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Priorities, 'street level bureaucracy' and the community mental health team

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Abstract
In the United Kingdom a combination of high profile incidents and reports personally critical of mental health policy in general and individual practitioners' actions in particular (Sheppard 1995) highlight the pressures which operate on mental health professionals in the community (Mechanic 1995a). These pressures are exacerbated by policy contradictions and resource limitations. Consequently community mental health practitioners (e.g. psychiatrists, community psychiatric nurses and social workers) can be sensitive to political and managerial agendas which may have a negative impact on their implementation of individual care programs (Marks **ef** *al.* 1994). Using the concept of 'street level bureaucracy' (Lipsky 1980), this paper examines recent literature. It is argued that practitioners' reception and implementation of policy is influenced by the need to balance the tension between four elements: the political and policy imperatives, the agenda of local management, the professional and peer cultures in which practitioners operate and the balance of perceived personal advantage. It is further postulated that managers and policy makers may have a vested interest in not scrutinizing practitioners' implementation of policy too vigorously as a way of deflecting responsibility for its consequences. The 'Care Programme Approach and recent legislative changes regarding community supervision (Department of Health 1995a) highlight the important and sometimes negative consequences for the service user that may result.

Introduction

Under 'New Public Management' government restricts its role to controlling finance, delegating policy implementation to local managers to take account of local conditions (Hunter 1993, Wilkinson 1995, NHS Executive 1996). Reflecting this, Community Mental Health Teams (CMHT) have been identified as the vehicle through which mental health care in the community, encapsulated in the 'Care Programme Approach', should be delivered (Department of Health 1995a, 1996). This will ensure that these teams become a fulcrum for many mental health policy issues, not least as they themselves are viewed as a controversial service delivery option, lacking a commonality of role and function (Galvin & McCarthy 1994). Commentators have identified problems of policy implementation at local level arising from the conflicting priorities to which health and social service commissioners, trusts and individual practitioners are subject within a context of limited resources (Wells 1996, Social Services Inspectorate 3995a).

Community mental health practitioners, such as community psychiatric nurses (CPNs) or social workers, can be sensitive to political and managerial agendas. This sensitivity may have a negative effect on their implementation of individual care programs (Marks *et al.* 1994, Roy *et al.* 1996). Such pressures have played a part in the slow implementation of the 'Care Programme Approach (Social Services Inspectorate 1995a). Securing practice change in this context is a well known policy and management concern (Nutting & Green 1994, Veeramah 1995 ,Nolan & Caldock 1996) and is likely to be complicated by the Mental Health (Patients in the Community) Act (1995) through the pressure its implementation may place on resources (MIND 1995). In this respect the tension between professional attitudes, clinical autonomy and practice with management and the priorities of government has a significance for wider policy imperatives. The tension between policy, managers and practitioners may be significantly affected by the subjective perceptions and personal agendas of those involved (Callahan 1994, Wells 1996, Loughlin 1996). Lipsky's (1980) work on 'street level bureaucracy' is pertinent in this context.

Street level bureaucracy
Lipsky (1980) is concerned to explain why service organizations behave in ways that may run counter to their publicly stated regulatory framework and policy priorities. He highlights the significant influence of workers in the 'personal' public services at 'street level' (e.g. social workers and nurses), and argues that, in order to understand the significant effects of policy, one must study the routines, subjective perceptions and behaviours of frontline employees in the public services as they operate policy.

The street level bureaucrat exercises a considerable degree of discretion in work involving face to face contact with service users (for example see Myers & McDonald 1996). There is therefore little opportunity for outside scrutiny, consequently they are not liable to strong managerial control. Indeed, the organizations in which these bureaucrats work can be significantly reliant on their discretion to manage the demands of users within endemic resource restrictions.

Individuals enter these organizations with a commitment to values and roles that emphasize 'service' and 'professionalism' (Hafferty & Light 1995). Working within a context of finite resources, the reality of their work rapidly leads to value and role ambiguity in relation to what they are asked to implement by policy makers and managers. The competing complex of demands and tensions between the organization and service users leads such 'bureaucrats' developing work practices to cope with the consequent dilemmas and stresses. These coping practices mediate central policy and in effect are public policy as experienced by service users, helping to explain the disparity that can arise between policy and implementation. The managerial means of asserting control, such as quality assurance and audit, rely on the autonomous professional reporting upon themselves. Therefore such information systems are significantly affected by those whose activity the policy and managers are supposed to control. Thus the policy agenda may appear to be met, but in fact can be significantly distorted at the 'felt' end of public experience.

There are three ways that street level bureaucrats may translate policy into practice. They may attempt to project a responsive attitude to the needs of service users to compensate for resource constraints. This suits both policy makers and managers who may not wish to be seen as responsible for resource shortages that result from their decisions (Mechanic 1995a). Workers' exercise of discretion may redirect organizational behaviour and priorities as a result of the aggregate of their decisions or by non-operation of those parts of policy they find objectionable (Henwood 1995a). Managers find this difficult to control as any action on their part is seen as an illegitimate interference in the professional relationship between practitioner and client. Third, street level bureaucrats may meet the explicit objectives of management. However, they can only do this, in a context of limited resources, by ignoring or paying lip-service to those activities which are not explicitly identified but are, nevertheless, important aspects of the service experience.

Using Lipsky's perspective one may identify four elements of tension which influence the street level bureaucrat as translator of policy. These are the political imperatives which dictate policy initiatives, management demands, the professional and peer cultures in which the practitioner operates, and the balance of personal cost and advantage. To understand the impact of these tensions on the practitioner one must first consider the processes involved in the development of policy.

Setting mental health policy priorities
Mental health policy encompasses macro politics, policy implementation and the actions necessary to implement policy (Tudor 1996). The setting of priorities at the macro level is inevitably determined by the political process as it affects social policy in general (Mechanic 1994). For example, Atkinson (1996) argues that the recent introduction of supervised discharge reflects the political philosophy of the 'New Right' with its emphasis on individual responsibility. Grob (1994) and

others (for example, Williams 1988) emphasize that mental health priorities often are the product of a number of factors. These include the prevalent opinions and values of the public, politicians and professionals, the available means of treatment in relation to the constitution of the mentally ill population and the recognized nature of mental illness. The UKs policy emphasis on the community care of mentally ill people demonstrates this proposition. This policy was a result of public concern over conditions in the large psychiatric institutions, the institutionalizing effects of these on the individual, the growth in the use of medication, the availability of flexible treatment approaches and the growth in the awareness and right of patient choice amongst professionals and lay persons alike (Health Committee 1994).

Three distinct approaches have been identified in mental health policy formulation (Callahan 1994). The first is characterized as 'informal' in which one priority is emphasized over an alternative for example, because of political pressure or to correct a perceived wrong. The essential feature of this approach is that it is reactive or symbolic in relation to transitory pressures. Such responses to transitory pressures can skew policy planning and development. The circumstances leading to the establishment of Supervision Registers in April 1994 and the policy emphasis on those deemed vulnerable and 'at risk' illustrate this. A television report in December 1992 on a psychiatric patient entering a lion's den in a zoo and the public's reaction prompted the government to immediately institute a review of mental health law. This resulted in policy changes 8 months later, the most prominent being the establishment of supervision registers of those mentally ill people in the community deemed 'vulnerable'. Atkinson (1996) cites this as a political response to a growing lack of public confidence in community care policy. These events have led to an emphasis in policy on the regulation of certain categories of mentally ill people in the community, the Mental Health (Patients in the Community) Act 1995 being the most overt sign of this.

The second approach is a 'formal and structured' non-technical process which attempts to systemize and order priorities into coherent units and groupings. Thus community care policy has been summarized as sensitive and flexible, providing choice, minimal intervention and prioritizing those with the most complex difficulties (Tudor 1996). Policy in this context is based on a dialectic between the professional values and attitudes of those charged with managing and implementing policy on the one hand, and the results of political and policy negotiation on the other.
The development of the 'Care Programme Approach is, to some extent, an example of this formal and structured process. The approach was first articulated in a Social Services Committee Report (1985), followed by government policy circulars (Department of Health 19901, and encapsulated in the guidance which accompanied the 1990 NHS and Community Care Act (Hudson 1993). Initially it was envisaged as applying to anyone who had been accepted by specialist psychiatric services. Such wide application had implications for resources and without extra funding the policy appeared impractical. It was this recognition, combined with evidence that the needs of patients with schizophrenia were not being met compared with other client groups (Hudson 1993), and critical reports (Ritchie 1994, Blom-Cooper ef *al.* 1995), that led to a policy emphasis on a 'tiered' system of prioritizing. Thus the full care programme approach is now officially seen to apply to only those with the most severe problems (NHS Training Executive 1995, Department of Health 1996).

The final approach involves a deliberate effort to incorporate some form of numerical equation into the process of ordering conditions for prioritization. The last of these three is often seen as the most rational yet, as critiques of the Quality Adjusted Life Year (QALY) demonstrate, rank orderings based on numerical equations may not be rational and value free (Harris 1988). Indeed most health economists would acknowledge that such an approach should not solely determine priorities and resource distribution (Knapp & Beecham 1995).

Central to all three approaches is the question of the level of resources that should be given to mentally ill people as opposed to the wider community (Mechanic 1995b). The question, as posed by Callahan (1994) for example, is whether policy should focus on promoting the well-being of the majority of the population in dealing with everyday life, or on mental illness, which affects a much smaller number of the people but can range in its impact upon the quality of life from mild to severe. In the UK provision of mental health services for mental illness is seen as a priority (NHS Executive 1996). However, Redmayne ef al. (1993) found that although mental health services were consistently identified by commissioners as a top priority, they actually ranked third in spending on community services. A comparison of expenditure per head of population in London for the fiscal year 1994-95 found that local authorities spent eight times more on services for the elderly than on mental health services (Woodley et *al.* 1995). Given this apparent discrepancy between policy and action it is understandable that a number of surveys report that financial pressures play an increased part in clinical and care decisions (Hogman 1996, Knapp 1996 Roy ef *a/.* 1996).

UK mental health policy, as laid out in the Health of *the* Nation white paper (Department of Health 1995a1, with its focus on suicide, and the 'Care Programme Approach, is firmly fixed on treating and containing mental illness in the community, and narrowing the work focus of practitioners to those deemed 'severe' (Hanily 1995, NHS Executive 1995). Although this overall policy development is the result of a 'formal and structured' process, in recent times the 'informal' approach to policy priorities has come to the fore. The importance of the latter interacting with resource constraints can lead to a tension between policy and roles for service managers and professionals dealing with mentally ill people.

Policy ambiguity, contradiction and the management agenda
Practitioners often expect to control their own practice (Hafferty & Light 1995). This poses a problem for managers who have to meet contracts and manage resources against a backdrop of complex and sometimes contradictory policy. At the same time, managers are reliant on the support of practitioners to carry out their function. If policy objectives are to be achieved, it is important for managers to avoid conflicts at the practice level that such policy might provoke. The management agenda therefore may be concerned with influencing but not controlling practice in order to steer a course between the demands of central policy and antagonising practitioners. Current UK policy developments illustrate this policy context of ambiguity and conflict which shape the relationship between managers and practitioners.

Lack of prescriptive central guidelines as to form and content in the 'Care Programme Approach'(Department of Health 1990, Hudson 1993, Schneider 1993) are justified by the need to develop approaches to suit local conditions (Department of Health 1995b, Mechanic 1995a, Trnobranski, 1995, Onyett & Ford, 1996, NHS Executive 1996). A feature of this stance was that, although the 'Care Programme Approach' extended the duty of health and social services to provide systematic aftercare, until the enactment of the Mental Health (Patients in the Community) Act 1995, it had no statutory basis (Kingdon 1996). Central government, recommends cooperation between social services, health commissioners and general practitioner (GP) purchasers, but fails to take account of important differences between them as to agenda and role (Ford & Sathamoorthy 1996, Hanily 1996). Thus Onyett *et al.* (19964 identify the conflict in the government's prioritizing severe mental health problems as an area which commissioners must address, while GI' fundholders demand services for patients with short-term mental health needs.

NHS guidance recommends a tiered 'Care Programme Approach be adopted so as to concentrate resources on people with the most severe mental health problems. For example, the recent legislation requires that resource priority be given to those placed on supervised aftercare orders (Department of Health 1995a). At the same time however, the NHS Executive emphasize that others

must receive its basic elements (NHS Training Executive 1995, Onyett ef *al.* 1996b). This apparent contradiction is not helped by a refusal to provide a definition of severe and enduring mental illness. Instead the Department of Health (Department of Health 1995~c)i tes five exemplars. Central government suggests assessment of need be used to define priority yet eschews any formal definition.

Thus it can be argued that the government requires managers to strike a balance between managing demand, needs and resources so the latter are not exceeded (Onyett *et al.* 1996131, but it avoids direct responsibility for what can and cannot be met. This means central policy creates a tension between meeting individual and management demands at the local, rather than national level. The lack of definition in relation to demand is particularly important due to the pressure on resources that may arise in relation to supervised qftercare (MIND 1995).

Resources, responsibilities and compliance: supervised aftercare
Treatment compliance of mentally ill people in the community has been a prominent issue in the UK since at least 1985 (Bluglass 1993a). This has mainly focused on compliance with medication, an issue which the 1995 Mental Health Act fails to address. A number of organizations have voiced the view that this legislation is aimed at ameliorating public dissatisfaction with mental health policy and hiding resource inadequacies (MIND 1995, Atkinson 1996). The use of supervision orders in the USA was initiated to resolve the revolving door syndrome, which was in itself a result of a lack of sufficient resources devoted to community care. Yet it is this shortage that undermines the effectiveness of statutory supervision orders (Fulop 1995).

In the UK central government insists that patients should not be discharged until adequate assessment of need has been carried out and appropriate resources have been supplied (Roy *et al.* 1996). However, the closure of so many in-patient beds has had a detrimental effect on discharge planning and is claimed to be a significant factor in 'bed blocking', leading to greater pressure on CMHTs and managers to contain psychiatric disturbance in the community in order to reduce admissions to hospital and thereby ease the situation (NHS Executive 1995). The recent legislation can be seen as part of this development. Concerns that community professionals have inadequate resources to implement the new measures reinforces the view that the legislation delineates the responsibilities of the keyworker without the means to fulfil them (Bluglass 1993b, Eastman 1994). In fact it is clear that practitioners in mental health often are the de facto rationers in relation to balancing demand against limited resources (Hogman 1996, Muijen 1996a, Nolan & Caldock 1996) and that policy guidance envisages a greater role in this respect (Department of Health 1996). Eastman (1994) states that, if people are to have their civil rights restricted, they should be compensated by the supply of adequate resources to facilitate compliance. Fears have been voiced that the legislation may be utilized to make an individual comply with an inappropriate and under-resourced treatment plan (MIND 1995). Recent research seems to indicate that intensive community support leads to higher in-patient admissions and further pressure on resources (Tyrer *et a/.* 1995). This provides support for the view that the ‘Care Programme Approach is likely to increase the demands on services (Wilkinson & Richards 1995, Hogman 1996, Onyett *et a/.* 199613).

If demands on services are increased, practitioners may look for means of maximizing the resources devoted to their individual clients. A perverse incentive of the new legislation therefore maybe to encourage patients or staff to demonstrate non-compliance in order to gain extra resources

Atkinson (1996) believes that the new legislation provides patients placed on a supervision order with a basis to sue local authorities for not providing services to meet their mental health needs. Indeed, an inpatient has already attempted to do so in relation to the requirements of the care programme approach *(*Health Service]ournal 1996). Mental health agencies in the USA have been

reluctant to implement similar provisions for fear of litigation (Fulop 1995). Managers concerned with conserving resources may be reluctant to encourage the use of supervised aftercare and to support practitioners who object to its implementation. However, the need to be seen to be sensitive to public concerns means that such support could only be tacit.

At an operational level management's role is to ensure practitioner's compliance with policy. This accountable relationship to management is weak (Onyett & Ford 1996). For example, operational compliance with supervised discharge is reliant on clinical discretion. If a discipline or clinical team set their face against implementing the new legislation there maybe little the manager can do, particularly as any such interference could be portrayed as an attack on clinical discretion, with all the attendant political fallout and bad publicity this would generate. It can be argued that local managers deal with this issue by setting in place the necessary systems to meet the agenda of central government but only pursue the question of practitioner compliance in general ways. It is understandable that managers have been found to avoid challenging the traditional culture of non-hierarchical and democratic teams in community mental health, so as to avoid looking closely at practice and power relationships (Onyett *et a/.* 199613). The result is that responsibility for policy implementation at the practice level can be deflected away from management. This relationship between management and practice is exemplified by the National Association of Health Authorities and Trust's focus on systems to implement the new supervision legislation, in contrast to the Community Psychiatric Nurses' Association's advice to its members to resist implementing the 1995 Act unless they feel local arrangements are appropriate (Cervi 1996).

Teams, practitioners accountability and practice

Mental health practitioners have to have a strong sense of purpose and the unique importance of their relationship with the patient or client if care is to be effective (Repper *et a/.* 1994, Onyett 1996). They usually share the social welfare values of egalitarianism, collaboration and maximizing the potential of service users (Lewis & Glennerster 1996). In particular most would subscribe to the view that their goal should be to provide continuity of care within a context of community orientated services that provide service users with choice, decent accommodation and constructive activities (Andrews & Teeson 1994, Mechanic 1995b).

The organizational context in which they are expected to operate may lead to practitioners' values and perceived purpose being quickly subject to challenge. To adhere to these values would demand that they operate proactively across a range of health and social agencies with respect to employment, education or housing, for example. Yet there is evidence that this is not possible (Lewis & Glennerster 1996, Onyett *et a/.* 1996). Mental health policy in the UK can be seen as reactive, focused on treatment and fragmented to a degree that does not facilitate such integration of action (Mechanic 199513). With this policy, and resource restrictions which lead to large caseloads, practitioners can become frustrated with the operational system in which they work and suffer from high levels of stress (Carson *et a/.* 1996, Fagin *et al.* 1995, Scott *et al.* 1995) The stress can be reinforced by the publication of reports which personally criticize individuals when things go wrong (Blom-Cooper *et a/.* 1995, Pallister 1996, Ritchie *et al.* 1994, Sheppard 1995) and serves to emphasize that community mental health practitioners are more likely to be held personally responsible than their in-patient unit colleagues (Mechanic 1995a, Ford *et al.* 1995, Muijen 1996 a, b).

The consequence of such high profile accountability is that the concept of professional autonomy in the relationship with the service user may be compromised. Although this concept is strongly supported as fundamental to good patient care (as well as providing practitioners with a means of resisting managerial interference in every day practice), it may be identified as a burden and threat in the case of specific clients. For example, under the 1995 Mental Health Act the designated supervisor is the main point of contact between the CMHT and the user. They are required to closely supervise the user compliance with a care plan and given discretion to decide what constitutes failure to comply. Yet they have no control over resources (Gupta 1995). As the patients placed under such orders are likely to be the most problematic in relation to the community, practitioners are bound to have a heightened degree of sensitivity in their decision making (Tyrer *et al.* 1995). Indeed the legislation may add tension and suspicion to the relationship with such clients (MIND 1995). This air of mistrust has occurred in other areas of community care. For example, the role of social workers in determining access to services has been found to affect their relationships with clients (Henwood 1995b, Social Services Inspectorate 1995~)S. uch tension and suspicion is identified as an important factor in violent episodes

displayed by persons in the community with severe mental illness (Hiday 1995). Hence, practitioners' professional autonomy is limited but the burden of accountability is increased. The management of the stress engendered by this clinical accountability therefore may become central issue for the practitioner.

ambiguity in aims, clearly defined roles and responsibilities within CMHTs which serve to diffuse personal accountability. The importance of the 'team' and locating accountability to operational management within it can serve to alleviate personal stress (Onyett & Ford 1996, Prance 1996). Indeed, there is much literature which now emphasizes the importance of developing team cohesion and relationships (Ovretveit 1995, Wilmot 1995, Chandler 1996). This appears particularly important when practitioners have to deal with dilemmas posed by limits on resources (Onyett *et al.* 1996a). Studies on 'burn out' seem to demonstrate the value of teams, as practitioners in teams which are supportive and have a strong sense of identity tend to suffer from less stress than others (Onyett *et al.* 1996a). Thus, the importance of being part of the team and not challenging its ethos may outweigh other considerations because of the personal cost involved in being isolated.

Teams in turn may develop clinical and organizational approaches to client care which foster a culture of defensive practice, (Roy *et al.* 1996). In their anxiety to avoid political and managerial pressures, teams may become concerned with 'managing' clients' immediate behaviour in the community. The objective of care then becomes limiting the number of in-patient episodes and, in the current climate, incidents of 'dangerousness', such as suicide or homicide (Dedman 1993, Jerrell 1995, Marshall *et a!.* 1995).This may meet the overt requirements of management and national policy, but gives little consideration to the individual's quality of life, nor the quality of care given to the service user at the inter-personal level. Indeed these 'safe' approaches may effect users' care negatively (Marks *et al.* 1994). For example, the emphasis of the recent legislation on the designated client supervisor's to consulting with both the user and others before changing care packages (Gupta 199.51, has been interpreted as extending the potential to challenge clinical and care decisions (McNicol1996)

his holds two prospective outcomes for the user and professional carer. The process of being seen to consult may 'become the main preoccupation of the keyworker as a way of avoiding such challenge. However, this need to demonstrate consultation may be too time consuming within the context of a crisis to prevent in-patient admission (Tyrer *et al.* 1995). The need to be seen to supervise the individual may lead to a custodial mind set in which the user's everyday life is over regulated, fostering dependency on the supervisor and team. Compliance thus may be seen as positive, whilst independent decision making on the part of the user as threatening. Lipsky (1980) identifies this perception on the part of the 'street level bureaucrat' as a principal influence on their interaction with service users. The service user who demonstrates compliance is rewarded with access to the limited available resources, whilst the non-compliant receives a negative and sometimes draconian response. It is well documented that practitioners are less well disposed toward the 'difficult' user (Ellis 1993), something the new legislative context may well exacerbate. Recent work (Repper & Perkins 1995) on the characteristics of client referrals rejected by a community care service would appear to support this contention. Repper & Perkins (1995) found that such rejected clients were often identified by the service as 'difficult', meaning aggressive or violent, or unwilling to accept that they needed care input. It could therefore be argued that these clients were denied access to services because they were of a non-compliant disposition.

Providing information

Management relies on practitioners and teams to provide information as to the effectiveness of their initiatives and policies. Audit often involves practitioners reporting on their clinical activity, particularly as much of mental health work involves one-to-one contact with little opportunity for outside scrutiny. However, management access may be complicated and hampered by a number of factors. Members of a CMHT may be accountable to different management structures. For example, CPNs may be accountable to one manager and social workers within the team accountable to another. These managers themselves may have differing agendas and objectives which further hamper an overall assessment of effectiveness. Furthermore, the notion that only fellow practitioners can supervise clinical work (Onyett & Ford 1996) may serve to limit the access of managers to this level of activity. Bearing in mind that it is this clinical area that contracts and policies are meant to affect (Hafferty & Light 1995), practitioners are placed in a powerful position. For in effect the management information system provides practitioners with a means to manipulate data so that management initiatives can be seen as successful or otherwise (see for example Schneider 1993). Indeed practitioners can avoid complying at all. A recent study found that practitioners in health and social services were equivocal and ignorant of the 'Care Programme Approach' (Social Services Inspectorate 1995a).

The weakness of audit can be implicitly seen in the fact that a number of commissioners and provider managers often appear to focus on systems, such as regular meetings between CMHTs and local GPs or referral letters including review dates, with clinical standards often articulated in very broad terms (Clinical Standards

Advisory Group 1995, Sledge *et al.*1995, Social Services Inspectorate 199513, Kingdon 1996,), rather than the inter-change between user, practitioner and team.

CMHTs and the level of resources
Underlying these issues is the relationship of the CMHT with the level of resources that policy makers and management give them. It is clear from the general literature, (for example, Jerrell 1995) and such policy documents as Building on Strengths (Department of Health 1995a), that CMHTs are seen as the route through which demand can be controlled and seems to indicate that those people with chronic mental health problems, identified as difficult to place because of the intensive community support they require, are admitted to hospital and then left so that community teams can contain their costs (Cutler *et al.*1992). **As** the 'Care Programme Approach uncovers hidden morbidity and users in general become more willing to pursue their demands, practitioners and teams will be required to resolve the dilemma of increased demand and finite resources (Nolan & Caldock 1996,Onyett,1996 a, b). In this regard, the policy emphasis on practitioners consulting users and carers about care programs serves two purposes. Practitioners, faced with the demands of service users to meet needs for which resources are not available, can appear to include service users and their carers in the decision making process. Through this process the practitioner has the opportunity to reshape the users perception of their needs to match the available resources. In this way user pressure is deflected. Simultaneously, managers and po!.icy makers can distance themselves from the consequences of policy through professional autonomy and accountability operating within this consultation process.

Conclusion

The high degree of accountability to which community mental health practitioners are subject may lead practitioners to 'play safe' in their care decisions and become concerned with the appearance of meeting explicit management objectives. Practitioners may provide managers with positive feedback about their practice so as to secure their employment and avoid interference. In return practitioners deflect possible criticisms from users by appearing responsive to their needs even when these can't be met. In this regard team support plays an important role. It provides practitioners with a means of locating accountability within a collective framework, while helping them cope to with the stresses of their work. Thus they assimilate the team culture from self-interest, and are unlikely to challenge its routines and practices because of the peer isolation this would engender.

Community mental health policy in the UK demonstrates the inter-relationship of such factors, which serve to affect the 'felt' reality of policy at the street level. **As** such it provides a robust example of the interplay of processes identified by Lipsky (1980) and practitioners' management of competing tensions. Apparently contradictory and ill defined policy development provides a confused environment in which mental health is proclaimed a priority but may be under resourced at local level. Managers are required to meet insufficiently delineated central prescriptions whilst simultaneously retain clinical good will. Therefore, they may focus on explicit aims which are easily demonstrable whilst avoiding or down playing those aspects of policy which might directly challenge professional autonomy. This can facilitate practitioner cooperation with explicit objectives, while distancing management and policy makers from the reality of the 'felt' experience of policy, which is ultimately left to the practitioner to interpret. Those with severe mental health problems living in the community face an increasingly intrusive regulation of their lives, in which the power of the mental health practitioner to manage and control their access to services is enhanced. Consequently, this area demands attention as practitioners deal with an intensifying tension between their values, their role and their work focus.

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