has been transformed from a profession with a commitment to enhancing individual well-being to one concerned to prevent harm, either to service users themselves, or to other members of the community. Although there are various explanations for such shifts, it is arguably no coincidence that they followed, in the UK at least, the election of a reforming Conservative government in the late 1970's, determined to establish neoliberal principles and practices within the structures and institutions of government, with a corresponding impact on 'social' thinking and practices. For many, this is a regressive shift, with largely detrimental effects.

In this article, I will report findings from a study of the impact of risk thinking in social work. Although to some extent, these tally with aspects of the dominant narrative regarding the generalised impact of risk thinking on social work practice, they differ quite significantly with regard to the specific role that actuarial knowledge plays in this. Firstly, the data suggests that actually, practitioners elevate risk levels beyond those which actuarial calculations warrant. Relatedly, it highlights that subjective practitioner judgement sometimes drives disempowering judgements, rather than actuarial knowledge. Finally, the data suggests that although risk aversion is, indeed, evident, this cannot be reductively attributed to actuarial knowledge generation strategies. Whatever social work's 'ill's', it seems that these are distinct from the role played by actuarial knowledge, which sometimes represents a potentially valuable source of knowledge for practice, and a counterweight against risk aversion.

Background

Various scholars have outlined the changes to social work associated with the rise of neoliberal thinking across the institutions and practices of government. Webb (2006), emphasised how the logics of risk, regulation and security intersect with neoliberal perspectives regarding choice, autonomy and individual responsibility. These differ markedly from the collectivist commitments that inform social work, and so their rise to prominence has impacted in ways which arguably compromise its integrity. Risk, it is argued, accentuates

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3 social exclusion, prompts over reliance on coercive approaches to practice, downgrades the
4 significance of social context, and undermines longstanding commitments to social justice
5 (Parton and Kirk 2010). Because of its predominant focus on potential harmful events the
6 energies and resources of practitioners are future oriented, to the detriment of the here and
7 now. Risk also privileges organisational legitimacy ahead of the right, proper or moral
8 response to individuals facing difficult circumstances. The nature of the services offered by
9 social work agencies emphasise emphasising the rights of the wider community ahead of
10 service user rights. The significance of social context is replaced by a concern with pre-harm
11 (Zedner 2006) and ‘prepression’, whereby risk ‘archives’ form the knowledge base for
12 categorization for pre-emptive intervention (Schinkel 2011). Judgements are informed by
13 cumulative banks of data drawn from similarly categorised populations rather than the
14 particular details of a case as interpreted by the professional. Significantly, as a result, social
15 work has become risk averse. Practitioners become participants in a repressive framework,
16 ‘unreflective co-conspirators’ in the politics of risk. The logic of risk functions as a
17 ‘predominantly morally conservative and repressive social, political and cultural force in
18 contemporary social work’ (Stanford 2008: 209).
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33 **Risk in social work practice**

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35 Although the notion of ‘risk’ originally referred to the probability of any particular event
36 occurring, in social work it has come to refer to the likelihood of a negative outcome – such
37 as a child death, a suicide, harm to a vulnerable adult or the commission of violence by a
38 service user. Social workers are now required to assess the likelihood of such outcomes
39 occurring in particular cases, and take appropriate action to prevent their occurrence. How
40 they might best do this remains contentious.
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46 The trajectory which the development of approaches to risk assessment has followed in social
47 work practice is similar to that in other domains, albeit with its own distinctive features. First
48 generation approaches are sometimes referred to as clinical approaches, wherein a
49 practitioner makes a judgement as to whether or not a particular service user poses a risk to
50 themselves or others on the basis of their understanding of that person and their situation
51 gleaned from the relationship they have established, case records and ongoing interpersonal
52 contact. These approaches have their roots in holistic, needs based approaches to assessment,
53 whereby “practitioners...relied almost entirely on intuition, experience and individual
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3 judgement to make their risk-based decisions” (Turner and Colombo 2008: 166). However,
4 unstructured clinical judgement came to be problematised, due to concerns that professional
5 discretion masked biased judgements (Monohan 1981) and so more effective risk assessment
6 processes and tools were sought.
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11 Second generation actuarial approaches to risk assessment are very different. They utilise
12 statistical analysis of relationships between social and psychological variables to calculate
13 probabilities at population level. Practitioners input data regarding static and dynamic
14 variables, history and context, into a software programme which results in a percentage score
15 – the likelihood of harm – or banding – low, medium, high or similar configuration. Such
16 knowledge has been characterised as “an anchor against the force of bias” (Jones and
17 Plowman 2005: 135). Quinsey et al provocatively suggest “the complete replacement of
18 existing practice with actuarial methods” (1998:22) with practitioners deliberately disengaged
19 so as to establish objective, reliable and scientific assessments.
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28 A major limitation of second generation tools, however, is that their results lack specificity
29 when applied to a person or family rather than to a population, raising questions about the
30 extent they are useful in working with individuals. Nor do they provide indicators regarding
31 intervention or risk management because they are not based upon dynamic associations.
32 There is also a suggestion that they encourage an inflated sense of expertise among
33 practitioners, given that “the pseudo-scientific nature of this process is undoubtedly
34 seductive” (Turner and Columbo 2008: 169). In mainstream social work, then, ‘structured
35 clinical judgement’ is now often the preferred approach in some settings, combining research
36 based considerations, including actuarial knowledge, with knowledge of the individual
37 service user that the practitioner has by virtue of clinical experience. Third generation
38 approaches integrate clinical and actuarial information, on the basis that the advantages of
39 each potentially outweigh their respective limitations.
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49 In theory, then, first generation approaches to risk assessment rely solely on clinical,
50 subjective judgement. Second generation approaches entail the straightforward application of
51 actuarial scoring based on objective knowledge. Third generation tools seek to ensure that the
52 strengths and limitations of clinical and actuarial approaches more adequately counter
53 balance each other by drawing on both objective and subjective knowledge. In reality these
54 approaches have been used variably depending on the context in which practitioners are
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3 required to undertake risk assessments. Arguably, in UK settings, clinical and structured
4 approaches remain generally dominant, although, in some contexts, there are initiatives which
5 seek to formalise and objectify the process and outcomes of assessment. The insistence that
6 actuarial scoring be incorporated tends to be limited to work with known offenders –
7 domestic violence, forensic mental health, dual diagnosis etc. Youth justice and probation
8 practitioners, for example, utilise ‘hybrid’ needs/risk approaches to assessment (Case and
9 Haines 2016, Deering 2011).
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19 **Explaining risk**

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21 How and why have such changes come about and with what consequences? There are notable
22 theoretical attempts to address these questions. Generally, these have a macro level emphasis
23 and emphasise the impact of social, cultural and technological change on society. Certain
24 authors have become synonymous with discussion of risk, and I will not rehearse the
25 positions of Beck, Giddens, Douglas etc. here. Suffice to say that such authors agree that,
26 paradoxically, modernity provokes ‘new’ hazards and changes perceptions of risk and in the
27 process undermines societal faith in the expertise of science and the professions. In seeking
28 to understand the impact of risk on social practices such as social work, however, it is
29 important to critically interrogate the links between changing political priorities and policy
30 and practice (Marston and McDonald 2006). Here, I will draw on some of the more
31 influential theoretical perspectives which seek to explain the significance of these
32 developments for social work
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45 *‘The death of the social’*

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47 A relationship between social transformations and policy and practice is suggested in Nikolas
48 Rose’s influential analysis (1996). Here, the logics of social government are problematised
49 and reformulated. The changing nature of social provision reflects a decline in faith in the
50 skills and knowledge of social professionals. This results from the confluence of ideology and
51 a lack of empirical evidence of effectiveness. The solution to ‘the problem of welfare’ entails
52 a shift from ‘social’ to ‘economic’ reasoning, choice and individual responsibility. Under
53 advanced liberalism, capable and responsible citizens will prudentially secure against risk.
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3 Practitioners assume responsibility for applying risk criteria to differentiate “the prudent from
4 the imprudent self, the self able to manage itself from the self who must be managed by
5 others” (Rose 1996: 14) via ‘dividing practices’, including risk assessment. Prediction
6 replaces diagnosis, and practitioners are reconstituted as ‘control agents’ with an explicit role
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8 “to minimize the riskiness of the most risky” (Rose 1999: 260)
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12 Despite a relative lack of faith in clinical effectiveness, there is nevertheless a belief that
13 security can be furthered via administrative methods. The “power of the single figure”
14 (Rose 1998: 187) assumes key significance and so traditional associations with ‘artful’,
15 subjective practice are replaced by claims to knowledge which attest to their own objectivity.
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17 Rather than ‘care or cure’, practitioners encourage self-management (Howe 2009). The role
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19 of the practitioner becomes primarily an informational one:
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25 *“As the logic of prediction comes to replace the logic of diagnosis...
26 professionals become, in certain fundamental senses, knowledge workers,
27 engaged in the accumulation, calibration, classification and interpretation
28 and communication of information relevant to judgements about risk”* (Rose
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32 1998: 185).
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34 35 36 **‘From dangerousness to risk’** 37

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39 Historically, dangerousness has been assessed categorically and clinically – an individual
40 either is or is not dangerous, and that judgment is best made by an appropriately qualified
41 practitioner (Castel 1991). However, this distinction came to be seen as problematic,
42 especially as ‘care in the community’ accelerated across the domains of social work,
43 provoking anxieties about behaviour, capacity and functioning post-deinstitutionalization.
44
45 Actuarialism offered a solution, by rendering the knowledge claims of professionals
46 probabilistic rather than absolute. Thus risk thinking “dissolve[s] the notion of a subject or a
47 concrete individual, and put in its place a combinatorial of *factors*, the factors of risk” such
48 that “the essential component of intervention no longer takes the form of the direct face-to-
49 face relationship between the...professional and the client” but instead concerns “flows of
50 population based on the collation of a range of abstract factors deemed liable to produce risk”
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52 (Castel 1991: 281). Relatedly, information supplants expertise as essential to the fulfilment of
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3 agency objectives. The traditional skills and knowledge of the practitioner are downplayed
4 by a shift “from the gaze to the objective accumulation of facts” (Castel 1991: 282) as
5 practice is reconstituted as “a *new mode of surveillance*: that of systematic predetection”
6 (ibid: 288). The relationship between practitioner and subject is less important because the
7 subject has been supplanted and reconstructed from risk factors. Their detection can be
8 imputed from statistical correlations. The presence of risk is indicative of a need for
9 intervention, but the nature of this also shifts from the transformational to the managerial, and
10 entails the use of ‘technologies’ that enable processes of categorization as a basis for
11 differentiation in the service of prevention and security.

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Consequently, it is argued that there has been an explicit assimilation of social work into
wider ‘regimes of control’. Actuarialism represents a “managerial attempt to regulate...the
overall probability of undesirable conduct” (Rose 2002: 9). Castel suggests that these
“preventative strategies of social administration...depart in a profoundly innovatory way
from the traditions of ... social work” (1991: 281).

‘From the social to the informational’

There is a parallel strand of theorizing which explores the role of technology in accelerating
the shift towards risk. Franko Aas (2005a) analysed the ways in which developments in I.T.
impacted on sentencing practice. Subsequently, this remit has expanded to examine the role,
content and function of changing forms of knowledge within decision making across domains
and jurisdictions. Parton (2008) suggests that such rapid developments have impacted
significantly on the nature and form of knowledge drawn upon. Reliance on formal rather
than informal knowledge sources means that social work decision making is positioned as an
objective process based upon factual knowledge. Risk becomes an ‘artefact’ phenomena
which ‘exist [s] in the formulae, theorems or assessments which construct them’ (Parton
1996: 111).

Webb suggests that “Actuarialism refers to the suite or programme of risk calculation
techniques that underpin social interventions in advanced liberal societies” (2009: 210).
Certain presumptions underpin faith in the basis for and accuracy of calculation: firstly, that it
is possible to predict *future* behaviour of individuals on the basis of *past* behaviour of
populations, using statistical aggregates of ‘risk factors’; next, these judgements are more
likely to be accurate when based on *objective* rather than *subjective* knowledge – numbers
“act as technical mechanisms for making judgments” (Rose 1999: 198); finally, outcomes

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3 will be improved if decision making draws on *actuarial* rather than *clinical* sources, based on
4 formal rather than informal knowledge. Consequently, data and information are privileged
5 ahead of relational understanding such that “complex explanatory narratives tend to be
6 compressed into shorter, instantly understandable messages” (Franko Aas 2005b: 152).
7
8 Holism becomes redundant as “master categories...obscure any ambiguities” (Parton and
9 Kirk 2010: 33). Consequently, practitioners “have no overall perspective relating to the total
10 life situation and biography of the client” (Fitzgibbon 2007: 88). With the emergence of
11 actuarialism in social work, “individuals are reduced to end oriented practices that are
12 configured by a form of political arithmetic” (Webb 2009: 223). The logic of risk, then, plays
13 a key role in a shift from inclusion to exclusion, from care to control.
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23 **The study**

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25 The findings in this article derive from a qualitative study which investigated if, how and why
26 concerns about risk have impacted on the theory and practice of work within various domains
27 of social work. The fieldwork - completed in 2011 - addressed the relative paucity of
28 research into risk *from the perspective of the social work practitioner* (Barry 2007). It
29 entailed two inter-related strands. Firstly, detailed genealogical case studies, which, following
30 Foucault (1977), analyse the origins and development of theory and practice in mental health
31 social work, forensic social work and probation practice as a basis for constructing a ‘history
32 of the present.’ Secondly, in-depth qualitative interviews with twenty nine practitioners,
33 from three domains of practice, in both community and institutional settings in northern
34 England. Sites were selected according to a theoretical purposive logic, with respondents
35 taken as having knowledge and expertise regarding if and how ‘risk thinking’ has brought
36 about affects in the operation of power and authority in practice. Key questions that arise
37 include “what forms of thought, knowledge, expertise ... means of calculation, or rationality
38 are employed in practices of governing?” (Dean 1999: 31). My focus, then, is on the forms
39 and sources of knowledge which practitioners draw upon in making decisions regarding risk.
40 In what ways do these correspond with the ‘generation’ of tool used in particular agencies,
41 according to the underpinning logic of risk? And how do practitioners perceive this as
42 affecting the processes and outcomes of risk based decision making? I will structure the
43 presentation of data around certain themes. Firstly, the role that the logic of risk – as manifest
44 in the risk ‘technology’ used in each domain - plays in the process of risk based decision
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3 making. Secondly, the extent to which risk aversion is evident in practice and how this
4 intersects with the forms of knowledge underpinning risk based decision making; and thirdly,
5 the extent to which in this study risk aversion appears to be a function of subjective rather
6 than objective knowledge. Although space precludes full exposition, in what follows I have
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8 nevertheless sought to do justice to the preponderance of perspectives within the data.
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11 12 13 14 **The logic of risk in practice**

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16 The 'logic of risk' suggests that levels of practitioner discretion in determining risk status in a
17 particular case vary according to the variety of 'tool' utilised in a particular context, here
18 conceived of as a continuum from pure clinical judgement to unassailed actuarial science.
19 The data suggests that matters are more complicated than this. Although there certainly were
20 instances of practitioners using assessment tools in ways which corresponded with stated
21 intentions, what was most notable was the extent to which practitioner accounts
22 problematized the assumption that the generation of tool influenced in any deterministic way
23 the decisions that practitioners make.
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33 ***Clinical judgement (Forensic mental health)***

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35 Here, it was clear that practitioners did not necessarily determine the risk status on the basis
36 of subjective knowledge alone. Instead, they described numerous systems and practices
37 which impacted upon the operation of clinical judgement in its pure form. For example, they
38 drew upon formalised actuarial assessments undertaken by other disciplines in their own
39 judgements.
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45 *"We do our own clinical assessment based on what we know about the patients, but we*
46 *do draw on what the psychologists have had to say too, and the nurses. They use VRAG*
47 *and SORAG or Hare on the personality disorder ward so we take that into account too,*
48 *they have a different perspective"* (Forensic social worker (FSW))
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52 Individual assessment was supplemented by high levels of reliance on case discussions
53 with peers, team managers and other professionals cross referencing their own views
54 with the opinions of others, as well as risk assessment tools developed specifically for
55 violent service users in criminal and forensic settings..
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3 *“It’s quite a responsibility when you think about it, not the sort of thing to work out on your own,*
4 *and why would you anyway, there’s a lot of people involved” (FSW)*

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7 Practitioners routinely referred to case discussions in team meetings and in supervision, as well as
8 multi-disciplinary and multi agency fora, including MAPPA, and the effects inter-professional
9 discussion had in informing both individual and collective determination of risk status.
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12 13 ***Actuarial tools (Mental health social work)***

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16 Here, there was an evident mismatch between the dominant narrative and how actuarial scores are
17 actually utilised within decision making. Practitioners did acknowledge that actuarial knowledge
18 had certain advantages.
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22 *“Decisions ... need to be accurate and backed up and so tools can be helpful. I*
23 *wouldn’t feel comfortable just guessing” (Mental health social worker (MHSW))*

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26 Here, clinical judgement is equated with guesswork, which is – by implication – inferior
27 to other approaches, and so there is an ethical imperative to ensure that decision making
28 is informed by more rigorous forms of knowledge. This is also the case below.
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32 *“The tool ... gets you to structure what you know and what you think is backed up. It’s*
33 *important that we use them cos our decisions make a real difference for people so we*
34 *can’t afford to miss things or just make assumptions” (MHSW)*

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37 Despite recognition of the possible value of actuarial knowledge, and although
38 practitioners did undertake scoring, this was not routinely used as a basis for
39 determining risk status. Although the agency represented itself as utilising second
40 generation approaches, there was no actual requirement that actuarial scoring be applied
41 deterministically in judgements of risk status. Instead, actuarial scores informed clinical
42 judgement, rather than ruled it. For example:
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47 *“There’s a policy, but its not, you know, the law, and that’s probably right, cos its helpful but not*
48 *‘the truth’ or infallible, sometimes it doesn’t apply to that particular person” (MHSW)*

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51 The issue here is specificity, an acknowledged limitation of the sort of population level knowledge
52 that actuarial scoring generates.
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3 *"I do it, and I know that's supposed to be it, that's the point of piloting it, but its not the custom*
4 *and sometimes its so obviously not right that yes we take it into account but because its not specific*
5 *to that person, then who knows, you've still got to make your own mind up"*(MHSW)
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9 Thus, even where an agency had explicitly decided to use a tool which in theory should limit the
10 role of subjective knowledge, in practice this is still allowed for.
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12 13 14 15 16 ***Needs/risk hybrid (Probation service)***

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18 Although third generation approaches arguably enable the tensions between informal and formal
19 knowledge sources to be balanced (Robinson 2003), it was evident that individual practitioners'
20 perceptions of their utility varied considerably. It was notable that the presumed ability of such
21 tools to balance competing variables led to 'new' practice dilemmas, especially regarding the
22 weighting of actuarial knowledge derived from static variables and clinical assessments of the
23 mediating or escalating effects of dynamic factors. Practitioners interpreted these weightings in
24 varied fashion. Although this corresponds with the logic underpinning this approach, this
25 manifested in ways which were probably unforeseen:
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28 *"It's tricky because you know it's supposed to be robust but you get different views depending on*
29 *whether someone gets on with him, when, obviously, well its not consistent, is it. But that's what*
30 *happens"* (Probation officer (PO))
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38 One of the factors which might determine an offender's risk status, it appears, is whether or not a
39 practitioner likes that individual at a personal level.
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43 Other practitioners found the expectation that they integrate their own subjective views with
44 actuarial knowledge frustrating or frightening. Some were concerned at the possible consequences
45 of suggesting that actuarial estimates were too high.
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49 *"If you've got an actual score that says there's like, a seventy per cent likelihood of reoffending*
50 *it's really hard to justify saying, well, despite that he'll be alright, cos that could come back to*
51 *haunt you, why did you over rule the score?"* (PO)
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55 Significantly, although other practitioners sometimes welcomed the opportunity that inclusion of
56 subjective judgement allows, they were hesitant in doing so:
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3 “You do need to be careful if you’re downgrading the risk status, you’re taking a risk doing it”
4 (PO)
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7 This accords with Witkin’s (2017) belief that risk is a risk for social work practitioners.
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10 In this setting, then, both clinical and actuarial knowledge inform decision making, but it is clear
11 that these influences do not function deterministically. The integration of different forms of
12 knowledge depends on factors that the individual practitioner chooses to privilege.
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15 **Risk aversion**

16 Perhaps more than any other factor, it is concern about risk aversion which underpins many of the
17 concerns that critics have expressed regarding the role of actuarial knowledge in social work
18 practice (Fitzgibbon 2011). Actuarialism quantifies risk, with numeric values “purporting to act as
19 technical mechanisms for making judgements” (Rose 1999: 198). This makes them more difficult
20 to disregard. In settings in which the logic of risk is predominant and practitioner discretion
21 constrained via reliance on actuarial scoring, practitioners are more likely to err on the side of the
22 caution, over-estimate risk and avoid positive risk taking (Peay 2003). Although practitioners
23 spoke of the dilemmas involved in risk based decision making, and of the strategies they adopted to
24 limit the impact of concerns about risk on their decision making, even so, risk averse practice is
25 common
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36 This is not to suggest that all social workers are always risk averse. Practitioners also described
37 situations in which they did seek to practice ‘positive risk taking’.
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40 *“I’m supposed to be on the lookout for signs of non-compliance, florid symptoms,*
41 *deterioration. But if I did something every time there was a ‘blip’, there’d be no point*
42 *letting them out in the first place. They’re constantly testing you, but they have to if*
43 *they’re going to adapt back to living in the community. Otherwise they’re over*
44 *dependent and can’t function”* (MHSW)
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49 Elsewhere, practitioners suggested that there is still a concern with issues of fairness in decision
50 making, which would not be the case if the precautionary principle was wholly dominant.
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53 *“We always weigh up the positives and negatives. If you just looked at what might go*
54 *wrong you’d never do anything for anyone. I’ve had a few times when it’s clearly been*
55 *unfair, cos we’re worried for ourselves really, but most of the time it’s fine”* (FSW)
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3 Nevertheless, the ability of practitioners to resist risk averse tendencies was constrained. Top down
4 concerns filter down to practitioner level.
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7 *“It’s not that I’m against taking risks, you have to judge how to proceed. But the*
8 *context is definitely very harsh and you can’t ignore people’s worries. We’ve certainly*
9 *tightened up, stuff that was custom and practice is rare now” (FSW)*
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13 Feelings of vulnerability are thus countered by adhering to policy. Similar concerns are
14 apparent in probation work.
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17 *“If someone is going to hurt someone, I need to do something now. Usually, that means*
18 *getting them back in. It’s better to be safe than sorry, I know it’s a cliché but it is” (PO)*
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22 Similarly, mental health social workers referred to instances in which criteria for access
23 were applied tightly because of concerns regarding the possible risk posed by patients
24 being discharged.
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27 *“Sometimes they just won’t wait, and you can be in trouble. Ideally, everything should*
28 *be in place before they come out and we’re sometimes able to delay it, cos if something*
29 *goes wrong and it comes out we just let it go ahead without stuff in place we’ll be*
30 *properly liable” (MHSW)*
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35 There were also suggestions that there was a justifiable need for practice to become more risk
36 averse, given previous service failures. This entailed shifts in positioning in the enduring debate
37 regarding ‘care versus control’ (Howe 2015)
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41 *“It’s always a difficult balance, but we need to learn from mistakes and that probably*
42 *does mean not taking as many chances, not being quite so optimistic. That does mean ...*
43 *clients will pay a price but maybe that’s as it should be” (MHSW)*
44
45
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47 *“Therapeutic optimism is all well and good but you’ve got to realise most people do*
48 *relapse, we know that, we can’t pretend they don’t and we need to take that into*
49 *account” (FSW)*
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53 54 55 56 **Fear of false negatives** 57 58 59 60

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3 It was also apparent that potential false positives – intervening to address a potential risk that does
4 not materialise - do not concern practitioners in the way that false negatives - not intervening to
5 prevent harm - do. Media, political and managerial scrutiny focuses on false negatives as
6 exemplifying ‘service failure’. In the main, this seemed to be because there is no way of
7 demonstrating that a false positive has actually occurred.
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12 *You might make the wrong decision, but you wouldn't know. Either you're right and cos*
13 *they're 'in' nothing happens, or you're wrong but they're still in and nothing happens.*
14 *You can't know, so it's pretty academic really.” (FSW)*
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18 Similarly:

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21 *“We're bound to be wrong sometimes, but there's no way of knowing, it's not like you*
22 *can do an experiment to work it out. I suppose that's where tribunals come in, to make*
23 *sure you're not being too cautious. But day-to-day it's not something my managers*
24 *hassling me about” (MHSW)*
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29 The suggestion here is that as there is no practical means of establishing whether or not
30 a judgement made by a practitioner has led to a false positive, this does not intrude into
31 decision making to anything like the extent that corresponding concerns regarding the
32 possibility of false negatives might. This conundrum is summed up by Castel: “When in
33 doubt it is better to act, since, even if unfounded intervention is an error, it is one that
34 will certainly never be known as such” (1991: 283).
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42 **Fear of blame**

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44 Thus the logic of actuarialism is not the principal influence on tendencies towards risk aversion
45 evident in the data. This pointed instead to the role played by practitioners’ own concerns regarding
46 the potential consequences for themselves should a false negative occur – or fear of blame.
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51 Various practitioners pointed to the role that that a hostile media plays in contributing to a climate
52 of fear for practitioners.
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3 *“You see in Community Care... naming and shaming incompetent workers. And there’s*
4 *the press and the news too, they’re always hard line. It’s a real worry because obviously*
5 *mistakes are inevitable and have real effects, and for us too” (PO)*
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9 *“Being on the front page of the Daily Mail, journalists on the doorstep, my kids being*
10 *hassled. I know it’s unlikely but that’s the fear, they blame individual workers. And I’m*
11 *not confident that management would protect me...there’s a real sense that its ‘look*
12 *after number one’. It’s natural, even, you have to put yourself first, and if that has*
13 *implications for the clients, then so be it” (MHSW)*
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18 There is a real sense that practitioners regard agency management as sometimes abandoning
19 practitioners to their fate:
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22 *“There’s been inquiries after serious incidents, they go through your records, it doesn’t*
23 *matter if you’ve covered the biggies, you’ve still got to make sure everything’s been done*
24 *by the book cos little minor things that you miss every day look bad when it goes*
25 *wrong” (PO)*
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30 This practitioner is suggesting that it is not the quality of practice which determines whether or not
31 blame is attached to a practitioner, but the extent to which policy and procedure have been adhered
32 to. These may have played little or no part in a serious incident, but with hindsight come to assume
33 inflated significance. Other practitioners elaborated on how this fear intrudes at a personal level.
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38 *“I didn’t used to be actually scared. Now if I’ve been out of the office for more than a*
39 *few days I’m literally terrified of going in cos I don’t know what might have happened.*
40 *And I’m not lax, but that doesn’t mean I can control someone’s behaviour, but that’s the*
41 *expectation. And I find myself more concerned about what might happen to me than*
42 *them, which is the wrong way round” (PO)*
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47 Despite these misgiving, there was also (somewhat ironic) faith in the power of policy,
48 procedure and protocol to protect practitioners.
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51 *“That’s where policy comes in. If you’ve stuck to it there’ll still be mistakes but you’re*
52 *covered. I’d think most people stick to policy these days. You might not get everything*
53 *done in time or much cop but when they’re high risk they take priority cos if you*
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3 *don't...and if you've stuck to the policy there's no dilemma anyway cos it's pretty*
4 *straightforward, do things properly and don't take risks" (MHSW)*
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7 Such a perspective, taken to its logical conclusion, would certainly inhibit scope for
8 positive risk taking.
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11 Here, then, practitioners are testifying to the effects that the context within which they
12 work impacts on the judgements that they make regarding the risk a service user poses.
13 The consequences for service users were clear in how practitioners described how their
14 own subjective interpretation of the intersection between the personal and professional
15 impacted upon their judgements
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21 *"It's not as though he actually met the criteria, because on OGRS [actuarial scoring*
22 *tool] he was quite low and he was certainly low risk of harm. But sometimes you just get*
23 *a feeling, its worrying...what if...and so I upped him to high risk and eventually he was*
24 *recalled" (PO)*
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28 *"Its your job on the line, you have to be careful. There are people who you just know*
29 *are risky. The tool might say something else, but you know them, so that's high and*
30 *that's that" (MHSW)*
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34 It is sometimes suggested that a return to relational practice, in which clinical judgement
35 is key, might be a remedy for risk aversion and promote positive risk taking. Here, it
36 appears that the opposite is the case. Practitioner suggest quite explicitly that they draw
37 on their own subjective clinical judgement to elevate risk levels beyond those which
38 actuarial scoring suggests is appropriate. It seems then that associations between the
39 logic of risk, in its actuarial form, and risk aversion are not as straightforwardly as is
40 sometimes assumed. Rather, the use of subjective knowledge sometimes enables
41 practice which deviates markedly from the forms of 'subversive' (Fook 2002: 147) but
42 constructive practice which proponents of 'artful' social work tend to equate with
43 clinical judgement
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52 53 54 55 **Discussion**

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3 It is evident then, that in the agencies in which this research was conducted there is no
4 straightforward correlation between the generation of 'technology' used and the actual process
5 followed in risk based decision making, which must be accounted for by factors other than 'the
6 logic of risk'. In particular, respondents routinely referred to how their subjective views intersect
7 with concerns regarding their own personal and professional well-being to impact on decisions
8 regarding risk status. It seems fair to conclude that such judgments are, indeed, 'risk averse'. It is
9 also clear, however, that evident risk aversion results from the context within which practitioners
10 are making judgements, which is characterised by a quite pervasive, generalised 'fear of blame'.
11 Parton (1998) identified the influence of 'blaming systems' on social work two decades ago, and it
12 seems that these remain significant. It is also important, I think, that it is not the logic of
13 actuarialism which necessarily promotes risk aversion. The continued significance of subjective
14 practitioner knowledge to risk-based decision making, particularly in overruling actuarially
15 generated knowledge and elevating risk levels, raises doubts about the preferred remedy to risk
16 aversion that many critics of the rise of risk call for. A renaissance in relational practice – whatever
17 its other merits – would do little to promote positive risk taking in a context in which agency
18 concerns regarding the consequences of false negatives mean that fear of blame continue to inform
19 the decision making of many social workers.
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35 **Conclusion**

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37 Small scale studies such as this, fixed in time and space, with limited representativeness,
38 generalisability and vulnerable to fluctuations in politics and policy, are not well placed to make
39 definitive, wider statements regarding the nature of contemporary practice. They can, however,
40 reasonably raise questions regarding existing, theoretical explanations and perspectives. The
41 findings of this study suggest that existing assumptions regarding the role that actuarially generated
42 knowledge plays in promoting risk aversion in social work may well be misplaced. They also
43 highlight the role that clinical judgement – a sometimes reified notion – can and does play in
44 inhibiting positive risk taking. This should not be too surprising. The original impetus for the use of
45 actuarial method in the social realm stemmed from concerns about injustices associated with
46 untrammelled subjectivity in professional decision making. This study reminds us of that potential,
47 as well as highlighting the ways in which the context within which practitioners make such
48 decisions can (and does) make the job of social work more difficult than it might otherwise be.
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3 The continued - and possibly escalating – effects of blame culture on practitioner decision making
4 rest on two misguided assumptions. Firstly, they assume that practitioner decision making is ‘poor’
5 and that blame is therefore deserved when things go wrong, while reform and regulation are
6 required to ensure it does not. In fact, there is little evidence to suggest that social workers are any
7 worse (or better) at assessing risk than any other professional group. Secondly, they intersect with a
8 pervasive but unwarranted expectation of infallibility. The roots of this expectation reflect
9 dominant neoliberal perspectives regarding individuality and responsibility and a clear emphasis
10 within ‘new’ public management that accountability and value for money within public service
11 practice (as was) requires ‘excellence’ in all activities. There is little room here for uncertainty,
12 ambiguity or imperfection, and so it is unsurprising that social workers are fearful about the
13 consequences of being seen to make the wrong decision.
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22 Whereas for some, the future of social work ought to be clinical, it is clear that the dichotomous
23 distinction between ‘clinical’ and ‘actuarial’, or ‘art’ and ‘science’, is not helpful. Knowledge
24 generated ‘scientifically’ is by no means certain (Firestein, 2012). In making the best possible
25 judgement (which is different from a judgement perceived to be accurate) practitioners must
26 integrate knowledge from an array of sources (Pawson et al 2003, Evans and Hardy 2010).
27 Actuarial methods represent just one source of knowledge in social work, and as such should not be
28 reified. Debates regarding the relative merits of actuarial and clinical approaches to risk assessment
29 are an example of the truly enduring nomothetic/idiographic tension within the philosophy of
30 knowledge, and we should not expect its exemplification in contemporary social work to resolve
31 this. At best actuarial knowledge provides a base line comparator against which to compare the real
32 people social workers work with. : “the world of pure probability does not exist except on paper...it
33 has nothing to do with breathing, sweating anxious and creative human beings struggling to find
34 their way out of the darkness” (Pratt 2016) We certainly should not over emphasise its rigour or
35 specificity. In fact, actuarial knowledge exposes the limits of science, not least its sometimes
36 limited practical utility (Firestein 2015). It is in the integration of knowledge – actuarial, clinical,
37 formal, informal, subjective and objective – that good social work practice *of necessity* prospers.
38 And as social work pushes at the limits of science, we must also surely continue to acknowledge its
39 debt to the realms of art, philosophy and imagination.
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