Risk, Regulation, Integration: Implications for Governance in Community Service Organisations

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Over the last twenty years a coalition of forces has radically changed the environment of human services delivery in Australia and most other western countries. These include the growth of community care and public policies supporting deinstitutionalisation, processes of competitive tendering for government contracts, the rise of new regulatory responsibilities for community service agencies, and the more recent shift to individualised models of care. At the global level, these changes were driven by the shift from 'macro-economic stabilisation and redistributive welfare policies towards the improvement of economic efficiency', which occurred in many western countries from the late 1970s onwards (Rothstein, Huber & Gaskell 2006, p.94). Braithwaite (1999) describes this macro-shift as the transition of government from the Keynesian state to the regulatory state.

In order to reduce their exposure to uncertainty and risk, governments have reduced their role as direct providers of services across many domains, and increased their steering and regulatory functions to manage and direct policy responses to societal risks (Ayers & Braithwaite 1992; Osborne & Gaebler 1992; Alford & O'Neil 1994; Rothstein 2006). With this change came the creation of new regulatory bodies to administer a massive transfer of business from the state to the commercial and community sectors (Braithwaite 1999). As governments reduced their direct involvement in service delivery, a particular form of regulation emerged, often described as 'responsive regulation', and designed in the name of efficiency to relocate responsibility with the delegated actors rather than the state (Ayers & Braithwaite 1992; Rothstein 2006). As a result businesses, community organisations, families and individuals are becoming more involved in their own regulation. And in some instances, the contractual responsibilities of community service organisations (CSOs) now include the regulation of citizens (Rose 1996, 1999; O'Malley 1996, 2003).

With the growth of home-based care, the protective, rehabilitative and recovery functions of institutions and hospitals have been transferred to community services and commercial businesses (Draper 2000; Duckett 2004). This change has seen the rapid growth of most pre-existing community service organisations, the birth of others and the growth of the private sector in the field of community care. Over the last decade, community services have had to confront a wide range of new risks arising not only from the unforeseen challenges of community care for people with disabilities, mental illnesses, and acute and chronic illnesses, but also from more complex and demanding regulatory regimes. For example, deinstitutionalisation means that most CSOs are now required to deliver safe, effective and accountable services from a wide range of 'unregulated' private and community sites, including service users' homes, public housing estates, group housing, and 'the streets'.

At the same time the level of complexity and the needs of clients, some of whom were previously detained in highly regulated institutional settings, is increasing. In this context person-centred planning and associated funding models contribute to the diversity and intricacy of frontline community care. Not surprisingly the complexity of this work has also led to an increasing demand for collaboration, coordination and integration between agencies with radically different traditions, charters, cultures and practices.

As a consequence of the coalescence of these forces, risk management has become central to the governance, accountability and service delivery practices of CSOs, particularly those supporting people whose age, health and disabilities engender risks to themselves and others. British researchers have made significant advances in studying the consequences of risk management for community-based health and welfare services (e.g. Alaszewski et al 1998; Carson & Bain 2008; Kemshall 2002; Rose 1998), but in Australia this field of inquiry remains largely undeveloped. British studies report both negative and positive outcomes from risk management with an emphasis on the negative impacts. For example, risk management may lead to a narrowing of service responses (Kemshall 2002), along with reduced flexibility and decline in service quality (see Culpitt 1999; Parton 1998). Kemshall (2002, p. 93) observes that the focus on risk may also create new exclusions and inequalities in service delivery because 'high risk' clients are prioritised at the expense of 'low risk' clients. Conversely, Titterton (2005, p. 91) reports on a number of innovative practices associated with positive 'risk-taking' by aged care services, noting that the use of 'risk' to 'empower vulnerable individuals has... received insufficient attention in the literature'.

In order to explore these issues in an Australian context, the Australian Research Council awarded a Linkages Grant to La Trobe University, the Victorian Department of Human Services and the Victorian Office of the Public Advocate in 2006 to investigate

how 'risk' and risk management strategies have been interpreted and translated into practice by Victorian community-based adult services. The project is entitled, *Managing Risk in Community Services: A Preliminary Study of the Impacts of Risk Management on Victorian Services and Clients.* This paper reports on findings from the first stage of the project, which comprised interviews with CEOs and senior managers of twenty-four Victorian community-based health and welfare agencies: seven mental health, five aged-care, seven disability and five multi-sector services. These interviews were semi-structured; researchers asked participants about general issues concerning governance, management of risk and adverse incidents, occupational health and safety regulations, their interpretations and experiences of 'risk' in their day-to-day work and the impact of risk management policies on their work with clients. (The second stage of our project, currently underway, involves interviews with program managers, frontline workers, clients and carers.)

All participating services were either public agencies or CSOs. Nineteen were based in the metropolitan region and five were rural agencies located in two regional centres. Fourteen of the twenty-four were CSOs and ten were public agencies, including one local government council, two regional offices and a specialist service of a government department, and six public health agencies. Our sampling method aimed for 'maximum variation' (Creswell 1998, p. 119) through inclusion of a diverse range of services in terms of their functions and responsibilities, and location across regional and rural settings and inner and outer metropolitan areas. In recruiting participants, we sought guidance from our industry partners, the Department of Human Services and the Office of the Public Advocate. In several cases we utilised informal networks as two of the researchers had extensive work histories with various Victorian health and welfare services. In constructing the sample, it was considered important to include both a wide range of CSOs and the key public services engaged in direct service delivery across the relevant sectors. This paper reports that there were shared and different experiences across the public services and CSOs. We report these differences as they inform the particular focus of this paper, namely the impact of risk management on CSOs.

The original focus of this project was to be on the arena of practice - the relationship between risk management strategies and actual service delivery. Yet, during the early stages of data collection we discovered the significance of a range of 'higher level' organisational risks, related to and separate from those involved in service delivery itself, many of which may be understood as *governance risks*. The fact that these issues were raised consistently by participants and, in most instances, described as their leading concerns, was one of the most significant findings.

Technologies of new 'responsive regulation' include not only procedures to improve the safety of clients, workers and community, but also the machinery of governance, financial accountability, transparency, and quality assurance (Ayers & Braithwaite 1992; Rothstein et al 2006). As a consequence the risks faced by managers in community services cross the spectrum from the direct operational risks to clients, workers and community, to include these new governance risks arising from responsive regulation. In this context community services are also called upon to form partnerships with other organisations to provide the integration and coordination needed to deal with complex problems and complex needs. In order for these collaborative and cooperative service delivery relationships to work effectively the most sensitive and sensible of all approaches to risk management is required, namely the development of trust and the willingness to share risk. However, whilst financial risk sharing has become a well-established practice in business and major capital projects such as public-private partnerships (Hodge 2004), it is not as straightforward for community services dependent on government contracts and the preservation of their reputation in competitive markets.

Given these issues it is not surprising, therefore, that services caring for vulnerable and sometimes troubling people in the community, previously the responsibility of high cost and highly regulated hospitals and institutions, report that they are significantly exposed by the 'practical limits' of their capacity to govern a wide range of risks (Rothstein 2006, p. 215).

In the following section, we report on a range of risk and governance concerns arising from these issues identified by the CEOs and senior managers participating in this ARC project. Based on this data, and international research, the paper then examines the implications of these changes for the governance of CSOs. This discussion also addresses the implications of the demands on both CSOs and the remaining public agencies involved in human services delivery to achieve integration across services through more intense levels of collaboration, coordination and partnership.

Perspectives and Issues Raised by Chief Executive Officers and Senior Managers

All CEOs and senior managers reported an increased focus on risk and risk management over the past five to ten years. For most organisations the management of risk had become more formalised and central to their duties over this time. Our discussions with CEOs and senior managers revealed that they were wrestling with a broad and complex range of risks, including direct 'frontline' service delivery risks to clients, workers and community, alongside relatively 'new' and ever-expanding categories of risk at the organisational and governance levels. Whilst some participants focused on discrete risks to clients, most discussions tended to focus on these organisational risks, together with risks around managing the workforce, retaining staff and keeping them safe.

This paper now presents examples of the diverse range of risks

identified by our participants, including the 'new' organisational and governance risks. In an attempt to remain faithful to the spirit of these discussions we have used the language and concepts of our participants as much as possible. Whilst recounting our participants' experiences, we offer brief reflections on some of the general patterns that emerged as we traversed this landscape.

Funding concerns and managing budgets were in the forefront of most CEOs and senior managers' minds. **Funding** was of particular concern to participants from CSOs and the local government council. Since the greater proportion of their funding derived from government grants, many felt extremely vulnerable in the face of changes in government policy and regulatory requirements, including changes of government itself. Some participants acknowledged that they might need to re-develop their services in different directions to ensure their ongoing viability, such as broadening the range of services they provide or selling specialist education and training packages to other services. The CEO of a small, multi-sector CSO, which focused specifically on clients from culturally and linguistically diverse (CALD) backgrounds, noted that the federal government's shift away from 'multiculturalism', with its connotations of separateness, toward mainstreaming and associated notions of cohesion and unity, may mean that the future of CALD services is under threat. This sense of vulnerability to changes in government policy was echoed by the senior manager of a large CSO providing home care to the aged:

Both our major streams of funding are government funded, so a huge risk depending on the government of the day and the priority that aged care in-home support is given. At the moment it's putting people independently in their homes is a priority, however down the track things may change and it might swing around to the priority being residential facilities or whatever, and so yeah being reliant on the federal economy and all those sorts of things honestly is a huge risk to us.

All participants, except those from the regional offices of a government department, identified **financial management** as a major risk to their organisations. The senior manager of a regional public mental health service commented that managing the budget was their 'number one risk' and that poor financial management would generate other serious problems, including damage to the public perception of the service, which in turn could hinder the organisation's access to funding and its relationships with other agencies. Similarly, the nursing services manager of a regional home-based nursing CSO cited 'budget integrity' as their major risk, heightened by increased demand for nursing services and increased acuity within their client group, which also meant that managing staff workloads was critical. As she explained:

The service demand has trebled... in the last year... so it's the service demand and the type of demand, the acuity in the community is much heavier. We're being asked now to look after people at home who even five years ago would have been placed in some form of care. So there are occasions where in fact we may send in two or three nurses to one client, so there's high maintenance stuff going on with increased acuity demands.

To illustrate she gave the example of a son who had promised his mother she would never have to go into care; however, his mother's health deteriorated to the point where three nurses were needed, partly to meet occupational health and safety requirements. To safeguard the budget, the nursing manager negotiated with him that he pay for the third nurse; the following excerpt reveals the pressures of interlocking financial, ethical and emotional considerations in providing community care:

In the end you know, we really worked very hard and very well with him to say, I think the time has come - we want you to make that decision, but the time has come where I am not sure we can keep doing this. So there are issues around the family who have promised – 'I won't ever put you in care'. Sometimes we just have to call it a day – and it's a struggle. We want those people to stay at home because they don't want to go into care. They want to go into the right care if they go in and often there's not a vacancy, so we sit it out and we wait and wait for the right vacancy to come up, but it's a real struggle for us and the family and the son who's promised... It's an emotional tug of war sometimes.

Essentially, what is striking about the analysis proffered by these two participants is the **intersection of multiple issues that give rise to new organisational risks** – changes in the severity of illness conditions, commonly referred to as 'acuity' by our participants, discharge policies in other service systems, fluctuations in demand, the risks arising from working in partnership with other agencies and the importance of safeguarding reputation in these contexts.

Several fast growing CSOs had experienced **major crises with their boards of management** over the past decade, particularly those 'grass-roots' organisations that had been established by carers or families of disabled clients. In one example, board members were predominantly carers of the clients of the particular service and as this organisation grew, problems of 'conflict of interest' developed, especially around situations where board members clashed with clinical decisions made by staff. The rapid growth in size and responsibilities of these organisations produced serious governance risks. A number of participants also mentioned histories of difficulties arising from poor financial management, 'in-fighting' and misrepresentation of roles. With the corresponding pressures of increased regulation in order to achieve growing accountability, transparency and performance standards, new protocols for the appointment of board members were subsequently introduced – and in the trajectories of several of the smaller not-for-profit agencies, boards of management were disbanded and re-appointed.

With respect to these and other issues, the interviews demonstrated a marked difference in governance risks identified by CEOs and senior managers from CSOs as against those from public agencies and government departments. For example, a number of participants from the not-for-profit sector emphasised **constraints in implementing reliable governance systems** as a direct result of 'infrastructure problems', mainly due to limited finances or a lack of dedicated funding set aside for the emerging systems requirements necessary for effective governance. The CEO of one disability CSO noted that they were unable to audit as widely as desired because of 'lack of funds'. The CEO of another specialist disability CSO claimed that implementing risk management systems was costly, particularly in terms of administration, citing that 20 per cent of the budget was needed, whereas their funding department had suggested that 12 per cent was adequate. Participants from a large psychiatric disability rehabilitation and support service discussed problems associated with the organisation's very limited infrastructure, particularly their lack of staffing in finance and information technology, including data protection. Recently they felt the need to run a risk management workshop but found the consultants' fees were too high and did not proceed.

These issues were not identified by participants from public agencies and government departments. Generally these senior managers reported that they had well-established infrastructure and systems in place for quality assurance, auditing and reviews, along with specific-purpose software to record, track and follow-up risks, access to lawyers for legal advice, and other resources.

Participants across all organisations, including the public agencies, discussed **a range of formal risk management and quality improvement processes** through which their practices could be monitored, evaluated and improved. Internal governance mechanisms often included staff committees to review policy and procedure manuals, critical incidents, financial management and occupational health and safety issues. In addition, all organisations already had adopted or were in the process of implementing standards and quality systems, and some were participating in ongoing external reviews or accreditation processes. Some reviews were initiated by organisations themselves, whilst others were instigated by their primary funding agencies. There was great variation in models of standards utilised by both public services and CSOs, some of which included the ACHS (Australian Council on Healthcare Standards), the ABEF (Australian Business Excellence Framework), the QIC (Quality Improvement Council), the ISO (International Standards Organisation) including AS/NZS 4360 (the *Australian Standard on Risk Management)*, the *Carver and Carver Policy Governance Mode,* and various sector specific standards in disability, housing and home and community care. Some CSOs in particular gave the impression of being saturated by the task of managing a number of internal and external accountability and monitoring processes. For example, the nursing services manager of a regional home-based nursing service commented as follows: 'so we manage it to death really almost'.

The CEO of a CSO, which provides disability services across metropolitan and country Victoria, reported that the introduction of **individualised service models** has generated specific stresses for frontline workers. 'Dignity of risk' can be difficult for staff, especially if something goes wrong. This particular agency has a strong 'person-centred' approach, and as a consequence workers have less control and autonomy in their day-to-day work and are more subject to criticism than previously. In parallel with this shift in practice orientation, the agency is expanding and 'centralising' its governance structures, and attempting to develop a more consistent approach to practice across the regions, which formerly functioned as separate, relatively autonomous divisions. Again, we see here the coalescence of several risks and stresses, arising from service changes and new regulatory requirements that must be managed at the organisational level.

Also relating to models of practice, the manager of a departmental disability service commented in similar vein that the **focus on community inclusion**, endorsed through the new *Disability Act 2006* and the State Disability Plan, 'is an excellent thing but you get glimpses every now and then of how difficult that is going to be for some of our clients, particularly those with offending backgrounds'. In his view not only does this endeavour require sound risk management procedures but it has implications for the extent to which case managers are able to enact the principles of person-directed planning models.

Most participants, apart from those working in government departments and public health agencies, described the challenges and anxieties associated with their **emerging roles as sub-contractors of services to complement their own core services**. The CEO of a community case management agency that supports aged clients and children and adults with a range of disabilities, reported that her agency, which had funding from twenty-two sources or programs, was also involved in sub-contracting over two hundred provider organisations across the health and welfare sector. In addition, this organisation was itself subcontracted by at least twenty other providers purchasing their core service of case management. Much of this complex contracting and sub-contracting, which occurs around home care and related specialised services, involves a web of interdependent relationships between numerous providers and case managers. Some of these providers are licensed or regulated, and some are only minimally regulated and have little capacity to manage their risks which are now 'shared' with a wide range of partners. The CEO of this case management service described this system as 'a nightmare for accounting and reporting'. Extensive resources were required to keep track of transactions and match invoices with services that had actually been delivered.

In this context of multiple, interacting services, the nursing serv-

ices manager of a regional community nursing service was troubled by **different thresholds for tolerating environmental and behavioural risks**. She explained that their service was trying to do 'a lot of cross-collaborative work' around those issues and had recently set up a 'shared care committee' with the local council. As a result, the two services had adopted the same risk assessment tools. For the most part, however, there were no formal procedures or clear lines of responsibility for sharing information about client risks, or making judgments about operational risks. Information sharing was often inconsistent and dependent on the quality of the relationship between particular agencies.

In this context, the manager of a public mental health agency was concerned that his **service did not collaborate sufficiently with other services**, explaining that most of their treatment and support was 'in-house'. Steps to involve and liaise with other agencies were usually taken only within a few weeks of the client's discharge, often leading to difficulties in the client's transition into follow-up care. He claimed that greater collaboration was needed with community-based social workers, drug and alcohol counsellors and general practitioners. The CSO participants providing services to people with a mental illness also reported this problem.

In addition, the manager of a clinical team within a regional public mental health service highlighted the reluctance of both clinical staff and disability support workers to share client information with one another. He argued that **upholding confidentiality** could itself create risks: 'When we've got a client in common and there are risks I'm of the view that we can share information - that if we didn't share information then that's a bigger risk then if something goes wrong'.

A senior manager of a large CSO that serves the homeless population cited **inadequate referral information** from other agencies as a major problem. He wondered if this tendency was deliberate at times, as a means of offloading 'difficult' clients. Lack of disclosure of risk-related information could disadvantage workers when a new client was accepted. In this context, he argued that risk has been transferred to CSOs in an incremental way year by year without explicit recognition that this is happening, and without recognition in the form of increased funding.

Guarding against negative publicity was seen as imperative by all participants. The CEO of a large metropolitan aged care CSO described the risk of damaging publicity flowing from tensions between clients' wishes and the actual service that was provided. Situations might develop when clients and their carers did not fully understand the service's brief and limitations. These problems, coupled with significant grief and loss issues experienced by many of the relatives and carers of their clients – who often transferred their emotions onto staff – had led this CEO to consider setting up a counselling service for carers.

The work of public agencies was especially vulnerable to **criticism or complaints in the media**. The manager of a disability service run by a government department cited what he referred as the 'Herald Sun test' as a yardstick in protecting the service's public image:

> At the end of the day what's this going to look like if it hits the front page of the *Herald Sun* and that is always in the back of your mind in terms of media interest and risk of exposure of negative publicity for the Department and the Minister... The driving focus or force that keeps us doing everything, the work that we do - that's around getting good outcomes for our clients and actually making a difference, but we have to be mindful that at the other end of that there's the sort of other political imperative around the services that we provide.

However, the same sensitivities were reported by most CSOs. For example, the CEO of a community nursing service highlighted the organisation's practice of countersigning all Guardianship applications made by staff, in an attempt to prevent them from making statements to the court that could be potentially damaging to the workers themselves and to the organisation.

The aged care services manager of a large inner-city council reported that many of its rate payers were under the impression that they were eligible for the council's home care services simply because they were rate payers. To **avoid conflict and reputational damage** to the council, it was critical for intake workers to explain very clearly the eligibility criteria for their service:

> If we're not managing the service well and providing customer service, certainly the customers and the clients will feel... disappointment with council. They feel very strongly, they're rate payers and they deserve a service and there's a risk of reputation... Yeah, there's certainly an expectation of entitlement and that's where we have to be really clear about who is eligible and who we do prioritise and target the service to... And some of that's done at intake and referral, so we try and make sure the people taking the calls can screen appropriately and refer people on appropriately.

The manager of a government department's regional service noted that **the rise of advocacy** also means that clients and others are more willing to challenge organisations nowadays, and these processes may generate new risks. He decried that fact that his department has four separate avenues for complaints, explaining that these systems were very complex and tended to 'suck up resources'. With a number of complaints mechanisms in place, including legal options, his organisation's reputation may be seriously affected. Interestingly, this problem was not identified by the CSOs.

The majority of participants from both CSOs and public agencies reported **growth in the complexity and multiplicity of clients' needs** and cited a range of related observations. The

closure of institutions for the intellectually disabled over the past fifteen years has increased the number of community clients with complex behavioural and communication needs. Homeless services have seen a reduction in the average age of their residents, along with higher levels of drug and alcohol misuse, behaviour disorders and other problems. Patients are 'older, frailer and sicker' when they arrive home from hospital, as a consequence of shorter admission periods and early discharge planning. The manager of a large psychiatric disability rehabilitation and support service noted increased complexity of need amongst their younger clients, including 'dangerous' behaviours, new forms of drug use and involvement with the criminal justice system. The area manager of a public metropolitan mental health service commented that drugs, particularly the increased use of 'ice', together with homelessness had contributed to the increasing risks in their 'changing client base'. On top of these issues, the 'rationing' of acute psychiatric beds means that higher levels of risk are now tolerated in the community, creating a heightened risk environment for services.

It is in this context that **problems associated with recruiting suitably qualified and experienced frontline staff** were seen as critical risks by over half the participants with two participants from the mental health sector identifying it as their priority concern. Shortages of home care workers and nurses were frequently mentioned, as was the problem of inadequate training amongst direct care staff and varying standards across technical and further education courses. A senior manager in the regional office of a government department, like several other managers, mentioned the problem of relatively poor award rates of pay compared with higher awards in other services or sectors. He also noted that the trend toward higher turnover of staff, with many graduates staying in jobs for only two years or so, meant added difficulty in managing service demands because of the lead-time required to train workers. With most cases becoming more 'complex' in nature there were few, if any, 'simple' cases to give to new workers.

The intersection of the range of issues discussed above seemed to have a synergistic effect on the stress loads carried by the community service organisations involved in our research – particularly at a time when many of the CSOs were expanding their services. In the next section, we focus on some of the implications of these findings for the governance of community service organisations, in particular the increased demand to manage complex multi-layered risks.

Implications for Governance

The evidence presented by the CEOs and senior managers in our sample was remarkably consistent, even though the manifestations of their experiences with risk were shaped by their agencies' particular functions and responsibilities in community care. The risks identified related directly or indirectly to their sense of responsibility for the well-being not only of their clients and patients, of their staff, and the community, but also of the reputation, professional standing and morale of their agencies. In short, the effective management of risk was clearly central to their understanding of good governance.

A detailed analysis of the risks identified by our participants revealed a complex matrix of risks, each to be identified, assessed and managed. To provide an overview of both the distinctive nature of these risks as well as their interrelationships, we have categorised them in terms of their source or origin. We believe this analysis offers a nuanced representation of the complexities confronting today's community services executives and senior managers.

(1) Risks Arising from the Changed Environment of Service Delivery

All participants identified the following factors as sources of risk, namely the delivery of services from 'unregulated sites' such as homes, community centres, and public places; the increased acuity, complexity and needs of clients and patients; the implications of policies requiring individualised service packages; and the consequent need for services to work together, form partnerships, and share risks.

(2) Workforce Related Risks

Most CEOs and senior managers identified a range of workforce issues which were related to the factors listed above. New models of service delivery and the complexity of clients and patients have implications for the safety, well-being and preparedness of the workforce. All services reported that training, work safety, and supply issues have emerged from the changing service environment, specifying in particular greater acuity and complexity, higher levels of drug and alcohol use in worksites (particularly private homes), and increasing responsibilities for clients with a mental illness. The safety and other complex issues arising from these factors impact on the capacity of services to retain their workers, a risk exaggerated by a long standing shortage of qualified workers. Again these risks are interrelated and compound each other.

(3) Financial Risks

The majority of participants from CSOs reported increasing financial risks arising from their vulnerability to changing government policies and contracting policies, growing competition in the service system, the vulnerability of the organisation to risks which impact on reputation, and therefore competitiveness and financial security, and problems arising from increasing unit costs, especially for more complex high need and/or high risk clients.

(4) Risks Arising from Regulation Itself, and the Technologies of Self-Regulation

Most of the participants reported a 'new' layer of risks, systematically identified in the international literature as *institutional* or *secondary risks* - in contrast with the *primary risks* involved in actual service delivery. These new risks entail a range of dangers or threats encountered by organisations through their attempts to manage primary risks (Rothstein et al 2006, p. 92), and their obligations to meet compliance requirements from funding bodies and regulators. In other words the demands for financial accountability, service performance reporting, registration, accreditation and quality assurance, become themselves a new level of risks, with a powerful capacity to enhance or diminish an organisation's standing in the eyes of funding bodies, government, media and community.

The evidence derived from this study suggests that the impact of these 'new' risks was greater on CSOs. All CSO participants welcomed compliance mechanisms, which enhanced their organisations' capacity to improve performance, accountability and the quality of their services. However, those managing multiple contracts from different government departments - and often from different levels of government - reported significant costs and risks arising from the need to institute new and usually incompatible data and reporting systems. This matter, identified as of considerable importance in this study, has been considered in a recent review of regulation of community service organisations in Victoria, and will not be further discussed in the context of this paper (Victorian State Services Authority 2007).

Furthermore, it should be noted that in meeting these compliance requirements most community service organisations were demonstrably disadvantaged in comparison with the public sector services participating in this study. Each of these latter services had very significant policy, procedure and infrastructure support from their 'parent' health network or department. Senior public managers at regional and area level did not have the same diverse and complex responsibilities to generate risk management, quality and accountability systems and procedures. Small community service organisations managing even a limited number of contracts or service agreements face the same compliance requirements as their public counterparts, often with a fraction of the infrastructure and capacity. Some services participating in this project have only rudimentary information technology and network capacity. The new responsive self-regulation technologies, crucial to today's accountability requirements, place considerable stress on the information systems of small and medium size CSOs, creating additional and troubling risks to their managers.

The interaction of these four categories of risks compounds the difficulties and challenges faced by *all* community-based services, both public and CSO entities. However, the findings reported here suggest that the risks involved in community care are borne unevenly across services and that some services are more disadvantaged than others as a consequence of the costs of meeting higher standards of governance and the management of risk.

Do Prevailing Models of Risk Management Work for Complex and Integrated Community Services?

Questions arise from this analysis, which will be further examined in the next stages of the project. These stages involve a more comprehensive examination of the impact of risk management at other levels of our participating organisations, including program managers, front line workers, clients, patients, families and carers. However, at this stage several observations can be made about some of the more systemic implications arising from our interviews with the CEOs and senior managers. These tentative findings are informed by overseas research, particularly from the United Kingdom, where the management of risk in community services has been the subject of considerable attention by government and researchers.

As noted in the introduction, western democracies like the United Kingdom and Australia have embarked on extensive reform of government services, regulation and contracting practices over the past two decades. In both countries this process of 'reinventing government' was based on the adoption of corporate models of governance, management and risk practices (Hood 1991; Braithwaite 1999; Hutter 2005). Hood (1991, pp. 4-5) spells out what he called doctrinal drivers of these reforms, including 'explicit standards and measurement of performance', 'greater discipline and parsimony in resource use', and the value of 'private sector styles of management practice'. Achieving these changes, according to Hutter (2005, p. 2) was seen to be dependent upon 'adopting private sector styles of management and an almost unthinking acceptance that private sector practices were the benchmarks against which to assess public sector activities'. In the early 1990s, the Blair government's 'new public management' program consolidated this adoption and application of enterprise-based models of management and risk regulation within the public sector (Hutter 2005). Victoria led Australia on this pathway, also from the early 1990s.

According to Braithwaite (1999), Australia's leading authority on regulation, corporate risk management practices were becoming central to both overall public sector reform and regulatory reform by the end of the 1990s, including the state's regulation of itself, the introduction of regimes of enforced self-regulation for corporations, and similar measures for the publicly contracted service providers. Both business and government agreed that approaches were needed which 'incorporated cost benefit analysis, were apparently "objective" and apparently transparent' (Hutter 2005, p. 2).

Corporate models imported from the world of business were seen to deliver these requirements (Hutter 2005).

In a short period of time, therefore, business risk management practices were adopted by government agencies and CSOs. The central objective of the new responsive regulation approach, as Scott (2004, p. 157) explained, was to stimulate regulatory approaches that foster and support the 'regulatory capacities which already exist' within organisations, businesses and individual citizens. This *responsive* approach to regulation aligns comfortably not only with contracting and commissioning processes, but also with the focus on individualised service models, participation of service users and the overall devolution of risk. The new regulatory state had arrived in the health and welfare industry.

Although corporate risk management may have been well suited to many functions of government, such as major infrastructure projects in public-private partnerships (Hodge 2004), it may be less appropriate for the complex risk sharing relationships now required in contemporary community care. For a number of reasons, as outlined below, enhancing the role of the service user and partnering with other service providers, while at the same time managing systemic or shared risks, may not match corporate objectives and models focused on protecting the business, shifting risk and avoiding blame.

In their contribution to the National Audit Office report, *Supporting innovation: managing risk in government departments*, Hood & Rothstein (2000) argue that there are distinctive regulatory issues and problems to be confronted in the public sector. In particular risk exists and is allocated across numerous public agencies, at multiple levels in those agencies and, in the Australian context, amongst their contracted providers. Further, the management of risk is complex and must be integrated and possibly shared across autonomous organisations. As Hood & Rothstein (2000, p. 26) argue, '[e]ffective policy delivery in many domains requires different public organisations to work together' and develop **'cross-organisational trust and management "craftsmanship" of a high order'** (our emphasis).

Few of the organisations in this project reported or identified such cross-organisation trust. While they reported positive collaborative relationships with some other providers, they described problematic relationships with others. Many relationships with both public agencies and CSOs were characterised by attempts to shift risk and sometimes blame in the event of problems. As noted above, a number of participants reported referrals which appeared to hide or deny risks, and were seen as attempts to transfer risks.

Hood, Rothstein & Baldwin (2004), in an analysis of different risk regulatory regimes, concluded that some significant problems have resulted from the adoption of business models which are not sympathetic to the requirements of public services, such as community based health and welfare services. First, they found that business risk management approaches are driven by the institutional imperatives of avoiding blame and litigation (Hood et al 2004, p. 176). Consequently, 'bringing business risk management to public services could easily augment the "blame prevention re-engineering" that is already too well established in public sector organisations generally and risk regulation in particular' (Hood et al 2004, p. 177). Such practices do not encourage services to support the risky choices of their clients, or readily engage in creative risk sharing partnerships with other services. A number of participants reported very problematic relationships with other services over the management of risk, whilst noting some very positive risk sharing collaborations.

Second, Hood et al (2004, p. 178) note that preoccupation with blame avoidance and organisational risk, particularly reputation and liability risks, diverts attention away from systemic risks: the primary risks that constitute the 'real' problem for the public and the government. This internal focus can lead to policy inactivity and the use of risk management as a 'fig leaf' to hide failure to address systemic risks (Hood & Rothstein 2000, pp. 26-7). For most participants in this study their concerns about the problems of growing acuity and complexity in their clients were of systemic significance, but the need to manage their organisation's risk exposure dominated their energies and those of other services. The systemic issue remained in the background, but essentially not confronted or addressed.

The third issue identified by Hood et al (2004) is that corporate models of risk management do not facilitate partnerships and collaboration. In the Victorian context the policies underpinning governments' approaches to complex community problems are framed in the language of networks, partnerships, coordination and innovation. However the corporate thrust of responsive regulation in general, and risk management in particular, does not actually encourage high levels of mutual trust across different sectors and agencies. If anything, according to Hood et al (2004, p. 178), it appears 'designed to make public organisations go in exactly the opposite direction'.

These findings from the United Kingdom, if applicable to the Victorian context, have profound significance for the management of risk in community care, particularly between relevant government agencies, between collaborating provider agencies, and between these providers and service users. The early findings of this study suggest that they are applicable, but they do not necessarily describe the common or prevailing situation with respect to the management of risk in collaborative work. Our analysis suggests that there are significant examples of very strong and trusting collaborative practice, although related largely to individuals and their readiness to enter into trusting connections, sometimes putting the organisation at risk rather than following agency risk policies. CEOs and senior managers committed to collaboration and partnerships

may in fact be increasing their organisations' exposure to risk. The corporate focus on risk regulation does not offer the opportunity to consider collaborative failure, especially failure shared across sectors and between funders and contracted services. Rather, the investigatory or review procedures of regulatory agencies and funding departments generally set out to identify the individual or agency most clearly at fault.

Looking Forward

These issues will be the subject of more intensive future analysis. Our research team hopes to determine where the analyses of Hood et al (2004) and Hood & Rothstein (2000) hold true and where local practices support trusting and well-constructed risk sharing practices. We will seek to assess whether or not 'systemic' risks are buried in the regulatory processes focused on agency risk and the protection of reputation and standing.

In the next stage of analysis, interviews with program managers and frontline workers are likely to reveal 'close-up' details and examples of risk sharing processes and collaborative work, along with particular challenges and frustrations of dealing with diverse concerns and different risk management thresholds across agencies. Our interviews with clients may also provide a window into how relationships between agencies and their different regulatory practices are experienced on the 'receiving-end' of service delivery. At this stage we can say that these issues are very important in the minds of the CEOs and senior managers involved in this project.

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