CHAPTER 6

Prompting Exclusion
How 'Did Not Attend' Policies Shape the Involuntary Discharge of Patients

Clinical work is always enacted in relation to the organisation of healthcare systems, and the economic and political rationalities shaping these (Scheid, 2004; Strauss et al., 1985). Local policies and routinised bureaucratic practices are key elements of the infrastructures undergirding care (Timmermans and Almeling, 2009). These can be reconfigured in relation to the shifting salience of national matters, such as waiting time targets. In Chapter 5, I analysed the configuration and performance of professional autonomy within clinical psychology against the backdrop of targets and financial constraint. Here, I explore the uncertainty, affective, and moral work inherent to clinical psychologists' adjudications of what should happen to people who do not attend the therapy appointments that have been scheduled for them. I consider in turn how such arbitration can be both enabled by and enabling of autonomous action in ways that have serious implications for potential or ongoing access to psychological care.

Formal and informal patient attendance policies are key infrastructural arrangements supporting professional decision-making in relation to what many term DNAs (people who 'did not attend' appointments). As such, these policies can prompt exclusion from services and contour clinical perspectives around why this might be desirable. Over the last 15 years or more, I have encountered multiple articulations of concern about how psychological services manage non-attendance. These have been advanced by people who have accessed services (or tried to), activists, and advocacy organisations, as well as some health professionals themselves. In my interviews with clinical psychologists, responses to queries about DNAs could be lengthy. They not only described the processes per se but also indicated how they related to DNA policies and to the broader labour of psychological care. I interpret these interview data against the backdrop of more casual conversations I have had with practitioners about 'non-attendance'. Such dialogues often made explicit many of the matters that

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can be implicit within my structured research encounters, and accordingly have shaped the analysis I present.

While healthcare is powerfully shaped by policies and guidelines (Berg, 1997; Timmermans and Berg, 1997), healthcare professionals are also well known for their improvisation skills (Jensen and Vabø, 2024; Kamp et al., 2023; Kuijper et al., 2022;) and can take a more 'discretionary' (Johannessen, 2017) approach to practice (Dew et al., 2010; Kellogg, 2011). Attendance policies are no exception, with nuanced negotiations of these often apparent within clinical psychology. As we will see, these are underpinned by processes of moral characterisation and configurations of expertise, which both unfold from and are constitutive of accounts of DNAs.

Non-attendance and Healthcare Resource

Patient attendance is an enduring issue for healthcare systems. Often, resource-related arguments about non-attendance inform discourse within political and policy arenas. An illustrative example comes from political reporter William Russell (1984), writing in the *British Medical Journal*, which triggered various letters in response. Russell's article described a discussion in the UK House of Commons around people not attending appointments, and the introduction of computers into the NHS to help monitor this. According to Russell, the then Under Secretary of State for Health, Conservative MP John Patten, asserted 'the need for hospital patients to recognise their moral responsibility to turn up on time for appointments in order not to waste valuable NHS resources' (Russell, 1984, p. 1928). While the politics of the NHS – and the associated responsibilisation of patients (Miller and Rose, 2008) – ebb and flow, such sentiments could still be encountered decades later. As one senior official commented following the rollout of more digital 'solutions' to DNAs within the NHS:

> It's important that people realise that not turning up to appointments can have a big impact on the care and treatment we are able to give other patients. It wastes Doctors' and Nurses' time too, which costs taxpayers money. (NHS England, 2014)

The financial dimensions of patient non-attendance at clinical appointments have also sometimes been made clear with regards to worries about waiting times following the COVID-19 pandemic (which has had significant impacts on how quickly people can be seen by services; Shah et al., 2024). Guidance released by NHS England in February 2023, for instance, included on its list of 'Benefits of reducing DNAs' the claim that

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reductions would contribute to 'improving the efficiency of resource allocations by systems and therefore improve how providers can use their capacity to deliver care' (NHS England, 2023b). Such coupling of concerns about DNAs and resource allocation is not unavoidable, however: resonant guidance on waiting times produced by the Scottish Government (2023) later that year centred attendance but avoided discussion of financial imperatives in relation to this (placing responsibilities on the NHS and individual clinicians rather than those seeking care). These rhetorical differences matter: rhetoric, after all, configures reality. Still, some in Scotland might argue that NHS England were simply more willing to 'say the quiet part out loud': Scottish health professionals are all too aware of the financial (and political) considerations shaping the policies that govern them.

Clinicians themselves have for decades reflected on who does not attend treatment, why, and what might be done about it (e.g. Baekeland and Lundwall, 1975; Dengrove and Kutash, 1950). This includes considerations and concerns around the economic and practical implications for services, which can also intertwine with worries about patients per se. In relation to the latter, unscheduled missed appointments are often regarded as having adverse impacts such as enhancing 'the risk of further deterioration, relapse and hospital readmission' (Mitchell and Selmes, 2007, p. 423). Apprehensions can also be articulated as worries that health services themselves are not always doing all they can to support people to attend appointments. For example, one *British Medical Journal* article, published a few years after Patten's reported comments, noted in its introduction that missed appointments in 'outpatient departments may lead to inefficient use of facilities and result in unnecessary costs and delays in assessing patients' (Frankel et al., 1989, p. 1343). However, the paper went on to argue that this was not 'a reflection of patients' generalised indifference to the service offered', but more an issue of 'communication and administration' (Frankel et al., 1989, p. 1345). Directly quoting Russell's article, it concluded: 'Before attributing the problem of non-attendance in the United Kingdom' to supposed patient irresponsibility, 'it is important to ensure that the administrative arrangements are likely to facilitate attendance' (Frankel et al., 1989).

Clearly, as a 'matter of concern' (Latour, 2004), different problematisations of non-attendance can operate in concert, with narratives of people not attending healthcare appointments reflecting varied political, normative, and clinical perspectives. Nonetheless, worries about the financial ramifications of non-attendance can be keenly felt, not least within the

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context of a health service that is widely understood to be underfunded and, relatedly, often short-staffed. Psychological therapy services in particular are often regarded as a 'scarce resource' (Houghton et al., 2010, p. 510), with non-attendance framed as a problem in relation to a logic of efficiency (Veblan, 1983 [1921]) that has come to configure clinical services and practices. These issues interact with and are shaped through health service debates and wider discussions of waiting lists (Pope, 1991), since a missed appointment can contribute to slowing a person's journey through a service. Consequently, tackling DNAs is regularly perceived at the clinical coalface as one means by which waiting time targets can be met (Tweed and Salter, 2000).

Despite ongoing sociotechnical innovation aimed at maximising attendance, DNAs continue to be a feature of clinical life. Accordingly, health professionals repeatedly negotiate (non-)attendance as part of their day-to-day work. In practice, clinical psychologists can experience a missed appointment in varied ways, including as 'rude' (Tweed and Salter, 2000, p. 472). However, this can also be framed as a 'relief' (Tweed and Salter, 2000): the time that would have been spent working with someone for direct therapy is 'freed up' for the clinical psychologist to deal with one of the many other tasks that demand their attention (e.g. writing notes about the last person they saw). Nonetheless, at national and organisational levels there remains a drive to decrease non-attendance, with ensuing responsibilisation (Miller and Rose, 2008; Rose, 1996) and subjectification (Hacking, 1995, 2002) of healthcare professionals and people seeking care. As the following sections will show, how this agenda instantiates within the NHS varies among clinical psychologists and services yet commonly acts to configure practitioners as autonomous experts. This is even as formal policies and procedures can act to prompt or nudge them in the direction of discharge.

What Do 'DNA Policies' Look Like?

DNA policies seek to encourage a particular disposition and set of actions on behalf of individuals referred to or engaging in therapy: most ideally, to be a regular and timely attender of appointments – and so to be a cooperative, 'good' patient (Lorber, 1975). However, DNA policies also configure clinical psychologists themselves. Specifically, professionals are incited through DNA policies to work with people in ways that are regarded as likely to reduce the likelihood – indeed, the organisational 'risk' – of non-attendance, and so decrease the chance of discharge.

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In other words, DNA policies act as a technology of government (Rose, 1999) which enjoin clinicians to practise in ways that seek to delimit the conditions of possibility for someone to be configured as a 'problem' (Lorber, 1975) or even 'bad' (Dingwall and Murray, 1983) patient. At the same time, people can be configured as such precisely because of and through such policies.

DNA policies are wide-ranging, although a rule of 'three strikes and you're out' (with three missed appointments leading to exclusion) is not uncommon. However, some services ostensibly permit only one unarranged missed appointment prior to potential discharge. Where I work in Edinburgh, the local Child and Adolescent Mental Health Service (CAMHS) – part of NHS Lothian – includes the following caution on its webpage:

> If you cannot attend an arranged/planned appointment, please contact your local team as soon as you can to reschedule. Please note, **if you do not attend (DNA) an appointment without letting us know, CAMHS will not routinely offer a further outpatient appointment**, and you will be discharged from the service. (NHS Lothian, 2025, bold in the original)

Harriet, a mid-career clinical psychologist, described a similar policy in her adult mental health service elsewhere in Scotland:

> [W]hen it comes to DNA for a *first* appointment like that, [if someone does not attend] then they're discharged. If it's DNA for a *repeat* appointment, we will send them a letter asking them to get in touch within 10 days if they still require an appointment and if they *don't* get in touch in the 10 days, we assume they no longer want psychology and we discharge them. And the GP gets a copy of that letter, so if the GP wants to chase them up, he can, or she can.

Given that the capacity of primary care is notoriously limited, one might wonder how likely it is that a GP would in fact 'chase' someone in this way. However, positioning GPs as having the capacity and expertise to engage a potential patient for psychological services and prepare them for therapy can help to absolve clinical psychologists of the practical and moral responsibility of doing so themselves. In the preceding extract, this absolution is also emphasised through presenting the task of engaging with people as discretionary rather than demanded by clinical judgement: GPs were said by Harriet to sometimes 'want' rather than 'need' to 'chase [patients] up'.

Other clinical psychologists likewise operated with slightly different policies for first as opposed to subsequent appointments, with procedures around discharge sometimes reflecting the patient groups the service was designed to work with. Also important was how long a person might have

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waited for therapy in the first place. Senior clinical psychologist Irene worked in England with people categorised with personality disorder, and her policy for assessment was similar to Harriet's approach for later appointments:

> We generally have a DNA policy that, well, it depends where you're at in the process but if you're just at the assessment process and you DNA, one DNA and we'd probably write to you and say, you know politely, 'you haven't, you haven't come, we're not sure if you want this. If you do, get in touch with us and if we haven't heard from you in a couple of weeks we'll assume you don't want it right now and discharge you'.

Harriet went on to describe her policy for therapeutic appointments in ways that reciprocally configured the ontology of her service, her patients, and herself:

> If they're in, if we're at the *treatment* stage, so bless them, they might have sat on the waiting list for two and a half years and then they DNA, we have a kinder policy. Particularly if we're cognisant that there are major attachment issues, because engaging someone with a significant personality disorder you kind of have to prove yourself, by putting up with being mucked about a bit in order to show yourself to be a worthy parent, if you like. So you put up with a bit more DNA with some of those. But notwithstanding *that*, we're also allowing for the fact that people have all sorts of difficulties in coming to sessions. And they've waited *two years*. So if they DNA a treatment session early on, at the beginning, we would offer them another session and when they've DNA'd *two*, they get the two week, 'we're not sure, get in touch'.

Much like Irene, senior clinical psychologist Ursula was sensitive to how a missed appointment might relate to particular contexts:

> [I]f somebody doesn't come for an initial assessment then we'll write, and invite them to come to contact us within two weeks, and if they don't contact us within two weeks then we will discharge. If somebody comes and then DNA's a subsequent session then we will send them a further appointment, and invite them back to continue the conversation, and also, you know, when people don't come, and clearly aren't, can't, won't, whatever, come, we will write to the referrer, and say, 'not really', especially if we don't know the client, you know, 'we don't know why they haven't come, please feel free to give us a call if you want to discuss this, have they got particular access problems, or if they've got, if they're very depressed', you know, if someone's very depressed, the motivation to get up and come out on a Wednesday morning at 10 is, probably, not great, and we've got to be aware of all of those factors when you're looking at your DNA rates really.

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Through this extract we can, first, see the efforts to which professionals will sometimes go to reduce the likelihood that a person is discharged prior to or at a very early stage of work with a clinical psychologist. Second, it is apparent that, on occasion, other healthcare staff – including non-psychologists – can be configured as having sufficient epistemic authority to contribute to the synthesis of certainty about what to do about 'a DNA'. Third, different strategies to managing non-attendance can be related to and help to solidify particular configurations of patients that might then have implications for therapy.

Structuring Care in Relation to DNAs

Given wide-ranging clinical and health services concerns about patient non-attendance, a variety of techniques are employed by services for clinical psychology – and psychological therapy and mental health more generally – to encourage people to come along to appointments for assessment and treatment. A regularly touted method of enhancing engagement with services is a simple telephone call reminding someone of their upcoming appointment (Pennington and Hodgson, 2012). Over the 15 years or so, SMS messages have become increasingly routine as well (Sanghara et al., 2010). These can even be used as an adjunct to therapy itself (Furber et al., 2014) – reworking long-standing temporalities and sites of therapeutic interventions, and reflecting a wider digitalisation of mental health (Pickersgill, 2019a). For early-career clinical psychologist Emma, reminders had been notably successful as an infrastructure to support patient attendance. As she reflected during a discussion about what she might do in relation to a DNA:

> [I]t's about, if they [patients] do miss a couple [of appointments], saying, 'well what's going wrong with our systems? Why are these reminders not working, or, you know, are you finding these sessions aren't helping you, or, do we need to just call it a day for now, and you can come back at a different time?' So, so yeah, that's usually two, if there are two DNAs in terms of no contact, no cancellation, then I would phone, I would usually phone them. If I can't get through on the phone I'll send a letter, offer them another appointment in the letter, if they don't turn up to that, then I would usually discharge, they might not get a discharge from the whole *team*, but I would say, you know, 'for things to move forward, we need a bit more, kind of, commitment from your end'. I mean, it's never happened! It's never happened in the service I'm in, because there are enough reminders that, you know?

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Expectations around attendance could also shape the content of clinical encounters. As Briony, another relatively recently trained clinical psychologist, reflected when discussing DNAs:

> I suppose generally what would happen is if someone did not attend and hadn't phoned or hadn't cancelled then we would send them a 14-day letter saying, you know, 'you didn't attend, please contact us within the next two weeks if you'd like to be seen again, if not, you'll be discharged back to your GP'. Generally, it's generally the usual rule. Certainly, I would discuss at the start sort of expectations of therapy, of attendance, of kind of what engaging in therapy means in terms of the work in between sessions and I think most of my colleagues would.

Arthur, who worked with people who had experienced psychosis, likewise made clear the salience of various material and discursive techniques to enjoin attendance:

> [W]e don't discharge people for missing an appointment. However, we are becoming much more robust in a clear contract with people at the beginning of therapy to say that we . . . expect people to attend a high proportion of appointments, and that if people have missed two or more appointments they will be contacted to ask whether they want to continue. And if we don't receive communication from them we'll assume they don't, so we'll write to them and ask that. But also that, we expect at least 60 per cent attendance at the planned therapy appointments, which we use, you know we put on all our material, and is up on the waiting room, which *means* that if people are missing appointments, even if they're turning up for further ones, it becomes an issue to discuss in therapy, that actually 'you're missing a high proportion of your appointments here, you know our policy says that we may discharge you if you can't attend these appointments, therefore how do we work on making sure that you're coming to your appointments'! It's something that we instigated a while ago to try and help *prompt* those conversations and *therefore* reduce the kind of the rate of dead time that you get with people that are not coming to appointments.

Attendance contracts of the kind mentioned by Arthur appear to be designed to cement expectations, with patients configured as having the facility to exercise the autonomy to sign them freely. In the process, considerations of the relations of power that shape the contents and enactments of such contracts in the first place are elided.

As mentioned in the preceding chapters, individuals seeking therapy might also be able to 'opt-in' to some services and book an appointment at a time convenient to them. 'Opt-in' approaches to service design and delivery are purposefully leveraged to limit non-attendance. They also come with the possibility of excluding people – especially already

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marginalised groups – who have not, for a range of possible reasons, actively opted in within a particular time-frame. Nonetheless, a requirement to opt-in to a service is a popular social technology configuring access to therapy, and which consequently shapes experiences of psychological care. As Amy, who was employed by a multidisciplinary weight management service, summarised:

> We have lots of opt-in procedures, so somebody has to go to their GP and say 'I'm worried about my weight', the GP then has to have the conversation of 'do you want to go to weight management, here's a leaflet'. If you want to go the GP will make the referral but the referral will not be actioned until the client has phoned us, phoned the call-centre and opted in. Then they get sent an appointment, that they have to opt-in to, so they have to say 'I will come to that', then they come to their appointment and we say 'okay, yeah, you're eligible to come to our service, to join our weight management programme, a psychologist assessment if you *want* it you have to phone again and opt-in'. So you have to then phone and say 'yes, I've had my assessment, I do want to come to a group'. So there's three opt-in points, so that has *massively* reduced the DNA rate

Perhaps mindful of the ways in which the structuring of her service could be cast as potentially exclusionary, such opt-in procedures were framed by Amy as having 'hugely reduced the number of people who were referred' yet who 'never knew they were referred'. Also flagged were people who might 'have just said "yes"' following a suggestion from another clinician that Amy's service might afford them some benefit 'because they don't want to upset the doctor or the practice nurse, or whoever'. These reflections configured patients as rather acquiescent to biomedical power, even as they were assumed to have the autonomy to clearly advocate for their psychological need through an iterative process of opting-in.

The rather lengthy process of ongoing opting-in to Amy's service, which required people seeking care 'to demonstrate quite a lot of commitment to their weight management, before they even get in front of any of us', aligned with other structural interventions:

> [O]n top of that, we've introduced lots of quite firm DNA cancellations, attendance policies basically. So every time a psychology assessment, appointment goes out, it very clearly says 'if you cancel twice you will be discharged and if you DNA you'll be discharged' and the policy's very clear because in the past we've had, you know, waiting lists of months and months and months and a huge DNA rate.

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Just as Amy made plain how opt-in procedures were a strategy for managing non-attendance, so too in the preceding comments does she render explicit how DNA policies relate to waiting lists.

In a similar way to Amy, Ursula also underscored the value of individuals actively opting in to services. The importance of this was articulated through configurations of patients who 'don't know' why they have found themselves within a service:

> Our DNA rate hovers around 11, 12 per cent. Which isn't too bad, but I think it used to be a lot higher, and we have done various things over the years, like, getting people to actually opt-in to therapy, getting them to complete a questionnaire, if they don't complete the questionnaire they don't get offered an assessment, well, they do if they, they don't have to complete it, they just have to return it, and say, 'I couldn't do it', or 'I don't want to complete it'. They still get an assessment, but we need to know that they're willing and able to come, because some clients, for a long time, you'd get, people would come and say, 'oh, I was sent, I don't know why I'm here', and there's much less of that now. So we operate an opt-in system around that.

Again, this extract simultaneously presents opt-in procedures as having value through decreasing the service 'DNA rate' while also, in effect, saving patients from seeing a clinical psychologist when they did not 'know why' they had been referred in the first place.

Moralising Non-attendance

People who do not attend scheduled clinical appointments are commonly subject to moral characterisations which cast them as 'irresponsible' or even 'irrational' (Buetow, 2007; Lester et al., 2005). Often ignored or minimised in the process is the wider social and personal context within which non-attendance occurs. There are a whole range of reasons why someone might 'DNA', including poor transport links to clinics, caring responsibilities that necessitate rapid reprioritisation, and homelessness which results in appointment letters never reaching their intended recipients. For mental health services specifically, the stigma and discrimination associated with psychological distress, including from some NHS staff, can discourage people from attending appointments (Rogers et al., 2001). Diagnostic and therapeutic journeys might also involve encounters with a range of different professionals which result in repeated affectively challenging requests to narrate difficult personal experiences (Biringer et al., 2017). Further, people are on occasion dissatisfied with the service they have received to date (Binnie and Boden, 2016) and doubtful about

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the efficacy of the therapy they are offered (Rogers et al., 2001). Perhaps unsurprisingly given some of the underpinnings of non-attendance, DNA rates are higher for people living in very socio-economically deprived circumstances, compounding the inequities to which they are already subjected (NHS Health Scotland, 2015).

Still, the moralisation (Strong, 1990) – that is, the casting of events and actions in moral terms – of patient attendance is not uncommon within healthcare. Moralised configurations of patients have also been evident within many of my encounters with clinical psychologists and others who provided psychological care. These can interact with wider political projects of health-related responsibilisation (Miller and Rose, 2008; Rose, 1996) – i.e. a normative encouragement to 'take responsibility' for one's health (notwithstanding the plethora of social, political, economic, and commercial determinants of illness). Emma's comments about her previous work in an IAPT service provide one example of such subtle moralisation and responsibilisation:

> [Y]ou've got to set those boundaries [in relation to non-attendance] that early on, because if people know what to expect, I mean, it's quite [psychologically] containing, and then also the demand on the service is so high, it's only fair to the other people who might be waiting. And, you know, it's, again, it's about helping people take responsibility for their own recovery, as well. You know, if they can't turn up to sessions, how on earth are they going to do [CBT] homework in between?

Moralising discourses can prompt exclusion from services before someone has even been seen by a psychological practitioner, as is clear in the following extract from an interview with senior clinical psychologist Esther. In this, she notes the problem of 'bad attenders' – some of whom are judged to be outright lying to healthcare professionals:

> Some of us are harder than others, and if we're working from people who've been on the waiting list a long time, then it's just one, one appointment offered and you're off. If they're really annoyed about it, they'll go back to the GP and get reinstated. Some of the GPs will know who are the bad attenders and we get quite a lot of letters now saying, 'they say they didn't get the letter. I don't believe them'. So we're getting some support from the GPs about, 'okay, if they don't turn up, we're quite happy with you not following it through'. People probably get two chances at it. And the other thing we count as DNAs are also cancellations on the day, because we cannot rearrange an appointment in that time.

Within my encounters with clinical psychologists, I did not find overt moral ascriptions to be as typical as more implicit forms of moralisation.

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For instance, when I asked Leanne, a clinical psychologist quite early in her career, whether she had a DNA policy, she replied:

> Yeah. And that, I think, most recently, that is with trying to be a bit tougher on that, in terms of first appointments, if they DNA. So the letter that goes out for the appointment mentions that if you don't, essentially, if you don't turn up without telling us, you'll be discharged. So, people, if they don't turn up get discharged, on their first appointment. It's slightly up to us, if it's during therapy. So, someone misses an appointment, we'd probably send them a letter, saying, 'sorry you missed your appointment, please phone in if you'd like another'. We wouldn't necessarily, we wouldn't just automatically send out an appointment. And if it seems like there's a bit of difficulty attending, we'd discuss that with the patient next time.

The language of 'toughness' is important here. To be 'tough' can be a valorous, sometimes moralised position, and in the preceding extract it is explicitly aspirational: Leanne and colleagues are purposefully 'trying' to be 'tougher', presumably in the face of experiences – of patients – which are found challenging. Leanne further reflected on what she 'should' do more of in the face of non-attendance:

> [T]here are actually contracts, which I really should, yeah, I should do - some people are probably better than others. Really, what we are encouraged to do is sort of sign a kind of attendance contract at the first appointment to say that we're, both of us [i.e., the clinical psychologist and their patient], aim to attend the appointment, and if, on their side, if there's maybe a couple of appointments that are cancelled at short notice, or missed, then they could be discharged. You know, so they realise that aspect of it. So, yeah, I should do that.

Natalie was, among my interviews, uncommonly straightforward in her description of how she made use of involuntary patient discharge to manage non-attendance:

> [I]f someone DNAs once then I just send them a letter saying, 'sorry you missed your appointment, if you would like another, then give me a call'. And, you know, they get two weeks to do that and if they haven't called then we discharge them.

I asked her whether, following this, there were instances where someone might try to regain access to her service. She replied as follows:

> Yeah, that's quite frustrating! You know, you'll just have discharged their file and then a few weeks later they say, 'oh, yes, could I get seen?' I'm quite soft I suppose, I don't make them, I probably would just see them then.

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> I wouldn't, you know, go back to the GP and say 'write another referral letter' or something like that.

Natalie cast people seeking therapy following non-attendance as creating work, and she configured herself as 'soft'. An implication of such a framing is the possibility that she could instead act in 'hard' ways (or perhaps 'tougher' ways). The term 'soft', then, and the assertation of what she would not do – specifically, 'go back to the GP' – suggest that requiring a patient seek another referral could be interpreted as a kind of administrative punishment for not attending an appointment. In these comments, it was precisely through providing an example of an alternative course of action in relation to non-attendance that Natalie underscored how unscheduled missed appointments can be moralised.

Sometimes, clinical psychologists explicitly or implicitly relate non-attendance to psychological 'readiness' for therapy. For instance, Roisin, who worked within a Community Mental Health Team (CMHT) in urban England, reflected:

> [I]t's good to have [a DNA policy] sometimes, because sometimes people just aren't ready, or aren't able to attend regularly to, to make use of therapy. So we do have a policy. I think, it's, I think it's something about if there are two non-attendances then you have to [discuss] with the person, but, generally if it is two consecutive then I would, but if it's just two spaced apart then I don't, I don't bring it up. It's just if it becomes a recurring thing.

As noted in Chapter 4, readiness is not only an epistemically loaded notion but a morally laden one as well; after all, in everyday life it is generally considered that 'being ready' for something is better than being unprepared. One example of how configurations of readiness operate in relation to (non-)attendance comes from a lengthy conversation with Leanne. During this, she further reflected on what might happen with a patient who frequently does not attend appointments:

> [I]t's always tricky, because, you know, especially ones that you sort of know, if people have got anxiety, or, you know, it can affect them getting to appointments. I mean, sometimes, I've sent back to the GP, if it's said in the letter that they're anxious, you know, and they've not come to their first appointment, and you think, well maybe it's because they're struggling to leave the house. But if that is the case, and they're not ready to come to our service, but I would maybe send – there's now an NHS telephone CBT service, and I'd maybe suggest to the GP they could maybe try that for now. But it is tricky, when you know that their poor attendance is probably to do with their problems, anyway. But there comes a point when you can't sort

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> of keep making allowances for that, that that's an example of them not being appropriate for the service yet, that maybe there's something else they could try and work on in the meantime.

Leanne clearly attempted to engage with people who do not attend therapy, and in the preceding extract reflected on an example of an apparently justifiable reason why this might happen, namely if someone was 'anxious'. However, this framing of the challenge experienced by a patient nevertheless participates in configuring them as not being 'appropriate' or 'ready' for the service. Despite the mutability of service ontologies discussed in previous chapters, it is the patient here who is deemed to need to change for the service, rather than vice versa. The moral dimensions of both non-attendance and readiness itself are strikingly clear within Leanne's suggestion that 'there comes a point where you can't keep making allowances' – a phrase which is colloquially associated with 'bad behaviour'.

Mental health policy and practice within the United Kingdom has long evinced forms of circular logic that can result in adverse outcomes for potential patients (such as those diagnosed with a personality disorder; Wootton, 1959). In the preceding extracts, we can see how this occurs through the articulation of psychological notions of readiness with institutional policies of exclusion. The former legitimates the latter, and the latter contributes to the veracity of the former: non-attendance is taken to signify a lack of psychological readiness, which is reified as a justification for terminating someone's therapeutic journey. As such, the 'fault' of non-attendance is configured as sitting with – indeed within – the patient. This is as opposed to, for instance, a framing of the clinical psychologist themselves as ill-suited to working with a particular person. In the process, the morality and expertise of the clinician come to be implicitly reaffirmed by discharge itself.

Negotiating DNA Policies

As the previous sections have indicated, formalised DNA policies do not necessarily remove the potential for clinical judgement and discretion. Rather, they can create spaces for the performance of professional autonomy. Senior clinical psychologist Esther, for instance, told me that if a person had 'accepted an appointment and then DNA'd, it's up to the clinician to decide whether they want to give them another one or not'. Another senior interlocutor, Susannah (based in CAMHS), likewise underscored the formal role of clinical autonomy in relation to discharge:

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> [Patients] get two DNA's they can have, and then, if they're a vulnerable family we would have to sort of you know read the notes, but they would be given what we call, 'a two-week letter', so that's, 'sorry that you've not come for these two appointments, if you'd like to come, get back in contact with us' and the GP or the referrer would also get a copy . . . The GP would always get a copy sorry. So it would flag it up to them, so if they wanted to contact the family as well they could, or if they have any concerns they could contact us to see, you know, we think you should still try and see them. So they would give that two-week letter, and then if they still didn't respond to that, it goes back through the referral screening group, and the clinician, senior clinicians in the referral screening group will review the case note and just make a decision about whether to discharge or not.

Similar to other cases discussed earlier, we can see how Susannah and her team actively worked to ensure that discharge was not a predetermined outcome of a missed appointment, despite the presence of infrastructure which might prompt that. I queried what factors would come into the final decision to discharge someone and was told the following:

> Well, we would take into account the kind of type of problem that they're presenting with. So obviously if it's a more high-risk thing we wouldn't necessarily discharge. We would take into account the social factors. You know, for example, if we know that the family, the parents got mental health problems or whatever, we might not discharge them, because we would maybe want to contact, you know, the referrer or social worker or whatever, to see if we needed them to facilitate attendance. If you know if there had been a history of poor attendance that might sort of raise the possibility of neglect and, you know, maybe the family not being able to kind of meet the child's health needs. So we consider the kind of factors really.

The inclusion of a wider social context within Susannah's account is notable and illuminates the extent to which many clinical psychologists are keenly aware of and can closely consider the wider circumstances in which their patients live, and which can shape the possibilities of their attendance at therapy appointments. At the same time, expert judgement – sometimes based on various assumptions, as well as the considered view of other professionals – is central to configuring a patient who is either in need of more support or who should be discharged from psychological care.

Sometimes, clinical psychologists seek to ascertain 'the meaning of the DNA', in the words of Charles, a senior practitioner in a large English city working with people 'who have a long-term condition' alongside 'a psychological difficulty'. He reflected:

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> I think we try and respond within a framework of knowing that when people have long-term conditions some days are okay and then some days are utter shit and actually expecting somebody to think 'I need to go and talk to that nice guy' is probably very very unrealistic because I am way down the list of things that need to be done today including 'will I eat, will I shower, how will I get to the loo?' So, we, you know, if people DNA we enquire about what is the meaning of the DNA. You know, 'was it that it was a bad day? How can we help you remember if that was not the reason?'. We are happy to do telephone consultations if people said, 'look, I'm really sorry, I can't come in because I'm just in pain'. We, we kind of try and throw a sort of a net around somebody and give them the sense that they are in our heads, even when they're not here, because when you've got a long-term condition people feel utterly isolated and that no-one understands

Charles clearly associated his adjudication of what should happen following 'the DNA' with the kinds of patients he saw, which was also apparent in my interviews and conversations with other clinical psychologists. Clarisa, for instance, was likewise a very established practitioner in the same city as Charles and explicitly related her approach to managing non-attendance to the nature of the patient group she worked with. She also, more implicitly, associated her mode of practice in relation to non-attendance with her expertise in being able to make a 'clinical judgement' about what should happen following a missed appointment:

> [W]e know that people with borderline personality disorders are likely to be quite chaotic. They would really struggle in forming attachments. Intentionally we have tried not to say that 'if you don't attend two or three sessions you're out', there's more flexibility there. I mean in other teams we have to really specify that 'if you DNA this many sessions and you're not engaging at all, we may have to discharge you', but when somebody *is* in therapy then I think there's a clinical judgement which a clinical [psychologist] needs to make, and work with the person to actually [understand] what's going on.

Importantly, DNA policies can also be more purposefully elided. Some of their flexibility and interpretability – and how those entwine with configurations of psychological expertise – are apparent within CMHT psychologist Roisin's observations:

> [W]e do have a DNA and cancellation policy that's sent out to people when they receive an initial appointment, and, it, it really depends on the individual service-user, and my work with that person, how I use that. Sometimes . . . (pauses) You can get some people who attend really regularly, and engage really well, and then they won't attend, and that will keep happening, but because they engage and they attend a number of times you

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sort of think, 'oh, yeah, we won't pay too much attention to the DNA and cancellation policy'! But then you get other people who will cancel a number of times, consecutively, or DNA and cancel, and then ring up, and then you need to sort of start saying, 'well, we need to maybe have some sort of contract, and you need to attend, but if you don't we need to discuss it, and see if there's anything else we can do. If there's not, we'll need to think about discharge.'

Patricia, who also worked within a CMHT in the same city region as Roisin, was unusually frank about occasionally evading her service DNA policy:

MARTYN: [Do] you have a formal DNA policy?

PATRICIA: Yes. Do I use it properly? No . . . Sometimes some people I use it properly, other times, I think it just depends what you know about someone. If you know someone's really struggling because of this real valid reason, you might be a bit more kind of lenient, or go to their care coordinator and say 'they haven't turned up again, I really should be discharging them but I know they've got this problem and that problem, can you really encourage them to come along this week because this will be the last time?' So I probably give people a little bit more leeway. I stick that [i.e., the DNA policy] up [on the wall] to make myself do it but it's just become part of the wallpaper so I even forgot it was there! So yeah, there is a formal policy that I should be adhering to, a lot more rigidly than I do.

MARTYN: And is that, and do you feel much pressure to do that or is that part of the freedom [you spoke about before]?

PATRICIA: I probably should feel the pressure and I probably don't.

This extract speaks to the moral configurations that come with a DNA policy – Patricia casts herself in a moral role by describing her disposition as 'lenient' – while also underscoring one way through which autonomy can be performed in clinical psychology. Yes, there is a policy; no, it does not have to be followed. The conversation continued:

MARTYN: But you feel it [i.e. not following the policy] enables you to care for patients better?

PATRICIA: Yeah, yeah, exactly, be a little bit more empathic and it seems a bit hard if you know the reasons, the problems someone's got and actually what's playing out in therapy and yet you kind of say, 'sorry, you've got this problem, you can't come'. 'That's what I needed therapy for!' You know? Then I try and give people a bit more of what I think is a fair chance, and that might mean for some people, well, yeah I do insist on the policy because I know they know, or I know there's something else going on, but for some people I might think this is part of the problem and if I can just get them back in this time and *talk about* the reason that they didn't come, rather than just say, 'I'm sorry, you didn't adhere to my rules so you're not coming back'

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Subtle moral adjudications can thus come into play in decisions about whether to continue with therapy: Patricia draws boundaries between people who have been given 'a fair chance' and who perhaps begin to attend appointments more regularly and those for whom it is deemed right to 'insist on the policy'. These different and patient-specific responses to non-attendance act in concert to configure Patricia as a good clinical psychologist: first by being compassionate; second by providing quality care; and third by being able to leverage expert knowledge to determine what might be 'going on' with a patient – and what the psychological ramifications of this might be – to chart a morally and epistemically legitimate course of action.

When There Is No Policy

While the consideration of non-attendance is almost ubiquitous within psychological care, not every service has a formal DNA policy. Such an absence could provide additional opportunities for the performance of professional autonomy, including positive discretion, as in comments made by Jason (who was based in secondary care in a rural English county):

> I've got clients that have DNA'd quite a lot. I work with quite difficult to engage clients, and DNAs and late cancellations are part and parcel of that work, so no I've got no set, set maximums or three strikes and you're out, there's nothing of that nature. I'm free to make my own clinical decision on whether or not the DNAs are hampering the *process* and therefore, *further* input may not be beneficial or whether the level of DNAs are actually reflective of the person's social and, emotional difficulties, and-and need to be thought of in that way.

Accounts of an absence of an attendance policy could also serve as vehicles for conveying the morality of clinical psychologists, as well as illuminating their facility and authority to control patient access on a case-by-case basis. As Olivia, another CMHT psychologist, described to me,

> We don't have a formal DNA policy, although we may be coming to that. We may be kind of setting out kind of leaflets and things about that. I think, because of the people that we work with, then often people do have medical appointments, they have family things that happen. They're often in quite sort of complex kind of social networks, if you like. So I think, you know, we do try and be flexible, so that if people are kind of cancelling for good reason, because they're ill, like I said, they've got hospital appointments, or their husband or wife is ill, or they've got to go to a funeral, that

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> happens more often than you'd want it to really! Or you know or there's some kind of huge, family crisis, involving the grandchild usually. Then again, we would try and be kind of flexible with that.

In these comments, Olivia articulated both how understanding she was of the challenges that some of her patients lived with while also undertaking the moral boundary work (Lamont, 2000; Pryma, 2017) of sketching out some of the circumstances in which she would 'try and be kind of flexible'.

Less 'flexible' was Kent, a senior clinical psychologist working with people with physical health conditions. He also described a somewhat moralised informal process for managing non-attendance in the absence of a formal service DNA policy:

> I don't have one [a DNA policy], no. No, I don't. I tend to have a fairly intolerant approach if someone doesn't turn up for their first appointment in that I will immediately discharge if they've been sent a letter with an appointment and contact details to get in touch if that doesn't suit, then I will normally discharge and won't bother trying to contact them, unless, and quite often I will also speak to the nurse who may have made the referral and double-check, 'well, is there a reason why this person hasn't come?'

Molly worked with people around the psychological ramifications of physical ill-health, and provided an even more explicitly moral account of the management of patient non-attendance:

> [M]y physio colleagues, for example, and nursing colleagues, will have a, 'if you cancel without a good reason you will just be discharged' [policy]. Whereas we work, I work with much *riskier* patients, where there are safeguarding issues, and I don't think I could, morally, just discharge those people for non-attending, so I'm probably softer with my DNA policy.

At this point in the interview, I felt that Molly looked somewhat uncomfortable. When I asked her about that, she paused before reflecting:

> I can see, I put two heads on, and I can think from a service level point of view, it would be ridiculous if a patient was only attending 50 per cent of their appointments, but then if you needed that link with a professional was a thing that was helping them stabilising, being able to look after their children, and remain in contact with the services and manage their pain better . . . So, from a service point of view it's ridiculous to be wasting, underutilisation of slots I think it's the way it's recorded. However, from a *human* point of view, I think, if someone uses 50 per cent of the slots you offer them, but makes good use of it when they're there, then *clinically* it kind of feels effective.

This extract entwines different rationalities for determining what do in the event of an unarranged missed appointment. Economic, moral, and

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epistemic modes of approaching non-attendance 'interfere' (Pols, 2003) with each other, resulting in ambiguity and, indeed, ambivalence. Notably, the 'human' perspective is validated in terms of what seems 'clinically . . . effective'. In other words, the exercising of everyday morality is configured as professionally appropriate in ways resonant with other domains of healthcare (Dingwall and Murray, 1983; Roth, 1972; Shuster, 2019). In doing so, the humanity of Molly's clinical work is underscored at the same time. This also defends against perceived attacks that refusing to discharge is economically wasteful. Molly was thus a good clinical psychologist in more ways than one.

Clinical Discretion and Exclusionary Inclusion

Unarranged missed appointments by patients occur across healthcare, with debates ensuing about the implications of this for resourcing and waiting lists. Local policy relating to (non-) attendance – commonly called 'DNA policies' – are one mechanism through which NHS organisations and services navigate this challenge. These act as a technology of government (Rose, 1999), aimed at shaping the expectations and experiences of clinicians and patients. DNA policies bind these parties together in a kind of transactional relationship (cf. Davis, 2013). In effect, access to care becomes dependent on the realisation of certain circumstances – most obviously and importantly that a patient attends a pre-arranged appointment – which can sometimes be reduced to the assumed dispositional and agentive actions of individuals seeking therapy. Where someone 'fails' to attend a scheduled therapy appointment, the possibility of care can be withdrawn. Indeed, some DNA policies mean that (potential) patients might never get to meet with a clinical psychologist in the first place. This could be due to automatic discharge following an initial missed appointment.

Through the infrastructure of DNA policies, clinical psychologists are supported to engage in 'negative discretion' (Barnard, 2023). In other words, practitioners can say 'no' – to actively elect to discharge people from therapy. Entailing uncertainty, affective, and moral work, decisions reached around discharge can be narrated through a discourse of inevitability (Leonardi, 2008; Pickersgill, 2024). Within this, exclusion comes to be configured as a principal mechanism to deal with non-attendance.

Processes of moralisation play a part here. For instance, a 'tough' approach to dealing with non-attendance is sometimes valourised by clinicians. Individuals can also be judged not to have a 'good reason' for being unable to make an appointment. When clinical psychologists classify

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people as, for instance, 'bad attenders', this action does not sit adjacent to and separate from psychological work. Subjectification occurs through categorisation (Hacking, 1995, 2002), and the informal categories that healthcare professions identify patients through (e.g. as 'a DNA') are well known to have implications for the scope and limits of the care provided (Latimer, 1997; Vassy, 2001). We might expect, then, that morally laden categorisations of patients contribute to the dynamics of psychological care that people who are not ultimately discharged come to experience.

Clearly, DNA polices can be regarded as a form of gatekeeping and a mechanism for modes of subjectification that might have adverse implications. Yet, they can also on occasion be facilitative of care (cf. Buchbinder, 2017). This is when their existence serves not to prompt exclusion, but rather to stimulate therapeutic work precisely to preclude this. An example is when DNA policies stimulate collaborative considerations of whether there are psychological dimensions to non-attendance that could be addressed by clinical psychologists. Alternatively, policies might catalyse a deeper exploration of the social conditions shaping 'the DNA'. An unscheduled missed appointment can be configured by clinical psychologists as a signal of other issues that might form the foci of therapy. This means that non-attendance and discharge are not always and quintessentially coupled.

When making a decision about discharging a person who 'DNA'd', clinical psychologists necessarily produce or affirm a particular ontology of their patient. Elements of this might be acquired from a range of sources, precisely to resolve an uncertainty similar in nature to that considered in Chapter 4 regarding referral. Specifically: Should someone be enabled – in fact, be permitted – to continue with therapy? Determining this enfolds psychological and sometimes even psychologistic characterisations of patients. Accordingly, decision-making about discharge can act as well to channel and reify the expertise of the clinical psychologist exercising their discretion. However, by defining a situation in principally psychological – as opposed to, for example, social – terms, it is hard to conclude that anyone other than a clinical psychologist should make discharge decisions. Potentially, those decisions are consequently more difficult for others, including people seeking therapy, to contest. This might be a particular issue when non-attendance is configured as evidence of someone not being 'ready' for therapy.

In sum, DNA policies connect therapeutic experience to the wider epistemic and economic dimensions of healthcare. Amid challenging waiting time targets and capacity constraints, they can prompt clinical psychologists towards the exclusion of some individuals to improve access

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to therapy for others. Indeed, DNA policies can compound pre-existing forms of disadvantage and marginalisation by excluding individuals living within circumstances that limit the possibilities of regular or timely attendance at clinical appointments. Accordingly, they underscore the logic of 'exclusionary inclusion' (Decoteau, 2013) that contributes to configuring psychological care. The existence, operationalisation, and negotiation of DNA policies thus represent a striking example of how an ethic of access can also have problematic effects.

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