Responding to mental health crisis at a street level: mental health practitioners as street level bureaucrats.

Abstract

Street triage practitioners, consisting of mental health social workers and nurses, act as a conduit between service users and emergency services and have a significant amount of discretion in determining the care and treatment pathways for individuals experiencing mental health crises. However, this is set on a backdrop of neoliberal reforms which have resulted in an increased focus on risk management, accountability, responsibilisation, and managing scarce resources. Based on ethnographic research undertaken in a street triage setting in the UK, this paper examines the role of street triage practitioners as 'street level bureaucrats' and explores the impact of neoliberal mental health reforms on street level practice, and how these shape and constrain the use of discretion in a street triage context. Revisiting the relevance of Lipsky through a neoliberal lens, the research paper identifies how street triage practitioners use their discretion to navigate practice dilemmas in a contemporary mental health landscape.

Key words:

Discretion, street level bureaucrat, neoliberalism, street triage, mental health.

Introduction.

Street triage has been defined as a collaborative mental health and policing approach to crisis care. Street triage practitioners, consisting of social workers and nurses, act as a conduit between service users and emergency services and offer advice, support and assessment for individuals in crisis. Such practitioners have considerable scope and discretion in exercising both care and control functions in mental health, including determining which service users should be deprived of their liberty and in what circumstances. However, this is set on a backdrop of market-based reforms in mental health practice which have reconstituted the focus of crisis interventions to prioritise technocratic practices including monitoring, risk management, safeguarding, resource allocation and defensible documentation (Hill and

Laredo 2020). Market based reforms under a neo liberal ideological approach have seen mental health services reduced, reformed and reconstituted. Mental health practitioners are required to work with less resources and manage higher levels of crisis at a 'street level', with responsibility for risk management transferred from the collective state to the individual mental health practitioner. These factors have constrained the discretionary spaces that mental health professionals occupy (Moth 2018), with questions concerning the continued relevance of Lipsky in a managerialist Social Work practice landscape, and debates centred around whether such neoliberal reforms have curtailed discretion, or whether it continues despite them (Evans 2010). Within this paper we highlight that macro social, political and economic reforms have created a more 'anxious', 'constrained' and 'pressurised' environment for street triage practitioners at a micro level, who are using discretion and social support to mitigate some of the pressure in marketised mental health services.

Methodology.

This research paper is derived from a qualitative methodology using an ethnographic approach for data collection. Ethical approval was granted from both the University and National Health Service Trust (UK), and all the research contained within this paper follows the ethical principles of informed consent, anonymity, and confidentiality. Within this paper all references to geographic locations, services and professionals have been anonymised. Ethnography involves the researcher focussing on human actions and interactions and analysing and interpreting meanings from these (Hammersley and Atkinson 2019). Ethnography was chosen as a suitable approach as it offers insight into how street triage practitioners utilise discretion in their natural practice environments. The ethnographic methods selected for the research study were a combination of participant observation followed by semi-structured interviews. The ordering of these research methods was deliberate, with the interviews taking place after the participant observations had occurred. This allowed the interview questions to be shaped by observations. The choices of methods aimed to offer a thick description of events by attempting to gauge an understanding of the meaning and context underlying practitioner discretion. The data was collected over twelve months, with the researcher embedded for one day a week. The everyday practice of street triage practitioners was recorded using an ethnographic journal, allowing the researchers to summarise initial observations, social interactions and professional practice. We then

collected semi-structured interviews (ranging from sixty to ninety minutes) with five social workers and seven nurses. Data analysis was undertaken using Braun and Clarke's (2006) six stage thematic analysis, which included data familiarisation, generating codes, searching, reviewing and identifying themes, and then producing a report. Within this paper we will explore three major themes that were generated from this process; discretion and transacted anxiety, discretion as influence, and discretion as resistance. However, before we discuss the findings we will locate the theoretical and policy context of street triage practice.

Street Triage: Theoretical & Policy Context.

Street triage as an activity within the UK has its historical origins within the street rescue social work of the late nineteenth century, there is a congruence historically between our 'neo liberal moment' of capitalism, and the 'classical liberalism' of the early nineteenth century. Both these moments in history have sought to create a political and economic system where the state seeks to provide a minimum level of help and support to individuals in mental health and social crises, with welfare services encouraging self-help, and simultaneously acting as a deterrent, as well as a safety net for the most vulnerable in society. Within contemporary society we have seen the collectivised social security concessions of the post war 'embedded liberal' period dismantled; this process of deinstitutionalization, initially heralded as a progressive move from the segregation and containment of individuals experiencing a mental health crisis, has seen the transfer of care from vast institutions to the community, and as we argue from community-based care to the individual at a street level. Initially community care was a well-funded and resourced process, however the subsequent economic reforms linked to the cyclical nature of liberal capitalism have resulted in a reconfiguration and reduction in community based mental health services. We are not making the case that the historical institutions were the apex of good care, there were many faults, but in the absence of institutions, we are often left with a limited set of choices often at a street level. The end result is a system of limited mental health services, that are often located at crisis intervention points within criminal justice, hospital and more often than not a street context. It is from this vantage point that we can observe street triage as both a direct result of market-based reforms, but also an opportunity for mental health practitioners.

With the reduction in general welfare institutions and traditional mental health services, a primary point of contact for those individuals experiencing mental health and social crisis in the United Kingdom has been the police. The use of criminal justice services such as the police as a form of mental health crises intervention is often problematic, as the intensity of a criminal justice intervention often exacerbates a personal mental health crisis into a public performance, compounding the stress and anxiety of all involved. The provision of street triage may be viewed as a pragmatic response to the loss of community based mental health services, it is also a window from which we can view how mental health practitioners have adapted to the macro social, political and economic landscape. We can observe and see how street triage workers adapt and shape policy using discretion to promote a more flexible and responsive approach to mental health crisis. Within the UK social workers and nurses act as gatekeepers and key access points for mental health services, how they respond to crisis and plan an intervention shapes the experience for service users at a street level. The process known as street triage, defined as a: "joint mental health service and policing approach to crisis care" (Reveruzzi and Pilling 2016 pg. 13), offers one such initiative. Launched in 2013, with pilot schemes funded by the Department of Health, Street Triage is a co-response mental health model where practitioners assist the police to support individuals with mental health needs to access appropriate crisis and other mental health care. There are several different models of Street Triage in operation in the UK, each one commissioned locally by mental health trusts and police forces (Kirubarajan et al 2018).

Street triage practitioners act as a conduit between service users and emergency services and offer advice, support and assessment for individuals in crisis. One of the primary aims of street triage is to reduce the number of mental health detentions by the police under S.136 of the Mental Health Act (MHA) 1983 (Irvine et al 2016). S.136 authorises a police officer to detain any individual whom they believe to be suffering from a mental disorder and is in immediate need of care or control, for up to 24 hours to enable an assessment of their mental health to take place. Although use of S.136 can be a vital way for individuals who are experiencing a mental health crisis to receive appropriate support, detention under S.136 can be extremely distressing for service users, and police identify that they do not have the required expertise or resources to support service users in mental health crisis (HMICFRS 2018). The use of S.136 can also be viewed as one of the fault lines in our health and social welfare policy within the

UK, with a lack of community-based services and support individuals are often encountering the police rather than early help or preventative mental health services. Despite this fault line and the lack of more appropriate services, street triage practitioners play a key role in determining the care and treatment pathways for individuals, and in deciding whether service users should be deprived of their liberty and in what circumstances.

Research on street triage has predominantly focussed on two main aspects; the correlation between the implementation of street triage schemes and the reduction in the number of S.136's, and stakeholder perspectives of street triage and how valuable and effective they perceive it to be (Puntis et al 2018). The focus in practice has been to reduce police involvement in mental health and promote better integration with mental health practitioners, however street triage can be observed as moving focus from the context of the emerging mental health crisis to the point of crisis assessment. The contemporary neo-liberal orthodoxy of minimum state intervention can be observed as diverting crisis rather than providing material solutions to the mental health crisis. Despite these complexities and the 'cracks' in our system, street triage practitioners can and do play a role in shaping better experiences and interventions, given the limited services and the laconic context of assessment at a street level. The use of discretion in decision making is key, yet scant attention has been given to the decision-making practices of street triage practitioners or how they utilise discretion in their everyday practice. Such practitioners have considerable scope in decision making in this context, and have significant discretion in exercising both care and control functions in mental health. However, this is set on a backdrop of neoliberal reforms in mental health which have resulted in an increased focus in practice on risk management, accountability, and responsibilisation alongside significantly decreased resources (Stanford et al 2017). These factors have constrained the discretionary spaces that mental health professionals occupy. The act of discretion has highlighted the importance of mental health social workers and nurses in street triage as a form of street level bureaucrats.

Lipsky and discretion in Social Work Practice:

Lipsky, (2010) in his seminal text, describes Street Level Bureaucracies as public services where workers directly interact with members of the public in the execution of their roles,

and who have a significant amount of discretion in their everyday practice. According to Lipsky, (2010), there is also a paradox inherent in the role of street level bureaucrats, namely that their role is prescriptive in order to adhere to policy aims, but simultaneously, the nature of the work requires tailored and improvised responses to individual circumstances. The use of discretion is central to this paradox, as Lipsky argues that macro policy is translated through the routines, practices, and decisions that street level bureaucrats make at an individual level, to the extent that these practices become the policies that they enact. Although Lipsky did not consider the impact of neoliberalism on discretion per se, he did discuss that resource inadequacy, high caseloads, and structural constraints are characteristic of Street Level Bureaucracy work. We must also remember that Lipsky and social work are both subject and contingent upon liberal capitalism, and it is our position that neoliberalism is just a shift in the political focus of the economic model of capitalism, the system shifted but remained the same, therefore Lipsky is both relevant and poignant for street triage practitioners. Despite these constraints, Lipsky maintains that street level bureaucrats have a significant amount of discretion at their disposal.

Discretion is a contested concept within the academic literature, but for the purposes of the current study, it is defined as both the capacity to decide what should be done in a particular situation, and a form of influence (Darling 2022). Within this literature, there are debates around the continued relevance of Lipsky's arguments to contemporary social work practice. In a practice landscape where the prevailing orthodoxy of neoliberalism continues to dominate, the impact that new managerialism has had on discretion within frontline social work practice has been questioned. A body of literature has suggested that new managerialism has infringed on the social work role and eroded the use of discretion (, Lymbery 2006, Moth 2018), with questions concerning the continued relevance of Lipsky in a managerialised social work practice landscape. Others, however, argue that increased regulations may enhance discretionary spaces as they create more contradiction, uncertainty and ambiguity which relies on the use of discretion to navigate (Evans and Harris 2004,Evans 2010). Evans and Harris (2004), reject the 'all or nothing' dichotomy regarding whether discretion has continued or has been curtailed in the face of new managerialism, and instead propose that discretion is situation specific and should be considered on a case by case basis. Similarly, Ellis (2011) postulates that Lipsky's concept of street level bureaucracy traversing

several professions and organisations does not give due consideration to the different manifestations of street level bureaucrats across different settings, and that discretion takes many different forms in social work practice. From such a stance, it appears that discretion is multifaceted and differs depending on the context. It is from this position that the current study contributes to this literature by examining the use of discretion within a street triage context, by exploring the impact of macro reforms on micro street level practice, and how these shape and constrain discretion. The authors argue that it is pertinent to consider this for two reasons. Firstly, to the authors knowledge, there is no research which specifically focuses on the use of discretion within street triage, or which utilises Lipsky as a conceptual framework in a street triage context, which makes the focus of the research worthy of consideration. Secondly, street triage practitioners, with an expertise in mental health, play a vital role in care and treatment decisions for those in mental health crisis. They arguably make decisions when the stakes are high. Gaining an understanding of how street triage practitioners exercise their discretion when making such decisions is therefore pertinent.

Street triage practitioners can be regarded as street level bureaucrats par excellence, as they literally locate their practices at a street level. Street triage provides an interesting environment to consider the role of discretion; an environment which is often acute, unpredictable, and complex, marred by a lack of resources, and in which other professionals, including emergency services, are present and involved in how discretion is utilised. The research examines the relevance of 'street level bureaucracy' as a conceptual framework to understand street triage practice and how the use of discretion was shaped and constrained by neoliberal reforms from the perspective of the street triage practitioners in the study. With this identified theme of discretion, we introduce you to our research findings below.

Discretion and transacted anxiety- 'passing the hot potato around'.

One of the themes generated from the research was the impact of anxiety on the use of discretion. This was described in two main ways by the practitioners: that of managing the anxiety of others, and discussions of their own anxiety in relation to the role. Within a 'risk based society' with limited resources professional anxiety is derived from the transfer or

shifting of responsibility from the state to the individual practitioner. This transfer results in a form of professional compliance where risk is dispersed, and practice becomes defensible through following process or "ticking the box" as we say in the UK, by seeking guidance and support of others to cover decision making processes. Street triage practitioners identified that they perceived other professionals to be highly anxious about mental health presentations, and in such cases, they would 'pass' this anxiety to street triage practitioners. One practitioner Jenny describes this process using the metaphor of passing a "hot potato".

"when police call us, it is often about passing anxiety to us, a bit like passing a hot potato around, no one wants to hold it and everyone wants to pass it to someone else".

Practitioners described that such anxiety did impact on their use of discretion, particularly in determining the level of intervention to offer someone. Practitioners identified that such decisions were constrained by the anxiety of others, with Michelle outlining:

"Sometimes the police will ask that we go out to a street triage when it isn't clinically indicated. Sometimes police will say, 'we can't leave unless you come and see the person.'"

Practitioners identified that they felt that their discretion was constrained in these contexts, and a key aspect of the role was about managing the anxiety of professionals rather than service users. Lisa described this in terms of trying to ultimately understand the role and purpose of street triage, and who the service was for, to support the service users or to manage professional anxieties, whilst acknowledging that perhaps these two factors were inextricably linked:

"If you manage professional anxiety then that helps the service user, as it potentially avoids a risk averse decision being made, so they go hand in hand really".

'Transacted anxiety' as a concept has been considered by Kettle (2018) in his study of child protection practice, where he examined how responsibility and anxiety were transacted between social workers and other professionals. In Kettle's study, social workers perceived that they were the recipients or repositories of these transactions of anxiety. This relates to the current study, where practitioners considered that anxiety was transacted by the police, and a significant component of the role concerned managing these repositories of anxiety.

However, transactions of anxiety were bidirectional in the study, with examples of street triage practitioners being the donors of anxiety to other professionals.

This 'hot potato' situation tended to arise when there was a discrepancy in perception between street triage and the police regarding the level of risk that a person was presenting with, or the level of intervention a person required, in cases where street triage practitioners appeared to be more concerned than the police. In such contexts, there was evidence of practitioners articulating and transacting anxiety and concern to the police. An example of this is given by Gemma:

"When we are worried, the police don't always see that and don't think the criteria is met for S.136. So, I will articulate my opinion to the police, that I am really worried, really concerned about the risks to this person".

Anxiety in the study was transacted, like the metaphorical 'hot potato' with examples of street triage practitioners and emergency services passing this anxiety to others and also being the repositories of this transacted anxiety. This arguably constrained the use of practitioners' discretion in terms of choices of intervention, as practitioners felt that due to the anxiety presented, they had less choice of how to proceed in such circumstances.

Practitioners also identified and discussed their own anxiety in relation to undertaking the street triage role. This was linked to assessment and management of risk and practitioners identified the magnitude of the decisions they were making in relation to service users, which sometimes weighed heavily on practitioners' shoulders, as described by Nancy:

"We are making huge decisions about liberty, risk, is someone going to end their life, do we really want to admit them to hospital, is that necessary, so you are obviously going to worry about that, these are big decisions to make".

Some practitioners identified an inherent tension in the role related to anxiety and the use of discretion, between doing too much, in terms of restrictive interventions for people due to anxiety, and doing too little in an attempt to take what was described as 'positive risks'. Practitioners felt this tension in practice and identified that despite mental health practice being subjective, and not an exact science, there is a felt pressure to 'get it right', as outlined by Jenny:

“None of us have got a crystal ball, none of us are perfect, mental health is not predictable, human beings are complex… but there is the worry that if it goes wrong, if someone ends their life after you have seen them, then you will be blamed and held accountable.”

This reflects the wider political agenda, where the neoliberalisation of risk has occurred in mental health practice. Here, risk is framed as an individual problem as opposed to a collectivised responsibility (Stanford and Taylor 2013) and the focus in practice has become preoccupied with fear where mental health professionals are treated as “societal scapegoats” (Foster 2013 pg. 120) and are blamed, shamed, and demonised when something adverse happens (Manuel and Crowe 2014). Practitioners did express worry about this in the study and identified concern about appearing in coroners court or of being deemed to have been negligent or found guilty of corporate manslaughter for ‘getting it wrong’.

When practitioners were asked if these factors impacted on their discretion in terms of autonomy to make decisions, practitioners were clear that these factors did not impact on their use of discretion, however, they did impact on how practitioners documented these decisions. Practitioners were all too aware of the requirement to defensibly document in such cases as evidenced by Helen:

“If you have taken a therapeutic risk sometimes and you think ‘how will this look’, you have to think really carefully how you document this to reflect the decision. The first thing they look at are your notes when things go wrong, so you always have to be mindful about what you document, yes, and also how you document this.”

Similarly, Dominique identified that this was something that she was very conscious of “but it wouldn’t stop me from making that decision. But equally I would be very clear why I had made that decision; I would consciously bat off any criticism or blame by making a clear entry on the system that reflected why I had made it.”

Building upon the key theme of Discretion the next section explores discretion as a form of influence.

Discretion as influence.

Discretion as influence was also identified as a theme in the current study. The legal interface between street triage and the police is interesting, in that the legal power to detain an individual under S.136 MHA lies solely with a police officer, however, changes to the MHA by the Policing and Crime Act (2017), means that before utilizing their powers under S.136, an officer, if practicable, should consult with a mental health practitioner. Street triage offers this consultation function to officers, to determine the appropriateness of the proposed S.136. This creates an interesting interface in practice as the police possess the legal powers to implement a S.136, yet officers can feel burdened by this, and do not feel that they have the required expertise to support service users in mental health crisis (Wondemaghen 2021). In contrast, street triage practitioners have expertise and training in mental health, but do not possess any legal powers under S.136 MHA 1983 to implement. This creates a space where discretion as influence occurs and decisions are negotiated, with street triage practitioners identifying that they had great influence in these contexts. This was described by Miranda:

"The Decision to implement a S.136 is a police power, but police will often be guided by what we recommend. Officers rarely disagree, they tend to go with what we recommend."

Similarly, Nancy described a discussion with an officer where she discussed the decision to implement a S.136 as being the officer's decision and not the decision of street triage, "but the officer said, we are always happy to be guided by you really". Research on the involvement of the police in mental health contexts has referred to officers as 'street corner psychiatrists' (Teplin and Pruett 1992) and mental health gatekeepers (Lamb et al 2002). In the current study, street triage practitioners acted as 'defacto detainers' and 'defacto libertarians' as they were able to utilise their discretion as persuasion and influence in the use of S.136 powers to either deprive an individual of their liberty or offer a less restrictive option.

Another key point was that practitioners in the study unanimously identified that they felt that they had very good working relationships with police officers, which had developed over time, and that officers tended to trust the judgement of street triage practitioners and their recommendations made around the use of S.136, and when this should and should not be implemented. This suggests that discretion is relational, and discretion as a relational

construct has been considered between street-level bureaucrats and their managers (Keulemans and Groeneveld 2022), and other actors (Miaz and Achermann 2022). This current research supports the relational construct of discretion but also considers that the relationships in question utilised influence, persuasion, and orchestration to achieve desired aims. This was discussed in the context of resource constraints, in the aftermath of neoliberal cuts which have resulted in a scarcity of mental health beds and community support options in practice. Street level bureaucrats face an impossible job, they need to perambulate a challenging practice landscape where demand outstrips supply and where they are likely to face the brunt for shortfalls in resourcing and service provision (Zacka 2017). Kate discussed this tension in practice, where there is often a lack of psychiatric beds available which constrains options on the ground, particularly when a person is presenting with risks, and there is also carer strain evident:

"The person is acutely unwell, family are on their knees, and everyone is looking at you to fix the problem. In these cases, I might recommend a S.136 so the person is then kept safe pending a bed being found."

Practitioners in the study acknowledged that in the face of scarce resources, at times they recommended the use of S.136 to officers for pragmatic reasons. They identified that other legal options were available, such as pursuing a MHA assessment, but in the absence of both beds and resources, they described that this could take hours and often days to mobilise, as outlined by Gemma:

"MHA's can take a long time loads of paperwork needs to be filled in to make the referral, which takes ages, lots of back and forth and then you might be told once it is accepted, that you are one of six community assessments waiting. Put no beds and lack of practitioners into the mix and it is not getting done anytime soon. In the middle of this, there is a person, who is acutely unwell and who is waiting to be assessed."

Quirk et al (2003) argue that there are often extra-legal and non- clinical influences in mental health detention decisions, with detentions being more likely when there are no viable alternatives to hospital admission. Additionally, Simpson (2020) identified that in mental health detention decisions, these do not consist of purely legal or technical considerations, rather morality pervades such decisions. In these emotionally fraught contexts, Street Triage

practitioners were invoking discretion as pragmatism and felt that they were basing their decisions on moral considerations, more specifically what they felt was the 'right' decision for the service user, even if this was at odds with what was right from a procedural position.

Discretion as resistance.

The final theme discussed is discretion as resistance. This resistance is categorised in two different ways in the study, resistance to new managerialism, and discretion as making time. Both are framed as acts of social solidarity at a micro level which directly challenges the macro neoliberal orthodoxy in which street triage practitioners located their practice. With respect to the former, acts of resistance were described and observed in relation to new managerial changes that were being proposed or had been implemented in street triage. The field work took place during a reconfiguration of service provision which entailed a relocation of other mental health services to be co-located with street triage practitioners, where they shared an office space and computer systems. This meant that there was a move to hot desking, to accommodate this increase in staff numbers. Some street triage practitioners were disparaging of this particular change, which was felt by practitioners to benefit the service rather than staff or service users. During an observation of a shift, the street triage practitioners inhabited a room that was unoccupied, made a sign out of pen and paper, which said 'street triage office,' and fixed this on the door of the room. Helen provided context to this act of resistance:

"People talk of new ways of working as a good thing but it is often cheaper or more efficient ways of working, like hot desking, which is no good for anyone. Changes are made with little thought on how that will affect us or the people we support. So, we have claimed this space as ours. There is a sign on the door now, so it is our space!"

Similarly, Lisa described a tension in practice around a pressure to focus on new managerial targets including data recording and monitoring at the cost of relational practice, "Sometimes it gets raised that we don't collect the right information at the time of referral. Management say, 'if you don't collect that information it can impact on funding and targets'. But my priority, when someone is acutely unwell, is to support that person, not to collect that data.

It is often not appropriate, so I don't prioritise it. We are caring professionals, not administrative robots."

Lisa's description in this context highlights the inherent tension between the need to collect key data which is linked to funding, and the drive to deliver compassionate care and support to individuals experiencing mental health crises. Discretion as resistance here acts as a direct challenge to neoliberal reforms, with practitioners expressing dissatisfaction about these and challenging this through acts of resistance, including refusal to comply. This is an example of how macro neoliberal reforms were resisted through the micro encounters of street triage practitioners, as they were perceived to be a threat to the role of practitioners as caring professionals. The second act of resistance was around making time. Practitioners in the study described the extremely fast paced nature of the street triage role, with Miranda describing this as akin to factory work:

"It sometimes feels like a production line in a factory where you are making quick decisions, you see someone, make a decision then move on, it's all very rapid and feels like you are processing people sometimes."

Practitioners also described that the nature of the role meant that people were seen very briefly and not usually seen again by the service for follow-up care. This following up was often left to other professionals, whom street triage practitioners referred to, or signposted to, however, Dominique identified that due to service pressures and constraints, this was not always picked up by services:

"A frustration of the role is we will signpost, but we never know if it has been picked up, we tend to only find out if that person comes back through and we ask the person, "did that service see you in the end?" And they say, "no I was never followed up," or "no I was told I didn't meet the criteria".

This led to practices of keeping people on when this was not strictly allowed, so practitioners orchestrated this and would find a justification to follow people up because there was a sense of wanting to do more for people. There was recognition that some service users 'fell through the cracks' and some practitioners outlined how they would bridge this gap by making time for service users. This was described by Kate:

“Sometimes I see gaps, or somebody warrants, no somebody fucking deserves something. I saw a guy the other day, the story broke my heart, and he didn’t meet the criteria for mental health services, but he needed something, so I just said, look, can I give you a ring in a couple of days? And I just did that really.He just needed to off load”.”

Kate described how she made time in this context and followed this service user up with a call, even though this was not strictly within the remit of street triage. Other examples of making time were described by Michelle when she described feeding someone’s pets after they were admitted to hospital:

“All I could think about was there were pets in the house. Who is going to feed them? So, I went and bought some cat food and fed the cats, all six of them.” Similarly, Laura outlined “We visited a lady who had very little food in the cupboards. It broke my heart. She had no one. So, we went to the shop, bought her some food and delivered it to her.”

Street triage practitioners in these examples are outlining the art of making time for individuals who require care, compassion, and support at times of crisis. Practitioners identified that the role of street triage was not to put food in people’s cupboards, or to feed their pets, or to follow people up when they did not meet strict service criteria, however, there was a sense from practitioners that ‘making time’ was a cornerstone of ethical practice. There was a recognition of the neoliberal fault lines that have been created in mental health practice and street triage practitioners, through the art of making time for service users, challenged this through enacting social solidarity. Social work practice has been described as ‘deviant’ in research by Carey and Foster (2011), with evidence of ‘positive deviance’ and ‘responsible subversion’ by the social workers in their study. However, as Carey and Foster (2011) note, deviance in the study was not ‘fired by grander political…needs” (pg. 586). In contrast to this, in the current study, discretion can be regarded as a political act, and was enacted as resistance through acts of social solidarity, including the art of making time, and resistance to new managerial changes that were imposed. Mirroring Hill and Laredo (2020) study, social solidarity was utilized at a micro level as a challenge to the neoliberal orthodoxy at a macro level Whilst the discretionary spaces have arguably narrowed as a result of such neoliberal reforms that have reconstituted practice, the practitioners in the study recognized the fault lines of neoliberalism and became ‘radical street level bureaucrats’ (Lipsky 2010), through enactments of resistance and social solidarity.

Summary.

This paper has highlighted that the use of Lipsky provides a useful conceptual framework, and street triage provides suitable conditions for practitioners to act as street level bureaucrats, both metaphorically and literally, as they work and locate their practices at a street level. The discussion has highlighted that as social workers, nurses, and mental health practitioners, we are all subject to the larger social, political, and economic forces we are constrained within. Despite these limiting constraints it is evident that street triage practitioners have utilised discretion to adapt and shape the rules, processes, and assessments to improve outcomes and provide better, more comprehensive services for those experiencing mental health crisis. While these are not revolutionary acts they act as a micro challenge to the macro prevailing orthodoxy of new managerialism, and remind us to not enter a narrative of reification with the dominant social, political, and economic context. The location of mental health crisis assessment at a street level can be considered as neither progressive or supportive, but a pragmatic response to the reduction and retrenchment of contemporary mental health services. The inception of Street Triage as a response to increasing involvement of the police in mental health presentations, is indicative of the failure of deinstitutionalisation and the lack of adequately funded community mental health services. The discussion and analysis within this paper has highlighted that street triage practitioners are acting as a "sticking plaster" and limited "salve" for such structural economic crises that are experienced at an individual level. The chronic underfunding of mental health services has reshaped the landscape of practice, to one that is fragmented, transient and where crisis presentations are increasingly experienced at a street level. To reduce anxiety and promote better practice we need to reimagine how we better respond to mental health crisis. We need to stop operating in the "gaps" and "cracks" created by market forces and begin collective conversations of how we fill those gaps with a progressive community development model in mental health.

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