CHAPTER 5

Performing Autonomy
Working with and against Healthcare Structures to Configure Access and Exclusion

Healthcare professionals, for the most part, tend to like their autonomy (Abbott, 1988; Freidson, 1988). They do not especially enjoy being told what to do by agents and institutions beyond their sphere of expertise and practice. This is not least when such instructions are issued from sites perceived as being underpinned by logics and concerns orthogonal to the operant values of the clinic. Policy edicts from politicians whose understandings of the needs of clinicians and patients are regarded as somewhat lacking can be especially poorly received.

Nevertheless, professionals must operate within such environments, and sometimes enjoin others to adapt to situations about which they themselves have doubts (Harrison and Dowswell, 2002; McGivern et al., 2015; Waring, 2007). Few domains are more politically charged than healthcare, and – as a public body – the NHS must be responsive to the shifting priorities of governments and ministers. This includes changes in funding, and particularly limits on it. Since 2010, the UK government has created considerable challenges for the NHS through financial under-resourcing (Ham, 2023). Commissioners, managers, clinicians, administrators, and other NHS staff have consequently had to torque their activities to suit a sociotechnical context within which many feel more is being demanded for less (Liberati et al., 2023). While initiatives such as NHS Talking Therapies have promoted certain kinds of practices and interventions, even these operate within a wider ecosystem. Comparatively well-resourced services never exist within their own hermetically sealed bubble, untroubled by bad weather and the choppy waters upon which they float.

In the case of clinical psychology, while individual practitioners might not like certain changes occurring within the psychological complex (Rose, 1985), their practice can nevertheless sometimes be reconfigured in response. We have seen in previous chapters how professional developments and discourses can shape wider contexts, yet specific clinicians might still find themselves practising in circumstances within which they

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experience practical challenges and frustrations. Consequently, clinical psychologists make do and mend as best they can; like all healthcare professionals, they configure their labours in relation to the organisational constraints and affordances to which they are subject (Scheid, 2004; Strauss et al., 1985), as well as, to a greater or lesser degree, seeking to contour these. They can, like other professionals (Bezes et al., 2012; Waring, 2007), also come to accommodate challenges. One means through which this occurs is via forms of ontological respecification (Schneider et al., 2022; Woolgar and Neyland, 2013). For instance, as we will see, clinical psychologists sometimes reframe – and thus transform – economic restrictions into useful encouragements towards good clinical practice.

In the previous chapter, I analysed the reciprocal configuration of patients, services, and professionals. This was part – and a result – of the process of working the boundary between certainty and uncertainty in relation to whether a clinical psychologist should work with someone following a referral (and, potentially, assessment). In what follows, I inspect these issues in greater depth, specifically to better comprehend how autonomy is imagined, negotiated, and performed in practice. The chapter will also go further in examining how targets, most strikingly in relation to waiting times for therapy, manifest within the accounts of clinical psychologists. I consider their role in (re)configuring the nature of psychological care and highlight the implications of this for access and exclusion.

Over the last two decades or so, NHS targets have come to focus not so much on the total numbers of patients on a waiting list as on the length of time from referral to treatment. It is, then, waiting *times* rather than lists per se that are key to governmental consideration (Sheard, 2018). While many clinicians will speak of challenges with waiting lists, the specific concern is how the length of those lists impact the time it takes for a person who is accepted into a service to receive therapy. Waiting time targets have commonly come to represent the metrics by which the accessibility of care is measured; accordingly, they often serve as the focus of attempts to 'improve access'. How long are patients waiting for therapy, how many of those 'breach' the target, and how can waiting times be improved?

Notable examples of these technologies of government (Rose, 1999) are targets relating to the Commissioning for Quality and Innovation (CQUIN) framework in England and the Local Delivery Plan (LDP) Standards – formerly the Hospital Efficiency and Access Targets (HEAT) – in Scotland. Launched in 2009 by the UK Department of Health, CQUIN provides financial incentives for actions such as reducing waiting times. As indicated earlier and as other sociologists have shown,

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these have fixed clinical attention on enacting initiatives that sometimes relate narrowly to an isolated target, rather than on good care more broadly (Bailey et al., 2019; Montgomery et al., 2020; cf. Bevan and Hood, 2006). Operating between 2011 and 2015, the Scottish HEAT targets stated that no one should wait longer than 18 weeks from referral for psychological therapy to treatment, and this continues to be required through the LDP Standards. The HEAT targets LDP Standards likewise can be read as seeking to improve healthcare and encourage accountability for positive results. Just like they do in England, targets steer and shape Scottish clinical practice as a consequence (Greer et al., 2016; Schang and Morton, 2017; Steel and Cylus, 2012).

Here, I am less concerned with the specificities of these targets than with their ambiguous role in practice, and their practical and affective ramifications. This includes analysing how clinical psychologists rework processes of entry into therapy, and the aims and character of care, to meet targets. Doing so illuminates how, despite – and indeed as one direct effect of – the disciplinary power (Foucault, 1989) of targets, practitioners find ways to perform autonomy within practice. In other words, clinical psychologists sometimes exercise their discretion precisely to address external demands, as opposed to meeting targets through practising in fixed, standardised ways. Attending to these matters indicates how shifts in psychological care in response to targets reconfigure clinical psychologists' relationships to their work and their patients. Targets can thus be understood as contributing to 'making up' (Hacking, 1995, 2002) the subjects configured through therapy – as well as those excluded from it.

I regard autonomy as a kind of enacted, negotiated, and relational practice (Gauthier-Mamaril, 2022) rather than one that is fixed or predetermined – hence my use of the term 'perform'. In this respect, I draw on sociological scholarship that indicates how autonomy is experienced and performed, in part, through negotiating and reconfiguring its always ambiguous boundaries (McDermott et al., 2023; Shuster and Lubben, 2022; Waring, 2014). To be sure, healthcare is often highly structured through national governance and a range of local tools (Berg, 1997; Harrison and Ahmad, 2000). Yet, clinicians of different kinds demonstrate a marked capacity to improvise in the face of challenges (Kamp et al., 2023; Kuijper et al., 2022). That includes through measures introduced with the aim of standardising clinical praxis (Jensen and Vabø, 2023; Timmermans and Berg, 1997). Autonomy might often be regarded by health professionals as being curtailed or limited, but it seldom seems to disappear completely.

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My approach perhaps stands in slight tension with clinical accounts of care which contend that autonomy has concretely reduced. My choice of words here – 'slight tension' rather than 'opposed' – is deliberate. I do not want to refute the claims of professionals who are practising in a financially challenged NHS. That being said, my relational understanding of autonomy likewise precludes me from wholeheartedly endorsing the statements of concern I have encountered. Some styles of autonomous practice are indeed possible to perform, even if the act of doing so is itself enjoined by the same targets regarded as reducing it. The normative corollary of this is that practitioners' claims around (a lack of) clinical autonomy need to be treated with respect but also require their own close inspection.

Waiting Lists

Let's start with waiting lists. As we have seen, these can be challenging to work with and were a problem for a clear majority of my interlocutors in clinical psychology. Such issues were systemic rather than simply affecting certain teams; although Grace, for example, had not traditionally had a waiting list for her rural Scottish service, other clinical psychologists had started referring to her to manage their own workloads. This created fresh demands that might be ameliorated within a better-resourced system. Practitioners sometimes expressed deep disquiet at just how bad things were and often continued to be. Senior clinical psychologist Carl, for instance, told me how he was '*grossly* unhappy about the fact that people have to wait' (emphasis in the original; same for all the quotes that follow). Louise, a more recent entrant into the profession working in an English city, described how 'it can feel quite heart-breaking after an assessment to then say, "well, it looks like the service that's best for you is an 18 month wait"'. Mid-career clinical psychologist Molly, who worked in the same NHS organisation as Louise, reflected:

> I guess every day, I probably have a moment where I feel really bad when I meet somebody that I *know* I could offer an effective intervention to, but I haven't got the capacity to do that. So, every day, my colleagues will come to me and ask my advice about patients and I know what they *need*, but I can't offer it.

Dealing with waiting lists, not least when confronted by the 'postcode lottery' (Ursula) of access to psychological therapy, consequently entailed an affective toll. This was in addition to the practical, cognitive, and moral labours inherent to the uncertainty work (Moreira et al., 2009; Pickersgill,

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2011) of ascertaining who should get an intervention, what sort, and why. As Molly vividly described, she felt she had to 'ration' her 'compassion':

> I *like* to think that, more compassionate people who genuinely want to help people who are drawn to this sort of profession, but then I think the practicalities and the daily grind of the resource limitations, mean that you have to kind of ration your compassion. Gosh, that sounds awful saying that aloud, but you do find that you are kind of limited in what you can offer people, you can't offer them this never-ending kind of access to what they want and they don't always take it up anyway do they, so you do have to have some limits on what you can offer people.

A range of emotions seemed to bubble below my interviews with clinical psychologists and sometimes surfaced starkly, such as when Grant, who worked in rural England, told me that 'the whole NHS ethos . . . of more for less' was 'bullshit'. Such bluntly stated views were more commonly expressed once my recorder was turned off. Salient among the affects channelled were frustration with limited resources through which waiting lists might be reduced, sadness and even anger that patients had to wait so long, and on occasion guilt that more could not be offered.

Managing Demand

To deal with busy workloads, demands for accountability, and emotionally laden moral and clinical decision-making, psychologists sometimes elect to use social and procedural technologies to manage waiting lists and referrals. These configure the referral process without necessarily or linearly determining it, and are examples of certain performances of autonomy that also create space for more. This might be through the discretionary classification – and hence subjectification (Hacking, 1995, 2002) – of people seeking care in particular ways that have implications for the temporalities of care (which can also be expected to have subjectifying effects). Amy, for instance, described how, in response to 'ridiculous' waiting lists, her service developed a process whereby (potential) patients were 'split' into 'priority' and 'routine' groups, with the latter 'only' receiving 30-minute assessment meetings. This agentic configuring of the service, and of the patient themselves, apparently 'massively helped' with the waiting list.

Other mechanisms for managing waiting lists and times are the delegation of decision-making to pre-packaged delivery models. Nonetheless, these are sometimes modified to better suit the contexts wherein they

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operate, and their operations can configure professional autonomy in turn. The Choice and Partnership Approach (CAPA) was an example of this noted in several interviews and conversations I had with clinical psychologists. CAPA is a model of engaging and assessing people for therapy, particularly in child and adolescent mental health (CAMHS) services, which centres an initial 'choice appointment'. This is an initial appointment at a time of the patient or their carer's choosing, as opposed to one that is decided in advance by the service team (Robotham et al., 2010). Dierdre summarised her use of this approach:

> I don't know if you've heard about the CAPA model? We used, I wouldn't say we did CAPA as it was designed but we did a choice appointment where we aim to have somebody seen within eight weeks and basically we do the assessment. Unless it was completely obvious that the referral was rubbish and it shouldn't be us, it was far better and better use of our time to get somebody in for an hour to have a discussion about what needs to be different, what is it that we're hoping to be different, why would it be us, and working out whether there's a mental health need that we are best placed to meet than trying to do that dialogue back and forth with their GP who doesn't *get it*. And who ultimately is not a mental health professional so that hour of time for that referral was often better spent on face-to-face assessment, and then a discharge, than it would have been back and forth to the GP trying to work out if it was for us or not.

In this example, we can see how CAPA was reconfigured to become 'doable' (Fujimura, 1987) in relation to the assemblage of personnel, demands, and concerns of Dierdre's service. This is itself a performance of autonomy, and the operations of CAPA – even while creating space for patient autonomy – also enact a particular configuration of professional autonomy. Part of this is that the expert – or not – contribution of GPs is rendered less relevant. Accounted for in terms of timesaving, it also squarely positions the clinical psychologist as the principal agent in the process of referral and assessment. Such an elision of physicians implicitly contributes to a bigger project of professional autonomy within a medically dominated NHS.

As we saw in the previous chapter, some of the uncertainties associated with managing waiting lists and referrals can be tamed through a careful configuration of services as having their entry determined by referral criteria. Referral criteria – or commissioning criteria more generally – can be framed as restraining the autonomy of clinicians (Mladovky, 2023). Still, there can be room for manoeuvre. Even in cases where there were 'very detailed referral criteria', clinical psychologists '*might*', as mid-career professional

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Verity told me, see people who would not meet these (in this instance, from a different geographical region). The 'might' here is significant: it gives space for the performance and configuration of autonomy.

Brenda, who worked in secondary care in the south of England, told me that despite quite specific commissioning criteria 'sometimes we plug gaps maybe, where we should . . . you know, *ethically*, it feels we need to plug the gap, we need to provide the service'. Yet as capacity became ever more restricted, things had to change: 'It's come to a point now where we have just too many referrals.' Consequently, Brenda felt that she and her colleagues were no longer able to carry on in this way – an unofficial pathway into her service for individuals who did not meet its strict criteria was now 'closed'. This was framed as an affectively and normatively challenging decision, but also one that was in some senses inevitable; as Brenda put it, 'what else can you do?' She went on: 'If we carried on. . .with. . .we're *hiding* a need that needs to be addressed.' Within this account we can see that autonomy is not so much straightforwardly present or absent as it is reconfigured and enacted in different ways over time.

Despite a reflexive understanding of the necessity of finding creative ways to access services, clinical psychologists can also express frustration with referrals they regard as misaligning with their expertise and service. This was palpable in an interview with Louise, which underscored her autonomy over whether to accept particular people into her urban English service (and where the moral aspects of patienthood seemed also to emerge through talk of 'worth'):

> I look at them [a patient referral] carefully to say, 'is this really appropriate?' The vast majority are, in some way or other, worthy of an assessment from my service at least, for me to determine whether I'm the right person, but it's the initial phase of looking at the referral when you usually don't have a huge amount of information, and I will often go back to the referring agency and just *double-check*, 'oh, so you've said, this, this, and this, what else might be going on? Am I really the right service?' And I ask that person to think about, and try and ask them to think about it in context, 'well, look, I'm very busy, I may have to prioritise this case over another one if you're telling me it's an urgent referral, and I need you to think carefully with me if this you know if this is an appropriate referral'.

Esther, in rural Scotland, likewise appeared frustrated when describing how 'psychiatry make referrals for people they don't know what to do with', in the hope that clinical psychologists might be able to help – yet, unfortunately, 'it doesn't necessarily mean we can do anything either'. Rory, a senior clinical psychologist working in CAMHS, implied that

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'inappropriate' referral could act as a strategy to absolve clinical responsibility while nevertheless ostensibly 'doing something':

> I mean, the elephant in the room is that very often people make referrals to mental health services because they've run out of ideas of what they can do themselves, and it's a way of getting it off their desk and onto somebody else's.

We can see that an unwillingness or inability to actively configure someone as suitable for a given service can result in another clear performance of professional autonomy: an intentional, rather than protocol-derived, denial of psychological care.

Technologies of Exclusion and Forms of Strategic Inaction

Informal techniques for managing waiting lists and referrals can be regarded as what sociologists like Claire Laurier Decoteau (2013) consider to be technologies of exclusion within healthcare. As we saw in the previous chapter, building walls around a service in the form of rigid exclusion and inclusion criteria can assist clinical psychologists in managing their personal or team's resource through forms of healthcare rationing that privilege some patients while disadvantaging others. Take the CAPA approach, for instance. Verity described having 'adapted' this for her urban service and liked that it meant 'people have to opt into it'. This was helpful because 'it kind of gets rid of all the people who DNA [did not attend] their first appointment, and who actually were not really on board with coming along'. Verity noted that she and colleagues would always 'contact referrers before we discharge people' – for example, if there are 'concerns about vulnerability for the family'. Nevertheless, clinical and normative concerns clearly interact to configure a space of autonomy within which psychologists ultimately have the discretion to continue to see or exclude someone from their service.

On occasion, the disadvantages for patients of high walls around services were explicitly discussed by my interlocutors. Ivor, a senior clinical psychologist working with older adults, was one example:

> I think, you don't want to be in a position where you're excluding a whole group from accessing any part of the psychology service, *unless* there's a good reason for that. Sometimes patients can find themselves falling through the cracks in between the sub specialisms and that's not great if it's unintended

The lack of a clear conclusion about what should be done to prevent patients 'falling through the cracks' implies another approach available to clinical psychologists to take to manage an overwhelming workload: what

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organisational studies scholars call 'strategic inaction' (Whittle et al., 2016). In this respect, autonomy is performed via decision-making *not* to do something. Arthur, who worked in an early intervention service for psychosis, articulated how waiting lists themselves could be regarded as a technology of strategic inaction:

> [These] tend to be self-serving in the sense that the longer people have been on the waiting list the more likely that either there's been spontaneous change or they've found other means or they *give up*.

In some cases, inaction was itself configured as a form of action: a purposeful refusal to take on more patients to manage a waiting list. In a similar way, inaction can manifest as a strategy of generating low expectations (Gardner et al., 2015); Rory, for instance, noted that for some time his team had 'made a point' of 'not overselling ourselves':

> We knew there was a massive demand that wasn't being met, but we didn't want to go out and just get swamped by referrals, which we then couldn't meet the need of.

Autonomous inaction could nevertheless have affective implications for interprofessional work, which were clear from senior clinical psychologist Irene's reflections:

> I can remember being shown the waiting list when I arrived [in this service] and it filled a room sort of thing. So, we shut the doors, worked through [the] waiting list, offered everybody a time limited piece of work and then when we opened the doors again we had a very *limited* criteria and we did that, and the GPs just hated it

The affective and practical aspects of in/action were also baldly stated by Louise: 'I don't accept self-referrals, as a gatekeeping mechanism. I just think I would be in danger of being overwhelmed if that was the case.' This assertion is striking because there is, unusually, no attempt made to position the decision as clinically necessary, epistemically warranted, or morally just. Rather, Louise's comments simply and straightforwardly underscored the considerable pressures practitioners are under and the mechanisms they must (not) put in place to make it through the day.

Prioritising Patients

Long waiting lists generate normative dilemmas around prioritisation (Allen et al., 2004; Vassy, 2001), contributing to wider practices of local 'micro-rationing' of care (Hughes and Griffiths, 1997). As Sylvia (a mid-career

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clinical psychologist working in an English city) told me, while external pressures meant that 'we have to prioritise', an almost unanswerable question emerged from this: 'How do you prioritise people who technically are all struggling?!' The intractability of such dilemmas could be interpreted as generating what philosopher Andrew Jameton (1984) termed 'moral distress'. This manifests through contexts of economic and symbolic restraint within healthcare, inflecting professional understandings of their potential to enact desirable therapeutic action (Molinaro et al., 2023). Dealing with ongoing challenges around resourcing, waiting lists, and targets clearly generated different kinds of distress in some of my interlocutors. In the words of Anita, a senior clinical psychologist working in primary care in a large English city,

> I think my kind of experience is that there's something quite punitive that comes with delivering an IAPT service, there's something quite punitive and punishing about what's required in terms of its expectations. And I think you can *really* lose sight of quality and burnout . . . And how you do that as a service head, and you protect your staff, is very, very stressful. And as a result of that I don't sleep. So it's taken a toll on my health, it takes a toll on your family.

Dierdre, working in a more rural location in Scotland, also contemplated how pressures and challenges configured practices of prioritisation and their normative dimensions:

> (With a sigh) Actually the bit that concerns me is that people that aren't being seen that need to be seen and we try and prioritise our waiting list clinically rather than by referral dates, so if somebody's urgent, they sit near the top of the waiting list than somebody that's routine but have been waiting for eight months. But *that* begins to really rub at this point when we've got managers saying, 'right, here are your people that are breaching [the waiting time target], when are they going to be seen?' But you know that the person that's really sitting at the top isn't breaching because she's got another 20 weeks to go before she breaches, but that she's urgently needing an intervention.

The economic context of concerns like those above was often made apparent. Echoing social scientific work into the effects of targets on professional practice (Bevan and Hood, 2006), Arthur noted that 'when money is very tight there can be quite a pressure on managers to organise the service in order to meet, to meet the target'. He elaborated as follows:

> There's a target which is coming up next year, well this year actually, for secondary care psychology services about waiting times. Now, the commissioners locally have agreed the target of trying to increase the percentage of

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> people who are seen within 18 weeks. That produces a dilemma because we could organise the service to make sure that 50 per cent of people are seen within 18 weeks, which would meet that target, but the way we'd do it is to make sure the other 50 per cent are waiting even longer. So it, it introduces a real ethical dilemma there, because the consequences of not meeting that target that is a CQUIN target is that we have money withdrawn, which means that we end up with less therapists and everybody waits longer.

In some cases, prioritising patients when also dealing with targets did not necessarily generate normative dilemmas, since the appropriate clinical response might be deemed clear. Yet, it nevertheless generated additional accountability work (Neyland and Coopmans, 2014; O'Reilly et al., 2009) as actions needed to be substantiated. This is indicated in comments made by Susannah, a clinical psychologist working in CAMHS in Scotland:

> So, obviously if we're trying to meet the HEAT target to see people within 18 weeks from referral to treatment, we've got to kind of keep on top of erm the waiting list. And, you know, we may have had to say, for example, if you know somebody's got a problem that they have to be seen more quickly for, like a severe anorexia or something like that, that can take up a huge amount of a clinician's time and it maybe then that some of the other ones that are waiting for a more routine appointment start to breach the 18 weeks, but, you know, that, that is not acceptable to, you know, the powers that be.

Technologies of exclusion, strategic inaction, and their dynamic relationship with practices of prioritisation must then all be interpreted against the background of increasingly stretched services and governmental initiatives aimed at enhancing access despite the constraints experienced by clinicians.

Targeting Therapy

Clinical psychologists are often deeply concerned about the wider context of healthcare and its shaping of their practical circumstances. While targets themselves were not necessarily framed by my interviewees as radically new – 'there has always been targets' – the germane issue was that 'now there is more of a pressure to meet them' (Verity). Senior practitioner Olivia, for instance, spoke of 'an increasing, sort of *push* towards seeing a certain number of people a week', while Dana – a clinical psychologist working in physical health – reflected 'that the numbers and things that we are expected to see aren't really realistic'. Frank, another psychologist with many years of experience, judged targets to be 'destroying clinician, individuality, clinician led thinking'; in other words, targets were judged to compromise professional autonomy.

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An exchange with senior clinical psychologist Ursula is illustrative of the operations of governmental power exerted with and through targets, and the normativities entangled with them. She noted that 'our service level agreement for our bit of the service is eight weeks from referral to assessment, and then a further eight weeks from assessment to being in therapy'. This SLA was 'imposed on us'. When asked whether it was easy to work, Ursula responded:

> No. (laughs) We don't hit that, we don't hit that at all. We don't hit it at all. I mean when the service level agreement came in with the new commissioning structure in 2012, April 2012, we had pre-existing waiting lists, and we had no extra resource to deal with that pre-existing waiting list. So, basically, we actually felt that we couldn't offer a different service to people referred from the 1st of April as the ones who got referred on the 31st of March. So we continued to operate a waiting list, which varies from about hmmm two months, sort of, within target to somewhere around ten. Ten months.

In Scotland, the aforementioned HEAT targets included clear waiting time targets, and these played a big role in the work of many, though not all, of the clinical psychologists I spoke with. Amy, for instance, noted that 'the scrutiny that we are under now . . . in terms of our waiting lists and who we see, when and why is *huge*'. She went on:

> I have to say, I let the managers worry about that and I just do, you know, I take the option of I can only work, I can only see a certain number of people and I will work *really* hard for those people, but I-I don't worry about it, there's nothing I can do about it, you know. We've cleared this big backlog of patients, that's my contribution!

The burden of scrutiny, then, was not necessarily carried by all clinical psychologists in the same way. However, even Amy's comments noting that the 'worry' over meeting targets was apportioned to managers rather than herself ambivalently reposition responsibility to her also: Amy notes how hard she has worked, and how her 'contribution' to the team meeting targets was through having 'cleared this big backlog'. Despite the somewhat humorous tone through which Amy narrated her experiences, a sense of pride also came through. At the same time, patients themselves – individuals in distress and seeking care – are aggregated and depersonalised as a problem to be solved. Targets can thus be viewed as disciplining and configuring the subjective relations clinical psychologists have with their labour, and well as subjectifying those with whom they work.

Amy's comments also hint at the efforts that had to be made to monitor a service, specifically in relation to data collection, for it to be accountable to targets:

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> But it is the level of scrutiny is huge now, compared to how it was, you know, when I started in the profession or even just a couple of years ago, yeah, the level of detail *exactly* how many people have been waiting, *exactly* how many days and *for what*, what are they waiting for? There's a lot more detail going into that now.

Natasha, a senior clinical psychologist in a Scottish city, underscored that such data work (Bossen et al., 2019) was an issue even when targets were being comfortably met: any data input errors generated alerts and concerns that had to be swiftly addressed to demonstrate that her service was, in fact, delivering according to the priorities set and demanded by the government.

Some clinical psychologists advanced concerns about the quality of care that could be provided for people in the context of target-focused services. Indeed, Ivor, in his relatively rural service, felt that the pressure of targets 'sometimes leads to discharging people where you think they could make more progress with more sessions'. Sylvia, from the perspective of working in a highly urban service, similarly reflected that targets in the absence of substantive additional resource meant 'a dilution in terms of what we're offering to clients':

> I *notice* the type of care in the crisis team that we were providing when *I* first started four years ago, for example, to what we're providing now. And I know, and I can say confidently, my personal opinion is that we're not providing the type of care that we were providing four years ago. What we're doing now is very *much* firefighting, very much trying to get people sort of discharged as quickly as possible, and get people *seen* according to certain *targets* and standards that we should, comply by to make sure that we just basically, it's just like a conveyor belt processing, sort of factory.

This 'firefighting' was also presented as having affective ramifications for staff – stress, sickness, and burnout – which, given the intersubjective nature of psychological therapy, means implications for patients in turn:

> Because we've had a reduction in terms of funding, we've not been able to sort of fill positions, um. And people are, you know, even more pressured to provide more with sort of less, and so we've got staff sickness and burn-out and all that sort of stuff. So they go off and the pool of people to manage this increasing workload is, is reducing. So, it's very pressured, it's very stressful, and you are just not able to give that same level of *care* that we've been able to.

The affective impacts of targets (Liberati et al., 2023), and the kinds of service organisation these enjoined, were also mentioned by some other respondents: Ivor spoke of the 'stressful' nature of being confronted by people who 'might benefit from long-term therapy' without being 'in a position to provide that'. For her part, Susannah described an 'incredible

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pressure on professionals to meet the HEAT targets' and underscored the 'scrutiny' of waiting lists from 'senior management'. She went on:

> [Y]ou've got more people coming in and it means you've got to have . . . a more rapid throughput and there's a sort of pressure on you, I suppose, to, discharge, so you can take the next people on. So I think it's actually put professionals under quite a lot of pressure.

Such pressures can be regarded as reconfiguring, rather than always and simply reducing, the autonomy of clinicians as they act to actively remake their work to meet targets.

'Pressure' and 'Focus'

For a smaller number of clinical psychologists, targets lacked salience; they were, rather, a problem for someone else. Their accounts emphasised, for instance, performances of temporal autonomy (cf. Goodin et al., 2008; Bailey and Madden, 2017), as in remarks from Tina, an early-career clinical psychologist based in an English city:

> I also can have sessions that are 20 minutes long or . . . two hours, if the person's going to be away or something like that, so you do have the luxury of . . . meeting the clients' needs, which is really nice, really. And that's when they need it most, really, when they're in crisis, they want someone to listen . . . So it is nice, I think, that we can do that, . . . and you don't feel the pressure – or I don't – in having my supervisor or manager saying, 'You have to see this many people. It's got to be this, this, and this.' It's not like that.

Still, the spectre of the comparator loomed large: Tina framed 'meeting the clients' needs' as being afforded a particular 'luxury', while colleagues felt the 'pressure' of managerial demands. Accordingly, the configuring of her own psychological work seemed dependent on the wider role played by targets. Not only one form of content within the wider terrain of mental healthcare, targets have become the context through which the psychological is configured.

While the clinical psychologists I interviewed and engaged with more widely were generally critical of targets, resonant forms of the ambivalence that threaded though Tina's reflections above were sometimes expressed by, particularly, clinicians working in Scotland (connecting, perhaps, to a wider rhetoric of progressiveness within Scottish health politics and policy; Greer et al., 2016; Stewart, 2013). Liam, for example, was a senior clinical psychologist in a community mental health team (CMHT) whose role was

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presented as requiring an unremitting focus on targets. Yet, these were nevertheless regarded as 'hugely beneficial' in terms of raising the visibility of clinical psychology within the NHS and affirming that 'it's just not acceptable that people should wait that long, for such an important service'. Based in a far more rural setting than Liam's urban Scottish practice, mid-career practitioner Megan likewise spoke about some of the pros and cons of the HEAT targets:

> I can see the reason why they're there, to try and, keep services ticking along, so people aren't waiting years and years to be seen. Because obviously, that's not helpful either. But I think there seems to be a feeling that if you don't meet the HEAT targets, you're going to get penalised in some way.

For her part, early-career clinical psychologist Briony spoke both of a 'pressure on services' as well as about their 'concern' that 'you can maybe meet the target, but how are you ensuring' the provision of 'quality therapy' alongside 'decent outcomes for people as well?' However, she too felt that targets also had some benefits:

> [The HEAT targets are] focusing the mind quite a lot, and services very much so. And in a way I think it's fantastic that we have targets that are about psychological therapies, you know? For so long we've often delivered good services but people have had to wait a year for them or people have had a really tricky path to that and might not have been able to access psychological therapy. So, I think that we have a target that's sort of putting that on you know the agenda is really good.

Esther similarly deployed an idiom of 'focus', noting that the HEAT targets had contributed to having 'really modernised us' and 'actually kind of responsibly demonstrating what we do' – albeit with challenges for clinical psychologists themselves:

> HEAT targets, painful as they are, has *focused* [our locality] on *this* is what we need to do. . . . I think the HEAT has been in one way a *blessing*, because it's focused on us, and got quite a lot of work going on about the staff that we need to deliver the service. But for the staff at the front line, it's quite hard work.

Verity illustrated some of the labour involved in configuring services to meet targets, but also enrolled them into a mode of 'doing good care' (Pols, 2003, 2006). Adhering to targets – and discharging patients to meet them – thus became part of how Verity configured herself as a good psychologist:

> [E]very Wednesday, we sit and we go through, and we work out how long people have waited on a waiting list, and, you know, if anyone ever looks

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> like they get close to breaching then we're, we're quick to get them picked up. I mean [the HEAT waiting time target] has a big impact on the way that we all work, because we all have to think more about discharging people, you know, and not holding on to people, I think psychologists are terrible for holding onto people forever

Another clinical psychologist, Chloe, working in primary care and part of the same overarching NHS organisation as Verity, Liam, and Briony, spoke of similar themes:

> I think for a while psychologists were quite guilty of seeing people for ages and ages and ages and not really getting anywhere, so it is about maintaining a short-term structured approach, and that will you know facilitate picking up more people because you're going to have faster rates of discharge and things

Despite, as we have seen, Arthur's concerns about targets, he likewise framed these as having some advantages: 'I actually think that without those targets the [early intervention] services [in my locality] wouldn't exist at all!' Accordingly, targets can 'have their benefit[s]'. Nevertheless, 'there can be problems' with targets: they can, for instance, 'start to distort the service'. To illustrate this point, Arthur gave the example of an IAPT service where a conversation with a potential patient following referral was conducted by telephone; classifying this as 'assessment' rather than simply a 'screening' 'had a *massive impact*' on whether the service met its targets. For Arthur, this was 'an example of how you can design the service to meet the targets, not necessarily to meet the needs of the people who are accessing the service'. Some clinical psychologists are, clearly, well aware of the 'gaming' effects of targets that social scientists such as Bevan and Hood (2006) have highlighted.

These reflections underscore the professional autonomy clinical psychologists can have to reconfigure their work to address targets, with implications for the ontologies of psychological care – and, of course, for patient access and experience. Performances of professional autonomy intrinsic to such reconfigurations of therapeutic temporalities and practices were not, however, necessarily straightforward. Rather, the clinical innovation of individual practitioners was sometimes presented less as an agentic and knowingly strategic move and more as an almost inevitable response to a kind of structural coercion. Similar to some other interlocutors, Anita highlighted how group therapy had become one answer to the question of how to manage waiting lists:

> [W]e have to create more capacity in treatment. So we're always balancing that out, *every single month*, how many have come in, where's the capacity

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> for treatment. And the shift that has come about is that we are *forced* to deliver more group work.

Despite the discourse of inevitability (Leonardi, 2008; Pickersgill, 2024) threading through such accounts, professional autonomy and creativity are evident in terms of how clinical psychologists meet the very significant challenges they face, in a manner that might not be feasible for others imbricated within the psychological complex (e.g. CBT therapists).

In sum, certain clinical psychologists seemed to find mechanisms of accommodating targets, including through framing them as enjoinments to good therapeutic practice. Such ontological respecification (Schneider et al., 2022; Woolgar and Neyland, 2013) in turn foregrounded particular configurations of the good psychologist. At the same time, performances of autonomy were also commonly cast as responses to economic, political, and institutional structures. In this respect, autonomy can itself be considered as a kind of local 'workaround' (Clarke and Casper, 1996) to adapt to structural impositions that reconfigured the content of psychological care.

Limiting Therapy?

Sometimes, services operate with limits on the number of times a clinical psychologist can meet with someone for therapy. Before concluding this chapter, I will talk briefly about the management of those limits, since they serve as an additional example of how waiting lists and associated targets shape psychological care. Their negotiation again demonstrates both the challenges and potential for performances of professional autonomy.

When discussing session limits in interviews and elsewhere, I was generally given figures ranging from 6 to 20 sessions, depending on the nature and complexity of the service and the cases seen. Session limits can align clinical and bureaucratic rationales; they might appear 'in a lot of clinical guidelines' while also being 'management based' (Grant), and psychologists commonly recognise that there are 'really big political, economic, resource reason[s]' (Irene) for their existence. Consequently, practitioners can explicitly seek to emphasise the limits to therapy at the very start of seeing a patient. By not doing so – and instead, for instance, 'at the beginning you say, "we're here to solve your problems"' – some psychologists were cautious of 'inviting a sort of an eternal therapy' (Carl).

Session limits affirm the need for patient prioritisation and extend the normative challenges related to those processes; as Will (a senior clinical psychologist in urban Scotland) reflected, difficult decisions sometimes had to be made in services 'where you can only have 10 sessions or

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something, or whatever random number gets picked out'. Specifically, should 'I continue to work with this person until I feel they've got the optimum benefit from it' if 'it means other people are having to wait' as a consequence? Dana, in rural England, reflected:

> I think they're [session limits] more difficult if you don't necessarily feel like the person is ready for that ending [of therapy], and it is more about, this is what I can provide, this is the system around me, this is as much as I can do. So it's splitting apart – endings being difficult just because you're a human being, and endings being difficult because a service is specified, a way of working with someone for a certain amount of time, and it doesn't feel like it fits, or has been long enough, or appropriate.

My interview with Brenda was also illustrative of how session limits relate to waiting lists and the wider healthcare context. When I asked how long she might work with someone, she replied:

> Ah! (laughs) Well, before, before the sort of accountability stuff came along, I think . . . I don't think that it was particularly right for that, people would, you know, clinicians would see people for some reason they kind of thought they needed to be seen, which had its advantages, but also disadvantages of actually not being able to do endings, and we don't have that, that luxury anymore. We've got too many . . . less resources, and too many referrals. We have big waiting lists so, we've had to come up with some ideas about how long we see people, and what's the purpose of seeing them. So, it's no bad thing. You know, much more accountable, do a lot more outcome results.

Like targets more generally, then, session limits can be reconfigured as beneficial to public and individual mental health. In the preceding extract, 'luxury' is deployed with some irony, but also almost pejoratively, in ways that attribute the benefit to longer-term therapy to psychologists themselves rather than those with whom they work. In so doing, Brenda, similar to other interviewees mentioned in this chapter, undertakes moral boundary work (Lamont, 2000; Pryma, 2017) between different kinds of clinicians.

Similarly, while not 'totally set in stone', the idea of session limits appeared to discipline early career clinical psychologist Leanne's practice, in that if the number of therapeutic sessions with a specific patient was 'creeping up', she would discuss it with a supervisor. Adhering broadly to them was one means by which she configured herself as a good psychologist through drawing implicit boundaries between herself and others:

> I'm sure that people do go over [the suggested session limit]. I haven't, too much, but maybe that's just me. So I tend to try and, I like things being quite focused. I try not to let cases drag on too much.

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More generally, just as waiting time targets per se could be respecified to substantiate some forms of psychological praxis, so too could session limits – at least in principle. Arthur, who, as noted earlier, accounted for the positives in waiting time targets, described how session limits could act as 'a kind of stimulus to be more creative' within therapy. He gave the example of brief interventions delivered in groups, asserting that these were 'actually *better*' in terms of 'the amounts of clinical change' for patients than 'longer individual therapies'. While this was not a common claim, its utterance demonstrates how autonomy can be performed in ways that enable clinical psychologists to adapt to the pressures upon them with patients configured as potential – even likely – beneficiaries of these adaptations.

Further, again similar to targets, session limits are not always an issue for individual practitioners. This is despite considerations of their wider significance. For instance, while mid-career clinical psychologist Natalie (based in physical health in an English city) was aware that other colleagues 'have got to have capped sessions', she was 'generally able to offer patients the number of sessions I feel that they need'. Still, sometimes she might meet with some individuals 'maybe sometimes less frequently than you might be, might be desirable, to fit in the people that you need to see'. Megan, who also worked in physical health, was likewise not overtly troubled by session limits, although she noted: 'I think my manager would be a bit peeved if every person I saw for, like, six months', given the ramifications of this for staff and service capacity and patient throughput.

Unlike waiting list targets, however, session limits are more negotiable as a consequence of the credentialed expertise clinical psychologists can claim and leverage. One mechanism for performing autonomy in this regard is through the reinterpretation of such policy as 'guidance' (Grey and Silbey, 2014). When I asked Grant, who worked in rural Scotland, if he had session limits, his reply was:

> No, I would say it's a *guideline* . . . the psychologists and the psychological therapists that work into community mental health teams, I would say have a *guideline* of around 20 sessions . . . however, it is on the basis of need and if, if there is a good rationale for working longer with somebody then we would continue to work with them, and I've got several people on my caseload that I've been seeing for a couple of years. So it's not unusual for people to go over that 20 sessions.

As with some others I interviewed, Molly framed herself as 'lucky' in relation to the governance of session limits, in this case because her manager 'trusts us to monitor that'. Patricia, working in a CMHT in the

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same metropolitan area, also invoked the language of luck. When responding to a query about session limits, she described how her team was 'kind of lucky at the moment' because 'it hasn't got that far yet'. However, she also noted wryly: 'It will, it's coming to me, I know it is!' Patricia described how she would 'try and utilise my self-discretion' in relation to how long she would see people for therapy, but 'unfortunately I'm inheriting this big waiting list so probably I will have to be tighter'. She reflected that it was important to consider how to go about 'balancing that and thinking about what's appropriate for each person'. Her mechanisms for doing so appeared to meet with wider approval – or at least did not seem to have caused any alarm: 'I've not been told off yet.'

These extracts illustrate how autonomy can be performed while also indicating how the spectre of harder limits on the number of sessions within which psychological care can be delivered haunts accounts of therapeutic practice. Adjacent services can provide worrying contrasts against which professionals frame themselves – despite wider challenges – as 'lucky'. Further, while clinical judgement can be exercised, supported by assertions of expertise, this may nevertheless require the data work of reporting and/or living with the possibility of being 'told off'. One clinical psychologist early in her career, Chloe, spoke of how she was 'very anxious' about the possibility that if 'somebody' looked at her records, they would see that she regularly exceeded session limits. In sum, session limits are shaped through waiting list and time targets and, like them, contribute to configuring psychological work.

The Constraints of Care

In this chapter, I have underscored some of the salient challenges and concerns that clinical psychologists have with waiting lists and times, and especially targets in relation to these. Over the 21st century, healthcare targets have proliferated (Bevan and Hood, 2006; Sheard, 2018) alongside the intensification of financial challenges to the NHS across the United Kingdom (Ham, 2023; Liberati et al., 2023). Here, I have explored how targets function as a technology of government (Rose, 1999). I examined how clinical psychologists describe the nature and ramifications of targets, and leveraged their accounts to generate further understanding of how professional autonomy is performed through conditions of 'targeted' care.

Waiting lists and targets operate as both circumstantial issues for healthcare professionals and more systemic matters shaped by harsh economic realities. Clinical psychologists, for instance, lament their effects on

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the care they provide, or they anxiously anticipate deleterious impacts in the future. Accordingly, targets can be considered as, in a Foucauldian sense, 'productive' (Foucault, 1989). This includes through channelling affects of anger, frustration, and sadness, and stimulating or recasting professionals' epistemic, practical, and accountability work (Neyland and Coopmans, 2014; O'Reilly et al., 2009). Consequently, targets can be regarded as (re)configuring the subjectivities of the individuals – clinicians and, I suggest, people seeking or undertaking therapy – that are embroiled within the psychological complex (Rose, 1985).

The intensification of professionals' work in response to policy shifts can enjoin styles of practice that result in reduced support for those whom they ostensibly labour (Watkins-Hayes, 2009). In the case of clinical psychology, resolving the problems of waiting lists and associated waiting time targets often involves processes of prioritisation that can employ implicit – and at times explicit – strategies of exclusion and even inaction. These techniques result in various kinds of informal categorisations of people seeking psychological care, which contribute to how people are 'made up' prior to and during therapy (Hacking, 1995, 2002). In turn, we might expect these processes of subjectification to become imbricated with how clinical psychologists practice with particular patients (e.g. those classified as unlikely to be 'appropriate' for a given service), contouring the nature and outcomes of therapeutic praxis. The social and organisational technologies employed within healthcare can thus be understood as having the potential to participate in the constitution of the psychological itself.

There are also more tangible implications for people seeking care. We have seen, for instance, how some clinical psychologists account for themselves and their acts as being configured through a kind of externally imposed pressure (Mladovky, 2023) that can encourage discharge. In that respect, decisions can be framed as active and autonomous. This is as opposed to an unreflexive failure to 'let go' of patients who are judged as unlikely to benefit further from the additional application of psychological expertise, or who were unlikely to benefit in the first place. Despite the challenges of healthcare targets, then, some clinical psychologists find ways to accommodate these and align them with pre-existing and reworked therapeutic rationalities (cf. Harrison and Dowswell, 2002; McGivern et al., 2015; Waring, 2007). Doing so folds the kinds of practice targets enjoin into ideals of good care (Pols, 2003, 2006).

On occasion, clinical psychologists narrate their tribulations through a discourse of inevitability (Leonardi, 2008; Pickersgill, 2024), explaining actions as logical consequences of wider contexts and individual

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circumstances. Still, practitioners are able to perform autonomy in certain ways, even if only to adapt to the pressures they experience. Such performances simultaneously advantage and disadvantage different patient groups, resulting in a kind of 'exclusionary inclusion' (Decoteau, 2013). Referral criteria, for instance, are a mechanism for ensuring that clinical resource is, ostensibly, apportioned to those deemed most in need, while also serving to address waiting time targets by effectively narrowing the population of potential service users. Understandings of need itself, however, can be regarded as configured by political exigencies around what money is invested and the epistemic politics of clinical psychology. These shape what is known about 'what works' and for whom – and thus who, ultimately, can access care. Often developed by practitioners themselves, referral criteria can consequently act upon others as technologies of exclusion. Given what we know about the imbrications of psychology and society (as discussed in the introductory chapter), the resulting 'micro-rationing' (Hughes and Griffiths, 1997; Vassy, 2001) might serve to benefit some seeking therapy over others. In the next chapter, I will attend further to some of these matters through an analysis of how clinical psychologists involuntarily discharge patients who do not attend appointments (DNA).

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