Coda
Psychological Therapy and the Ambivalence of Access

An ethic of access circulates internationally, underpinning global and local strategies aimed at proliferating the availability of care and treatment (Biehl, 2007; Cloatre, 2013; Fassin, 2012; Greene, 2011). In the United Kingdom, this ethic has driven forward policies and practices orientated to improving access to psychological therapies – not least the iconic IAPT programme itself. These have been widely heralded, served as international exemplars, and catalysed research and innovations on therapeutic interventions and in relation to notions of the psychological per se. Crucially, many more people have experienced therapy as a result. Challenges, however, remain. An imperative to get through increasingly long waiting lists within tight time-frames, for instance, can result in care being enabled for some patients by restricting it for others.

Over the preceding chapters I have examined some of the social dimensions and ontological implications of endeavours to enhance the availability of psychological care, and of their ramifications for clinical psychology in particular. My analysis has been grounded in a range of texts (journal articles, policy documents, clinical guidelines, and more) and interviews (predominantly with clinical psychologists, as well as policymakers, advisers, and others who hold power to shape the contexts of psychological care). It was also situated against a backdrop of wider work I have undertaken exploring what Rose (1985) calls the psychological complex. This includes research and dialogue with patients and campaign groups, and increasingly as a direct collaborator with clinical psychologists and psychiatrists.

In part given these assorted engagements, I had various potential readers in mind when writing this book. First were sociologists like myself, and colleagues in adjacent fields. For them I have illustrated how a seemingly progressive and widely shared ethic can imbricate political, legal, epistemic, and affective operations across scales in ways which reconfigure professional praxis such that a range of issues and ontologies are also constituted

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as a consequence. There are, I suggest, relevant insights here for researchers working in different contexts and jurisdictions that are trying to understand better how ostensibly valorous initiatives can sometimes lead to unfortunate results.

Second, I thought this book might find its way into the hands of some mental healthcare professionals themselves, especially clinical psychologists. To these readers I want to be clear that I respect psychological expertise, and am cognisant of the considerable benefits that people can be afforded by a positive therapeutic relationship with a thoughtful, compassionate clinician. I am optimistic that any practitioner who reads this work will agree with me that close yet supportive scrutiny of clinical contexts and norms is always important for enhancing practice. Hopefully, then, this at times critical account of psychological work will further contribute to the necessary reflexivity of professionals that is overall a hallmark of healthcare.

Third, I imagine some readers will be drawn by their own experiences of psychological therapy, not least if these have been difficult or adverse. I know very well that exposure to psychological services can be detrimental as well as beneficial. Negative experiences of therapy – and of particular therapists – can and do occur. Many people are also structurally or interpersonally prevented from accessing care in the first place. By showing, for instance, how processes of entry into and involuntary exit from services are adjudicated, I hope to have provided additional evidentiary support to all those campaigning to improve the accessibility and operations of psychological therapy.

Condensing Configurations

Politics, policies, and everyday exigencies reciprocally configure the contexts of therapy, the care practitioners provide, and the identities of therapeutic professionals. Take, for instance, professional claims-making about what clinical psychology is and should be, particularly in relation to psychiatry (e.g. formulation focused, non-diagnostic, and so on). Claims about the profession do not merely reflect the nature of clinical psychology; they actively configure it. The tactics and processes of boundary work clinical psychology performs in relation to other professions have helped to stabilise it within the NHS as a key provider of psychological care. Accordingly, debates within, assertions about, and the practices of clinical psychology play a role in setting agendas about the nature and delivery of psychological therapy more broadly. Ultimately, these inform

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the kinds of expertise that people seeking care find themselves with access to, and thus how their subjectivities are configured through therapy (cf. Hacking, 1995, 2002).

As such boundary-work underscores, clinical psychology is but one facet of a larger psychological complex, even as it is among the most salient within that. Understanding the instantiation and ramifications of an ethic access to psychological care in the United Kingdom thus also requires consideration of other activities and initiatives, which themselves shape the work of clinical psychology. IAPT/NHS Talking Therapies is, as noted, a signature example of how access to psychological interventions has proliferated, with clinical psychologists' roles within it emphasising leadership and management more than therapy directly. At the same time, that initiative has also pushed clinical psychology towards a far more metricised form of practice. This is in part via the significant political support that the data and cost-orientated approach to IAPT attracted.

IAPT is certainly not alone, however, in shaping the wider experiences of clinical psychologists and other psychological practitioners, and the ways in which therapy is accessed. The changing understandings of personality disorders documented in Chapter 3 are particularly noteworthy in this regard. Through the discourse and activities propelled by the updating of the 1983 Mental Health Act of England and Wales, personality disorders became configured as treatable – with psychological interventions commonly foregrounded. People detained in prisons and forensic mental healthcare settings consequently found psychological therapy more accessible, albeit constituted through overtly disciplinary logics. Beyond these contexts, psychological care also became somewhat more available to other individuals living with a label of personality disorder. This was due to those reworked understandings of treatment efficacy and of treatability per se. As 'personality disorders' have become increasingly framed as dimensional 'personality difficulties', the focus of clinical psychologists and other psychological therapists on these has intensified. Such shifts illustrate how legal innovation participates in configuring the focus and availability of therapy, the spatial dimensions of its accessibility and administration, and the psychologies of those to whom clinical (and penal) intervention is directed.

While initiatives to improve access to therapy are often portrayed as laudable, they nevertheless clearly have inherent normativities that demand consideration. Psychological practitioners are themselves often all too aware of these: of how economic restraint in some areas – and largesse in others – configure the contexts in which they work, and of how political and professional machinations impact their therapeutic foci. For these

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practitioners, the metrics that have come to govern psychological care (e.g. how many patients does a service see, and how quickly) are a significant concern. Worries circulate about what happens as a result. This includes anxiety that CBT is over-emphasised in UK mental health, given its suitability for the time-limited approaches favoured to facilitate greater movement of people into and out of services. This centring of CBT is widely understood to have implications for the innovation, evidence production, and implementation of other forms of psychological therapy which could improve population and individual mental health.

As indicated earlier, one consequence of an ethic of access is that psychological care has become subject to a range of (ac)counting practices. In outpatient settings, where most treatment is delivered, these direct the attention of clinicians not only to the person in the room with them but also to all the people waiting to be so. The temporalities and possibilities of care are often closely defined, metricised as a more or less prescribed number of 'sessions' with a patient (even as clinical psychologists can sometimes evade the limits they are encouraged to adopt). This brings the end of treatment into its beginnings, with projections about the duration of therapy shaping practitioner engagements with those whom they treat, including as part of patient assessment and even decisions about whether to accept a referral. Within these processes, the clinical gaze is also now commonly orientated to a person's 'readiness' for treatment, and thereafter their attendance at therapy appointments is a key object of governance.

If psychological therapy has become ever more configured through bureaucratic, economic, and sometimes directly political considerations, experiences of delivering care also appear to have shifted. Many clinical psychologists, for instance, speak of being under intense pressure. One corollary of this can be an affective disposition to those with whom they work that itself generates feelings of concern. As Molly described in Chapter 5, clinicians are implicitly enjoined to 'ration' their 'compassion': moral distress (Jameton, 1984) appears to be increasingly characteristic of psychological care. A logic of 'exclusionary inclusion' (Decoteau, 2013) consequently permeates psychological services, allowing practitioners at least to try to manage growing demands and to make it through the day while preserving their professional, epistemic, and moral identities.

Psychological Manoeuvres

The need to improve access is thus experienced not simply as a straightforward matter of fact by therapists but also as a matter of quintessential

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concern (Latour, 2004). Clinical psychologists, among others, widely believe that there is considerable unmet need for psychological care. This sentiment aligns with that of policymakers who have introduced healthcare targets as one attempt to stimulate the increased accessibility of care. Yet, the capacity of psychologists to provide this is not unlimited. Given the financial challenges imposed on the NHS across the United Kingdom (and, indeed, health systems in many other countries), targets are ever more challenging to meet.

Within this context, local policies and actions which aim to enhance patient throughput and reduce waiting lists can flourish. Service-level opt-in procedures and attendance/DNA policies are key examples. As a result, processes of referrals and discharge become embroiled with an ethic of access in ways that generate or intensify practical uncertainties with moral and affective valences. Should someone be accepted into a busy service, for example, if they do not quite 'fit'? Under what conditions should a person who misses a therapy appointment be involuntarily discharged? To what extent does – or should – the length of a waiting list matter in relation to managing the uncertainty work of who should be granted access therapy? These are not easy questions to answer, and clinicians are generally not well supported to grapple with them.

Despite wider challenges, clinical psychologists continue to have opportunities for enacting their professional autonomy. This includes the performance of negative discretion (Barnard, 2023), such that practitioners can say 'no' to referrals and 'no' to someone continuing with therapy. The discretion of clinical psychologists is shaped by infrastructures like DNA policies, which might ostensibly define whether a patient should be involuntarily discharged. However, autonomy is also channelled precisely through these, such as when policy ambiguity configures a therapist as central in deciding whether to discharge someone based on their 'poor' attendance. The exercise of negative discretion can also generate positive effects for someone else seeking care: through the release of clinical capacity, it affords a therapist the opportunity to say 'yes' to them. As devices which help to enact and configure the disciplinary power of therapists (Foucault, 1988), waiting times targets and DNA policies are thus intrinsically ambivalent. Specifically, they operate simultaneously as what we might refer to as engines of access alongside what Decoteau (2013) calls technologies of exclusion.

Sometimes, as we have seen, a person who might prima facie be an 'inappropriate' referral can still gain entry to a service. Doing so entails a certain set of ontological alignments between (shifting) understandings of a

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patient's subjectivity, of the nature of a service, and of the professional identity of the practitioner adjudicating the referral. Other people might not obtain access in this way, however. Clinical psychologists are adept at justifying their decisions, leveraging different epistemic, moral, and professional registers to do so. But if all choices that practitioners might make can easily be accounted for as 'correct', this leaves individuals who are denied therapy little room for contesting professional power and accessing care. Decision-making around access to therapy that is based on ostensibly psychological grounds (e.g. unreadiness for therapy) might be especially hard to challenge given the epistemic and administrative authority of clinical psychology within the NHS. As discussed in Chapter 1, there are, to be sure, other psychologies circulating in this ecosystem. Still, clinical psychology holds considerable power and has worked extremely hard to achieve and maintain that. If a clinical psychologist configures a person as not really 'ready' for therapy, or simply a 'bad attender', then an ontological respecification (Woolgar and Neyland, 2013) that enables their care to continue is not straightforward to achieve.

It is obviously essential that clinical psychologists employ their expertise when deciding who should access their care, as well as regarding the possible cessation of therapy. A healthy degree of clinical autonomy is vital to this. Nonetheless, potentially significant space remains for personal prejudices to unintentionally become inscribed within decision-making. In the introduction to this book, I underscored how the social is constitutive of psychological praxis; accordingly, expert judgements cannot be assumed to exist in hygienic isolation from, for instance, raced, gendered, and classed perspectives on persons seeking therapy. It is entirely possible to imagine a situation in which an overwhelmed clinical psychologist unreflexively attributes a person as insufficiently psychologically minded and not 'ready' or 'suitable' for therapy. Such a scenario could be more likely in stretched services with long waiting lists, wherein practitioners are expected to deliver results increasingly quickly, and limits are placed on opportunities for self-interrogation of clinical decisions. Even within contexts where autonomy is experienced as severely impacted by systematic underinvestment in healthcare, the accountabilities of clinical psychologists thus cannot and should not be elided. When autonomy is presented as being so curtailed that providing care to some people necessarily requires others to go without, close consideration is still needed of what forms of autonomous action remain, what it does and does not afford, and who it (dis)advantages.

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Moving Forward

We need to think more collectively and creatively about how clinical psychologists are enabled by healthcare infrastructures to make the best – most clinically appropriate, most ethical, most equitable – decisions they can within often very difficult circumstances. Currently, the degree to which there are checks and balances in place regarding decisions about access to or curtailment of therapy across different services is not always clear. More constructive challenge as part of team-based referral or involuntary discharge discussions could help, notwithstanding the issues about epistemic hierarchies I raised earlier. Returning to the example of someone not being 'ready' for therapy, the fact that this characterisation is so hard to refute is precisely why its deployment within decision-making demands reflection. When the enactment of decisions that can prevent or curtail therapy requires consultation between colleagues, we might expect an even more robust consideration of potential exclusions to result.

Further, despite the problems with DNA policies, these can at least provide a route by which patients might, potentially, contest professional decision-making (e.g. through presenting the circumstances of a missed appointment in ways that configure these as recognisably 'legitimate'). However, I am somewhat ambivalent about the utility of more policy to address access. National policies can overlook the needs of local contexts, and service-level polices can sometimes be transplanted to other psychological settings without sufficient consideration of their applicability and utility. Policy is accordingly – and as many clinicians rightly attest – far from the answer to everything (Kellogg, 2011; Watkins-Hayes, 2009). It at once ameliorates some concerns and generates others.

IAPT has shown us that ambition and purpose can have profound effects on the provision of therapy; equally, it has illustrated that prescribing too rigidly what a service is and how it should operate causes its own issues. Over time, the initiative – and now NHS Talking Therapies – has grown in ways that grant increased flexibility to providers. There are, however, notable limits to this, configured in part by policy that dictates the large volume of data clinicians are required to collect. I maintain that there must be scope for services – within and definitely beyond NHS Talking Therapies – to evolve over time. This should be explicitly via ongoing, dynamic engagement with those they seek serve.

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Rather than finite policy recommendations, then, what I instead propose here is that a companion to an ethic of access is required; namely, an ethos of reconfiguration. This can be characterised as a programmatic willingness to be operationally flexible, to embrace community-driven service (re)development, and to further animate and support healthcare professionals to actively seek out opportunities for this. An ethos of reconfiguration would emphasise variability and malleability, within mental healthcare in general and the provision of psychological therapy in particular. Services should be enabled to reconfigure themselves in light of ongoing user and community feedback and changing needs. Instead of being seen as a failure to get it right in the first place, ongoing processual revision could be championed as evidence of substantive community engagement, responsiveness to changing needs, and critical clinical reflection.

As part of this ethos, different NHS organisations, and individual services and clinicians within them, must be granted the dedicated time and resources to work in partnership with communities to ascertain how best to deliver enhanced access to care, for whom, and what that care should look like. In some cases, this could result in the development of 'simple', bespoke solutions. For one service, it might be that therapy appointments shift to take place in the evenings; in another, it could entail practitioners moving to a new building with better public transport links. In some contexts, it might mean doing away with appointment letters altogether and instead discussing arrangements for care directly over the phone. Elsewhere, it could be that online therapy sessions become the norm. Perhaps some services should avoid diagnostic terms; maybe in others counselling psychologists rather than clinical psychologists should comprise the majority of the team. The point is that there is no one-size-fits-all model for the provision of psychological therapy; this is highly contextualised not only by the economic and professional considerations of NHS bodies but also – and more importantly – by the material and psychosocial circumstances within which these operate.

If these examples look like nothing more than tinkering around the edges, this only underscores the gravity of the situation. When I have discussed these matters with clinicians, the response is often the same: even seemingly limited changes can feel impossible to make given the pervasive lack of funding for mental healthcare. X, Y, and Z might help, but where will the resources to make those modifications come from? Every little change in the NHS takes time, and therefore costs money. Healthcare

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professionals are too often unable to manage even their current work under existing funding arrangements, without taking on extra labour to find better ways of delivering care.

Money, Money, Money

For at least two decades now, reports by advocacy groups and activist collectives (Mad Youth Organise, 2025; Mental Health Foundation et al., 2006; Mind, 2024; Mind et al., 2013) have provided personal testimonies and quantitative figures about the difficulties many people face in accessing psychological care, with long waiting times commonly underscored. Recommendations about how to address this issue sometimes emphasise the need for waiting time targets and almost always the requirement of greater financial resource. I worry how the former can be used by politicians as a means of responsibilising the NHS without granting them the ability to deliver. However, I agree wholeheartedly with the latter point. It remains entirely apparent to me that NHS services are significantly underfunded, and clinicians alarmingly overstretched.

The impact resources have on the instantiation of an ethic of access cannot be overstated. These are intrinsic to the structural conditions that configure care, and they need to be vastly improved. It is a lot easier to support someone to undertake therapy within a healthcare system where clinicians are not constantly being urged to consider all the other people waiting to see them – sometimes for years. If this book is, among other things, a critique of how professional discretion within psychological services can at times be problematic, it is also a demonstration of how the politics and economics of austerity contribute to configuring those circumstances and, indeed, the psychological itself. The possibilities of subjectification I have highlighted would obviously be textured differently in a less impoverished NHS.

Healthcare professionals across disciplines are doing difficult jobs in challenging circumstances, and clinical psychologists are no exception. During my fieldwork and after, I have also consistently encountered what I experienced as genuine concerns for individuals and for populations. Despite my critique, I align with an ethic of access. This is even as I insist on the necessity of problematising some of its specificities and ramifications. Such criticality absolutely does not confute the proposition that so many activists, academics, clinicians, and policymakers have advanced in the past, and still widely articulate; specifically, that more, much more

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investment in mental healthcare is needed – locally, nationally, and internationally. Without it, services will continue to come and go, clinicians will continue to have to find workarounds that benefit some and hurt others, and many people will continue to go without care.

Demanding more money for public services is, of course, a cliché. Unfortunately, it is one for a reason. As such, and in seeking to resist the discourse of inevitability that substantiates chronic underinvestment, it is one with which I am forced to conclude.

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