CHAPTER 4

Prefacing Care
The Reciprocal Configuration of Patients, Services, and Professionals during Referral and Assessment

Within the United Kingdom, IAPT/NHS Talking Therapies is surely the most visible example of attempts to enhance the accessibility of psychological care (Pickersgill, 2019b; Pilgrim and Carey, 2012). Beyond this well-resourced initiative, however, there have been funding changes for mental healthcare more broadly. These have resulted in cost-cutting measures and created workforce challenges, with claims made that patient care has been compromised as a consequence (Gilburt, 2015). There are various effects of this on whether someone can access therapy (and if so, what kind and for how long). Even if a service is technically available, for instance, and a GP has referred someone to it, the referral might still be declined by a busy psychological practitioner.

This chapter examines how clinical psychologists manage, and make decisions around, patient referrals – the prefaces of care per se, which can either enable or preclude access to therapy. Such negotiations involve a rather different type of boundary work to that seen in the previous chapters: the negotiation of the boundary between certainty and uncertainty, and the subsequent substantiation of the decisions that follow from this. Following a referral, clinical psychologists must resolve an uncertain situation: Should they accept this, and continue forward to an assessment? Thereafter, they must decide whether the person referred is suitable for their service – and, indeed, for therapy more generally – and find ways to justify whatever happens next. These decision-making practices involve a form of morally inflected professional judgement (Styhre, 2013) that involves configuring different kinds of ontologies which entail their own set of boundaries.

One interpretation of uncertainty is as an affective state of individuals acting within specific sociopolitical and clinico-epistemic infrastructures. It can also be viewed as a constitutive characteristic of biomedical practice in which clinicians and researchers variously both live with and set about clarifying different kinds of ambiguity (Calnan, 1984; Fox, 1980;

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Timmermans and Angell, 2001). Uncertainty is not necessarily something that practitioners refrain from acknowledging (Gerrity et al., 1992). Still, it is often – but not exclusively – 'worked upon in medical settings to effect its elimination' (Ross, 2017, p. 90), with certainty 'a moral ideal to be achieved' (Adamson, 1997, p. 135). In conditions of uncertainty, expert knowledge can act as a key resource within decision-making (Sulik, 2009), serving to reinforce the autonomy and power of practitioners within clinical interactions (Broom and Woodward, 1996).

The practices of clinicians might not be directly or primarily experienced and self-categorised as being carried in a state of 'uncertainty', while nevertheless the tasks being undertaken are precisely aimed at clarifying a hitherto undefined plan of action. Such manufacturing of certainty requires engagement with a range of epistemological and normative ambiguities: What do we know? How should we act? What will come to pass as a result of (in)action? Uncertainty is thus, in a sense, productive (Moreira et al., 2009; Reed et al., 2016; Thompson-Lastad and Rubin, 2020). Moving towards its resolution can involve epistemic development and the production of sociality through the imagining of different subjectivities and futures, and the animation of affects and actions to realise or avoid them. Importantly, however, the risk remains that none of this will result in a situation regarded as satisfactory by healthcare professionals working the boundaries between certainty and uncertainty – or those seeking therapy who are subject to its effects.

Within clinical psychology specifically, practitioners must decide what patients to work with, and to what ends. This can be tricky, not least given the indeterminacy of therapy: what should be done about a referral is not clear in part because what will happen as a result of an intervention cannot be known in advance (cf. Halpin, 2022; Hayes et al., 2020; Hollin, 2017). Decision-making around referrals – as with so much else – further involves assumptions about persons that can invoke gendered, raced, and classed imaginaries and which might ultimately be deleterious to potential service users (Kugelmass, 2016). Alongside these issues are the configuring and navigation of less obviously fraught yet nevertheless charged matters, such as particular framings of a service and of the expertise of therapists. Configuring these can also result in potentially iniquitous forms of professional action; for instance, when a service might have an informal policy of declining to accept for referral people who live with certain psychiatric diagnoses (such as borderline personality disorder) (King, 2001).

In navigating uncertainty, clinical psychologists – like other health professionals (Kuiper et al., 2023; McEvoy and Richards, 2007) – juggle

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service demands and pressures, patient requests and concerns, and their personal ethical and epistemic frameworks for considering who should receive therapy and why. This juggling is itself a social process: ultimately, decisions rest with individuals, but choices are shaped through imagined socialities and actual engagements. The uncertainty work (Moreira et al., 2009; Pickersgill, 2011) of adjudicating access to psychological therapy can consequently itself be characterised as a social process, as well as the affective state noted previously.

In considering the prefacing practices of psychological care, I focus my analysis on clinical psychologists' accounts of how decisions are made – that is, how certainty is synthesised – about what to do with people following processes of referral and assessment. Decision-making, I argue, requires configuring at least three kinds of ontologies: the ontology of a potential patient, the ontology of the service in which they work, and the ontology of their profession. Their configuration does not occur in isolation; rather, to different extents and in varying ways, these processes happen in concert. Moreover, it is important to stress that potential service users might strategically configure their own self-presentation in ways that can contribute to securing access to care and particular kinds of treatment (Hillman, 2014; Stivers and McCabe, 2021; Wamsiedel, 2020). Hence, my emphasis on professionals should not be taken to suggest that their power in defining situations or selves is anything like absolute. What sociologists have called the 'candidacy' of people for therapy necessarily involves particular presentations of the self by those seeking it (Dixon-Woods et al., 2006; Liberati et al., 2022; Mackenzie et al., 2013), which are likely to articulate with the ontologies principally under consideration here (Chinn and Abraham, 2016; Kovandžić et al., 2011).

Aside from the insights from the literatures noted earlier, my approach in this chapter and the ones that follow is, as noted in the introduction to this book, shaped by the scholarship of Ian Hacking (1995, 2002) and Nikolas Rose (1985, 1996), among others (e.g. Danziger, 1990, 1997; Foucault, 1988, 1989; Woolgar and Neyland, 2013). More specifically, I take from them as useful the notion that ontologies are brought into being through discursive and practical work, including processes of classification and categorisation (rather than necessarily and straightforwardly pre-existing social interaction). These processes of configuration are also open-ended. While working the boundary between certainty and uncertainty might result in a particular course of action under specific circumstances, decisions can be challenged and revised, and the ontologies of patients, services, and professionals are subject to reconfiguration. Another

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assessment, a patient complaint, staff burnout, and so on can all reposition the boundaries of particular ontologies, and thus – at the same time – the boundary between certainty and uncertainty. A formal revision to service criteria, for instance, might reconfigure multiple ontologies, involving the re-specification of various boundaries as a result – triggering, perhaps, the making of different clinical decisions. The ontologies that form the focus of this chapter, then, are very much works in progress: processes of configuration have products that can always be unsettled and remade.

In what follows, I articulate the (overlapping) ways through which ontologies are configured in interviews with clinical psychologists based in a range of services, from highly urban to very rural, in England and Scotland (data which will also ground the two chapters that follow this one). To begin with, though, I summarise how processes of referral and psychological assessment play out at a general level. Within my analysis I respond critically to my interlocutors' accounts while also taking seriously the notion of psychological expertise and their expressions of frustration – and sometime despair – that therapy was not better accessible (Matza, 2018; Zhang, 2020).

The Process of Referral

Unlike seeing an IAPT therapist, most people must be referred by another health professional before they can access a clinical psychologist, for example a GP or even another psychological practitioner. This referral may be in the form of a letter to a relevant clinical psychologist or can be sent to a service as a whole for consideration by a team. That team could either be comprised primarily of clinical psychologists or include a range of practitioners such as community psychiatric nurses, social workers, and occupational therapists. Despite the concerns of some clinical psychologists about psychiatry (discussed in Chapter 1), the service team could in fact involve a psychiatrist as well: despite disputes between the *professions* of clinical psychology and psychiatry, individual *professionals* often collaborate well together. In multidisciplinary teams, decisions must be made not only whether to accept a referral but also whether the person seeking access to therapy should see a clinical psychologist specifically. Emma, who worked in a multidisciplinary team in rural England, described how 'we have a team meeting every Wednesday morning, where we look through the new referrals, and then decide who is going to go and do the assessment'. This entails a set of assumptions about potential patients, as well as the negotiations of boundaries between professionals: Whose expertise is best suited

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for the subject that has been produced through the process of referral and the referral meeting itself?

Services vary with regard to which parts of the NHS referrals come from as well as who issued them. Services admitting, for instance, 'people with *serious* mental health difficulties, or quite *complex* difficulties' (Brenda) might largely take referrals from a Community Mental Health Team (CMHT) (emphasis in the original; same for the quotes that follow throughout the chapter). Referrals for people experiencing distress relating to a physical complaint, such as cancer, could be from a nurse. In these instances, the referrer might speak to a clinical psychologist prior to a formal referral to get a sense of fit for service. As Felicity (who worked in the same NHS organisation as Emma) told me, a cancer nurse might 'ring me up or email me about someone, and we'd have a discussion with them'. Hence, and as will be unpacked later, decision-making around referrals can take place prior to their instantiation.

Referrals can also come from beyond the NHS altogether. Susannah, a senior practitioner in Scotland, told me that referrals to her child and adolescent mental health service (CAMHS) could come from schools and social work. This practice is less common outside of CAMHS, and we might speculate about how in those setting referrals from beyond statutory services are considered compared to those from well-known and trusted NHS referrers – given the extent to which the perceived expertise of referrers is salient to clinical psychologists (as we will see later here and in the next chapter). At the same time, however, clinical psychologists can sometimes have very close relationships with third-sector bodies, with this positively influencing their considerations of referrals from such organisations. This is in contrast to, for instance, unknown GPs based in large practices in big cities, whose propositions might perhaps be subject to more rather than less scrutiny.

It can also be possible – as has been championed by IAPT/NHS Talking Therapies – for people to refer themselves for psychological therapy. Nevertheless, this remains relatively rare beyond primary care settings. Anita, a senior manager who worked in such a setting in a large city, was one of the few clinical psychologists I spoke with whose service accepted self-referrals. She described her and her team's hard work at seeking to grow self-referral despite capacity constraints and concerns: 'We market materials in different languages, you know, bus stops, on stations, newspapers, we leaflet every household, we publicise ourselves in the newspaper or any magazine that might be going out.' However, even when a clinical psychologist might in principle be 'happy to accept self-referral' (Harriet),

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this is, as mentioned, uncommon. Indeed, my interviewees on occasion expressed overt scepticism or disquiet about it, with Ivor (a senior practitioner in rural Scotland), for instance, cautioning that 'the danger is you get a lot of worried well people coming forward'. On the one hand, some clinical psychologists can be alarmed at the need that lies outside their existing waiting list, with further lowering of barriers to access having the potential to make a challenging job even harder. On the other, practitioners can be alert to the possibility of a kind of 'false need' and its potential to distract from those regarded as truly requiring their care.

Regardless of the mechanism by which someone comes to be referred to a clinical psychologist, what happens afterwards depends sometimes on its urgency, but also – as in other healthcare settings (Buchbinder, 2017) – on what professionals judge to be the nature of the service. This includes who it is targeted towards, staff capacity, and its position vis-à-vis other services. In some cases, a single person will screen all referrals, refusing and accepting different patients and taking some to a team meeting for further consideration. Within other settings, in the words of senior psychologist Esther (based in a rural Scottish service): '*every* referral has to be *considered* at a team meeting before they get allocated'. Having introduced the seldom simple process of referral, I next turn briefly to consider what generally happens if someone is considered potentially appropriate for the service to which they have been referred.

The Process of Assessment

Following what is often termed a 'successful' referral, people seeking treatment will commonly be 'assessed' by a service team member. Assessment seeks to ascertain the nature of the presenting problem and whether psychological therapy (and that particular service) is the best means of addressing it. If it is a multidisciplinary service, assessment will not necessarily be undertaken by a clinical psychologist; instead, another clinician with psychological expertise might work with the referred person to jointly articulate their requirement (or not) for therapy. The time taken to see someone for an assessment varies – this reflects, for example, the service size, location, and focus. It can, on occasion, proceed at pace; Arthur, who worked in an early intervention service for psychosis in rural England, told me: 'What we try to do as a team is, get hold of people, preferably on the same day that we get a referral at least by phone and arrange to see them within a week.' Others, however, might wait much, much longer. Time from referral to assessment is also shaped by varied

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waiting list targets. For example, Irene, a senior clinical psychologist practising in adult mental health in the north of England, described to me how targets drove 'how quickly you have to respond to those referrals'. Waiting lists, targets, and their roles in configuring access to therapy will be considered more closely in the next chapter.

Assessment is sometimes framed as the beginning of therapeutic work itself. This might be in terms of building what clinical psychologists regard as an alliance and collaboration with a patient that will provide a good basis for therapy. It could also entail the recommendation of psycho-educational resources through which people seeking care can 'skill themselves up and inform themselves' about the nature and purpose of psychological treatment, as described by Harriet, a mid-career psychologist who worked in adult mental health in rural Scotland. Some clinical psychologists described the boundaries between 'assessment' and 'treatment' as blurrier still, imbricating the prefacing of care with therapy per se. One interviewee working in secondary care, Grant (based in the north of England), reflected candidly on this: 'To be honest, I struggle to distinguish assessment from treatment.' For him, 'as soon as you start hearing somebody's story and you start listening to somebody's story you're giving them space to do something that can create change'.

Yet, assessment and treatment were clearly and sharply bounded by other clinical psychologists with whom I spoke: Irene – quoted earlier, and part of the same NHS organisation as Grant – very explicitly accounted for assessment and treatment as distinct. This was part of a longer answer to a question I asked about how she preferred to manage her waiting lists. She reflected regretfully how she might say to someone at the point of assessment that 'unfortunately this isn't, this isn't us beginning therapy', before telling them that they will 'be waiting for possibly two years' for treatment – when that estimate was itself 'sugaring the pill'. Such a sweetener was needed because 'I can't bear to look someone in the eye and say, "you'll be waiting three years"'. Consequently, we can see that the boundaries between assessment and treatment might be understood as more necessary to retain in situations where resources were tight and waiting lists long.

The process of assessment also enables the assessing clinician to form an understanding of what they see as the 'suitability' (sometimes described as 'readiness') of someone for psychological therapy. As will be illustrated in the following sections, appraising suitability requires the resolution of an array of uncertainties. Will the individual referred for care engage sufficiently with the therapeutic process such that enough gains are made to

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justify seeing them over and above another on a waiting list? Are there any predisposing factors that might interfere with therapy? Are they the kind of person the service should be seeing? An assessment thus involves not only configuring the presenting issue but also the subjectification of the person being assessed.

Configuring Patients

Towards the end of my interview with Ivor, a senior clinician working with older adults, I asked what complaints would be made 'when psychologists get together'. His answer: 'probably the workload, number of referrals that come in'. This refrain is common. Lots of referrals make for long waiting lists, and these can sometimes be felt to be endless – with associated targets something that, as senior CMHT psychologist Liam described to me, 'dominates my daily life, my nightly life'. Decisions around prioritisation are always a challenge within healthcare (Allen et al., 2004; Berg, 1997; Dew et al., 2010; Hoeyer et al., 2015; Vassy, 2001) and can be difficult to make and to defend. The following is a lengthy extract from my interview with Irene, whose comments illustrate how moral and procedural uncertainties around prioritisation can be rendered explicit and subject to reflexive work:

> We try to think about it from a perspective of, 'These are our clients, aren't they? These are our patients and we have all these needs, don't we? What's the best way to use our time really? What do you think?' And to try and think about that. So sometimes generally people just wait chronologically on that list, but sometimes people will be prioritised. And it feels to *me*, that as the lead, part of my role is to, probably, be somebody that people look to, to say, 'What do you think, Irene? Should we be prioritising this person?' That always feels to me like a really important decision, because on the one hand it's easy to sit down with somebody in a room and think, 'Oh, bless, you know, really damaged, really ready to work, what I wouldn't give to start doing therapy with this person right now'. But they're the person that you're in a room with, whereas the other people on the list might just be names. They might just be names because you saw them six months ago and you've forgotten them. They might be names because your colleague saw them and you didn't make that personal connection with them. So making that decision to prioritise somebody, we try to think of that, well, I think of it as an *incredibly* important decision.

The problems of workload and waiting lists are compounded – and rhetorically managed – when referrals are framed as 'inappropriate'.

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As Briony, an early-career clinical psychologist in an urban Scottish service, told me, 'sometimes you'll get referrals and you'll think, "that's definitely not for us"'. A referral might, for instance, be configured as inappropriate if someone was drinking alcohol or consuming illegal pharmaceuticals in a fashion that clinical psychologists considered excessive and in ways regarded as contraindicative to therapeutic success. Consequently, illegal substance use is not an uncommon exclusion criterion for a service; senior practitioner Esther noted that if someone had not 'stopped' drinking they would be sent 'back to another service'.

Dierdre, who worked with children in Scotland, described an inappropriate referral as follows:

> A referral that doesn't meet the complexity for a specialist to a free mental health service but there are lots of other services out there. There's social work for, I mean there are referrals that still come to us where it turns out children are just in an abusive situation and they are presenting with mental health problems, but we're not the first line agency.

Another senior clinical psychologist in an urban English service, Ursula, reflected that she might not accept a referral into her service as a consequence of 'social' issues:

> [I]f people have got a lot of kind of *social* type difficulties, they've got housing difficulties, no fixed abode, that kind of issue, we would tend to want them to be in a position where they've dealt with the social issues before they come and try and look at the psychological issues.

Key, then, to the work of determining whether to accept a referral is a requirement to configure a perceived need for (a certain style of) treatment within someone seeking care. This process is contoured by understandings and experiences of wider service pressures, resource challenges, and forms of priority setting (Allen et al., 2004; Vassy, 2001), which are themselves politically shaped (Joyce, 2001; Moreira, 2011; Syrett, 2003). However, need itself is not enough, and configuring the patient exceeds the configuring of need per se. Important as ontologies of distress are, so too are the wider psychosocial dimensions of a person that are deemed to modulate distress and the possibilities of intervening in it.

This configuring might initially be undertaken in the absence of the very individual seeking or referred for therapy. In this respect, decision-making is made actionable through inscriptions of people found within referrers' letters, any additional locally available information, and perhaps an informal conversation with the referrer. Leanne's reflections illustrate this point:

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> [I]t would be easier if things were much more clearcut. But I just don't think, I think you've got to accept there's always going to be a bit of occasional grey areas somewhere. So, sometimes, I phone a GP and ask for a bit more information about a referral, to try and help make that decision as to whether the referral is appropriate

Such conversations can place uncertainty work upstream of the actual referral. As Leanne said,

> [I]f we're referring within the mental health directorate, so that's referrals from other psychiatrists, or the community mental health team, we're supposed to sort of really, instead of just sending in referral, have a conversation with someone before we do that. So we don't end up knocking referrals back

Naturally, practices vary. For instance, Grace, a senior clinical psychologist working in physical health in the same NHS organisation as Leanne, said she would undertake an assessment even in the case of an ostensibly inappropriate referral:

> Even if somebody's quite *extreme*, you know, maybe there are issues with alcohol, there might be issues with suicidality, I think there's still a duty of *care* to do an assessment of that *person* rather than saying, 'oh well I can't see them'. I would do an assessment and then link up with whoever I thought more appropriate agencies, or try to with the person's permission as well!

However, Grace also stated that she was sent inappropriate referrals only '*Very very rarely*'. Hence, the extent to which the ontology of a patient is configured at a distance seems, to an extent, to be a function of a wider workload that itself relates to how the service is construed both by the psychologists working in it and by those referring to it (see, relatedly, King, 2001).

A mid-career clinical psychologist working in adult mental health in Scotland, Harriet, also emphasised the importance of meeting with everyone who passes an initial referral screening 'to determine if psychology's for *them*'. This determination is a key point during a process of ontological configuring: it is where a psychologist makes certain that the patient is the kind of person who not only fits with the service but will benefit from therapy. Such a framing of assessment implicitly configures psychologists as having specific expertise not only in the administration of psychological therapy but also in ascertaining its likely success. This notion of the expert psychologist will be explored more fully later in this chapter.

The attribution of 'readiness for therapy' is a salient aspect of the uncertainty work of determining if psychological therapy should progress, and clinical psychologists tend to strongly emphasise its import.

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Ascertaining 'readiness' might involve configuring someone as being suitably 'psychologically minded'. This is a term that has circulated within the psy-professions for more than 50 years now (e.g. Appelbaum, 1973). Epistemic authority for ascertaining this can, to an extent, be delegated to various technical instruments. One of these is the Psychological Mindedness Scale (Shill and Lumley, 2002), which was used by Brenda, a clinical psychologist working in secondary care in the south of England. However, not all practitioners use this kind of tool; most I have spoken with instead deploy clinical experience and judgement to configure and perceive psychological mindedness within someone.

The determination of psychological mindedness can have significant effects: it subjectifies a person *as* psychologically minded, itself hardly a morally neutral ontology within the context of (potential) psychological care. The concept also reaffirms the expertise of clinical psychologists, since they can often claim to have the best skills among an interdisciplinary team to recognise psychological mindedness. This does not necessarily afford benefit to specific patients, however, since an expert (and hence hard to challenge) declaration of the absence of psychological mindedness can contribute to the preclusion of therapy.

One senior clinical psychologist, Esther, spoke of the importance of psychological mindedness while simultaneously reflecting about its lack of conceptual clarity: 'I don't think anyone's come up with the definitive idea on that.' Esther described how she would often be asked to do assessments for 'difficult' cases, with a particular view of ascertaining whether someone would benefit from psychological therapy. I asked her, 'How do you make those calls?' She answered:

> We would look at, what, what, what they're being referred to us as, first of all, and we're trying to move towards when the referral comes in there's a triage system and someone is triaged as suitable, or not, at the first point of call. So are they keen to be seen? Is it *their* choice to be seen by us or are they being pushed into it? Will they *work* in therapy, and will they attend sessions? Then we also look at what therapies are available for them. And our biggest problem has been junior doctors getting rid of mixed bag personality disorders, who don't want to work [at therapy], who've been in the service for years and actually there is no known evidence-based therapy to work with them. And they're the ones that everyone thinks, 'oh, I can't bear seeing that person again', and sometimes we have to be fairly brutal and say, 'well, what *can* we do?'

Esther's concluding question relates to the professional skill of clinical psychologists in appraising a person's capacity to benefit from therapy.

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Other sociological scholarship on mental health has underscored the continued moral dimensions of the psychological complex and the varied ontological, epistemological, and practical exclusions that can occur within it (Brossard and Chandler, 2022; Lane, 2020; Mladovsky, 2023). We might, then, take the position that there are good reasons to assume that the synthesis of certainty in this respect will be far from free of bias (Kugelmass, 2016). As the final substantive section of this chapter will elaborate, navigating the question of whether to work with an individual deemed unable to benefit from therapy itself contributes to configuring clinical psychologists' professional ontologies.

In summary, referral and assessment generally entail the configuring a patient as being like 'X', where 'X' is a multifaceted biopsychosocial matrix. 'X' might, for instance, encompass (1) someone's demographic categories like age and ethnicity; (2) psychological identifiers such as the nature of the presenting issue and 'readiness' or 'motivation' for therapy; and (3) social and personal indicators including employment status, and the existence of networks of support beyond the NHS. Importantly, 'X' might also be defined in the negative, and more clearly enact ontological boundaries, as in 'not like A, B, or C' (e.g. not a regular user of illegal substances, such as heroin). The subjectification that results from such uncertainty work produces typifications that make professional work more straightforward to undertake. At the same time, people seeking therapy are also situated within a larger moral order of value in relation to how viable they are as successful therapeutic subjects, and what factors are taken to impact on such viability (Latimer, 1997). While patient ontologies were often concretised in person, through the aforementioned accounts we can see that certitude about the (in)appropriateness of a referral can also be synthesised in the absence of the very person subject to such adjudication. In these instances, inscriptions of them within the text and talk of other professionals are framed as more valuable in limited-capacity services than time spent assessing someone face-to-face. (Pre-)Assessment in the absence of the individual referred for psychological care can thus act as a kind of implicit or even explicit healthcare rationing. A provisional configuration of a patient as like 'X' can be later substantiated, or further clarified, through actual discussion with them. Aside from the dimension of readiness for therapy, the centrality of certifying whether a someone is like 'X' is to ensure compatibility with an ostensibly predefined service ontology, legitimising initial decisions made about the acceptance or denial of a referral. However, as we will see, service ontologies are also often configured through the prefacing practices of clinical psychologists.

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Configuring Services

During my fieldwork, I was occasionally informed that the establishment of IAPT had resulted in disinvestment in other services and/or longer waiting lists. Some respondents who were involved in the development of IAPT itself hotly contested such claims of disinvestment. Still, the lived experience of many clinicians – at least as narrated to me – was one within which IAPT had impacted the wider mental health ecosystem in a range of ways, including some that were overtly negative. As Kent, a senior clinical psychologist in urban England, put it: 'commissioners feel that they're already funding services to take care of patients' needing psychological therapy, 'but then the services that are being funded don't really feel that they have the *capacity*, or the skills' for particular individuals. Ursula, who worked in an English service geared towards 'complex' forms of psychological ill-health, asserted that 'we're getting more referrals that IAPT won't see', which 'increases the demand on our service, whereas actual resources aren't getting any bigger'. Some practitioners – like Dana, a clinical psychologist working in physical health in rural England – were concerned that there was 'such a gap in service between primary and secondary mental health care that lots of people are falling in that'. Similar reflections are often made by people seeking access to psychological care, who can experience being too unwell for entry into some kinds of services at the same time as being not unwell enough for others.

The impact of the mental health and social care ecosystem on specific services is not just restricted to the ramifications of IAPT, however. Rather, wider shifts in the landscape of formal services and the finances of third-sector organisations in light of the politics and economics of austerity in the United Kingdom have shaped what is possible for patients and what is doable by clinicians. This creates circumstances within which psychologists are confronted with uncertainties that might not otherwise be encountered. Dana foregrounded this through an example of being referred a patient – such as someone with a head injury – on the basis that the referrer did not 'know how or what to do with that person'. She reflected that 'if there were local [third-sector] services for them', then 'they would be doing those things in the community'. Accordingly, an absence of wider health and social services can coerce clinical psychologists into ontological negotiations they would rather leave for someone else.

Clinical psychologists often told me that waiting lists placed them under a great deal of pressure. As noted above, this will be unpacked more in the next chapter; here, it suffices to say that such experiences of pressure

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shape decision-making about referrals. Partly to manage demand, some services – like the CAMHS service mid-career clinician Verity worked in – had 'very detailed referral criteria' and inclusion/exclusion criteria for what kinds of people should be seen. Some clinical psychologists were critical of these: as one senior secondary mental healthcare practitioner put it, 'I *hate* services that are precious' (Louise). Nonetheless, inclusion/exclusion criteria and tightly defined service remits are common.

Such criteria are not, however, necessarily immutable. Senior clinical psychologist Arthur, for instance, framed his rural English service remit as feasible to flex to accommodate people judged to be most in need; in his words, there could be 'a kind of *stretching* of the services'. In a resonant account, Carl – another senior practitioner in the same NHS organisation – discussed how he managed a service focusing on 'the severe and complex part of, of psychology, related to adults'. Sometimes, however, individuals were accepted who were regarded as belonging to 'a group who are, if you like, severe and not complex'. This was, as Carl admitted, 'probably quite a small number'. Still, it is clear that some clinical psychologists are, on occasion, able to reconfigure the boundaries of their service to accept patients who they perhaps formally should not. This is suggestive of a kind of moral economy, participation in which itself implies a resistance to bureaucratised forms of care that has the potential to stifle compassion and empathy (Matza, 2018). At the same time, it also raises questions about equity of access in relation to potential patients who are *not* accepted following a referral – in other words, the people for whom services do not 'stretch'.

Less commonly, some interviewees were explicit about the boundaries of their service, reporting a lack of facility to stretch it. Leanne, a clinical psychologist in Scotland early in her career, underscored how the presence rather than absence of other services impacted how she saw her own service and those referred to it. She indicated how the existence of other options for people seeking care enabled her to reify service boundaries, as part of a process of what sociologist Mara Buchbinder (2017) terms 'facilitative' gatekeeping. In a discussion about referral processes, Leanne simultaneously described both limits for her service and a kind of person who would not necessarily benefit from it, and noted that exclusion could feasibly be beneficial:

> [M]aybe [a referred patient is] not even appropriate for this service, it might be a case of writing back to the GP and suggesting that the problem seems to be mainly about relationship issues, and they don't seem too severe, maybe they could benefit from, perhaps, from being sooner, from

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> Relationships Scotland, for example. You know, there's agencies that we might think are more suitable.

Resource restrictions and allocations were also sometimes deployed within the interviews as devices through which to configure and legitimate service boundaries. Leanne configured an identity for her service in relation to the funds that were available to support its operations:

> [W]e had this kind of awkwardness of referrals come in, and it's to do with stress around chronic pain. We've had to be really strict with that, and I mean, that's felt really difficult, because obviously people are struggling. But it's been health related, we've had to sort of explain to the referrer that we can't take them because there's no funding for a post.

Limits to capacity were alluded to by Esther while discussing assessment:

> It may not be that psychological *therapy's* needed, it's maybe that they need support and that's what we're *very* clear about, the service doesn't offer support. We *have* to do psychological therapy. We're a small service offering, sort of, a specialist component to the mental health unit and *that's* what we really have to do. With no workforce that's important that we stick to the psychological therapies

Clinical psychologists working in services where they managed the psychological issues relating to physical ill-health generally appeared to have less difficulty in clarifying service ontologies and making decisions about access. In essence, choices were made largely in relation to the physical issue for which a service was specifically funded to provide care. When I asked Felicity, a relatively recently qualified practitioner, whether there would ever be instances where a decision would be reached that a referral was in some sense not quite right for her service, she replied:

> Yeah, yeah. And I think there are some referrers, and I suppose in our referral criteria, it's, kind of, that the psychological difficulty's meant to come about as a facet of their physical health problem. So, and we do get some people referred who've had a severe injury or a mental health problem, and then have got diabetes, and so we get sent them. And so we do try to pass those back to kind of the mental health teams. Or if it's something that can be managed by primary care mental health, if it's, kind of, panic attacks, even if it is about panic attacks during treatment, then we might, you know, see if they could, they could offer some input. So we do do signposting at that time.

However, even for ostensibly closely characterised services aimed at addressing the psychological dimensions of physical ill-health, ontological

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stretching could still occur when, for instance, 'clinical judgement' (Amy) suggested this was necessary. As Felicity continued,

> [T]here's also issues about unmet need, I suppose, and things like, pain services. There isn't any, service at the moment for kind of a pain management programme where I'm based, and so I get sent quite a lot of referrals for that. And that's not always been a consistent thing. Sometimes I have kind of had a couple of people on my caseload who are from that route, but as our service has developed and as the lead from my service is trying to think about developing a, a pain service, but asking for more money for that, we've kind of said we're not going to take those referrals but we're going to log how many that come through to us.

These comments demonstrate that the stretchiness of a service is itself a property that can shift and change over time. Again, this is accounted for as a consequence of the wider ecology of services. In Felicity's case, a decision was reflexively made to exclude people seeking care to galvanise support to develop an additional service. Hence, denial of access can be presented as a rational course of action that reflects the clinical and economic realpolitik of the NHS. In so doing, the pain of specific individuals becomes reconfigured as a resource to support the expansion of psychological therapy for a larger population.

To recap, formalised service boundaries were often in place to manage waiting lists, yet clinical psychologists could sometimes renegotiate inclusion/exclusion criteria to accept particular people into therapy. Reconfiguration of a service ontology might be in response to wider resource challenges and the risks of patients falling between the cracks of different services. Resources were similarly introduced by respondents to account for why they might not take on particular individuals, ossifying service ontologies. Likewise, the presence rather than absence of alternative services could be invoked to concretise service boundaries. The discursive processes through which clinical psychologists configured service ontologies, then, was in part a function of the wider economic and organisational context within which those clinicians were embedded. At the same time, clinicians also exercised individual agency in how they engaged with this context in the resolution of 'uncertainty moments' through implicit and sometimes explicit judgements about who is most in need of access to psychological care. Sometimes, this will mean accepting people for therapy even though they do not quite seem to align with the formal service remit. Others who are referred for different reasons or whose presenting issues are constructed differently by a clinical psychologist will not, however, be accepted into a service. Service ontologies are consequently negotiable,

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yet not infinitely so, further complicating the algebra of healthcare rationing, and (dis)advantaging some patients over others.

Configuring Clinical Psychologists

Through talk of referrals and assessments, the clinical psychologists with whom I spoke tended to configure their own ontologies as professionals alongside those of patients and services. During my fieldwork, two key moral and epistemic constructions commonly emerged: the good clinical psychologist and the expert clinical psychologist. Within these, practitioners as individuals and as a professional group can be regarded as synecdochical.

Earlier I described how the prefacing practices involved in accepting a referral often entail a requirement for a given clinical psychologist to configure a potential patient as being compatible with a particular NHS service. I also showed how a seemingly settled service ontology can sometimes be reflexively reconfigured to accommodate a particular (kind of) person. This can even include someone characterised as 'unready' for therapy. Arthur reflected on this as follows:

> [L]ocally there hasn't been a high percentage of people who are being told that they're, they're not ready for a service. Actually I suspect there might be a lot of people who are *not* ready actually, but who are offered a service. I think partly that's been produced by the fact that often they're not in touch with anything else, so there's pressure on the person assessing to say well we need to provide-they clearly need something.

This account appears to be framed critically, on two counts. First, Arthur seemed to imply that clinical psychologists should not take on people who were 'unready' for therapy. Second, he critiqued the 'pressure' placed on professionals to nevertheless do, thus exonerating clinical psychologists for acting in ways that might otherwise be undesirable. In this respect, Arthur paints a complex picture, one in which the challenges of delivering care for many results in it being apportioned to some specific individuals who otherwise might and – according to the epistemologies of practice performed by a variety of clinical psychologists – perhaps even *should* go without. While morally ambiguous, the professional figures painted here are nevertheless, ultimately, good: they are clinical psychologists who do what they can to help in difficult circumstances.

Notions of readiness and psychological mindedness were leveraged in some interviews in discussions that presented exclusion from therapy as a form of care, and which consequently preserved the clinical and moral

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identity of a psychologist as 'good'. Brenda explained that it was important to ascertain that someone was 'ready' for therapy before accepting a referral, reflecting:

> [I]t's kind of, making sure that person's actually ready and motivated for treatment, so they don't come in and come out too quickly in terms of that they're not ready, and they've often . . . kind of research of that, you know, are treatment failures at this stage as often people go through an awful lot of, interviews and assessments, and they'll end up not being able to manage the therapy and then dropping out and then feeling quite a failure about it.

Yet, through the course of the interview it appeared that Brenda's default position was in fact to accept someone into therapy. She described how she would undertake psycho-educational activities with a patient to increase 'psychological mindedness so that they really are open and ready' for therapy. Consequently, Brenda's talk configures her as a good clinical psychologist who exercises evidence-based clinical judgement (Timmermans and Angell, 2001) in three ways: first, by describing work with patients to actively configure them as subjects amenable to therapy; second, by implying that not accepting someone for therapy is a form of care, since it would prevent them 'feeling quite a failure' if not ready for a psychological intervention; and third, by alluding to research that grants epistemic legitimacy to her account.

Similar sentiments were expressed by Chloe, an early-career psychologist working in Scotland:

> [I]f you take on someone at the wrong time the chances are they might have a negative experience of therapy, so they'll have an experience where therapy hasn't worked and then that makes them *much* less likely to come forward again, so you've got to be very mindful of that.

An account of readiness was not always essential in constructing a clinical psychologist as 'good' when not accepting someone for therapy, however. For instance, Clarisa, a senior clinical psychologist in urban England, noted that 'if the person doesn't really sit with us', then 'I think it's our responsibility to really help the person to be signposted' to another service. Through underscoring the assistance that would be provided to a person in absence of psychological treatment, Clarisa (and several other interviewees) configured themselves within their talk as caring practitioners even while describing a context in which they would refuse access to their services.

Closely relating to the good clinical psychologist was the figure of the expert clinical psychologist, who was, for instance, skilled in making judgements about readiness in the first place. Issues of expertise were

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commonly raised in discussions about access to services, with respondents sometimes foregrounding the different kinds of understanding, knowledge, and experience clinical psychologists brought to bear in practices such as multidisciplinary assessment (or discharge) meetings, as well as in treatment itself. Regarding assessment, Anita, a senior practitioner working in primary care, reflected that some CBT therapists are 'not able to really *fully* assess or formulate and think about engagement' whereas clinical psychologists 'are able to do that. And I think that skill is quite unique, which really enables engagement.' In relation to treatment, Leanne described how in her service 'the slightly, I suppose, less complex cases, would go with the CBT therapist, and the clinical psychologist would take the more complex ones'. These comments are a reminder of some of the points underlined in the first part of this book: that in times of strained resources, where clinical psychologists are an expensive professional group and waiting lists threaten to grow and grow, configuring the boundaries of expertise can be a well-rehearsed and strategically enacted process.

Configurations of expertise were also supported by a discourse of scarcity (Frank, 2013); in Leanne's words, psychology was a 'really limited resource'. One dilemma relating to this was reflected on by Carl, who talked about the challenges of undertaking some kind of 'stop-gap' work with people on long waiting lists in his rural English service, for example 'bibliotherapy with occasional meetings'. However, a consequent 'conundrum' is that '*every* time you do that, you take away from, you're using the same resource that's been used to do the end-point therapy'. Carl did not think 'psychologists should be doing that, actually'; rather, 'someone else should be doing it!' – presumably someone less well paid. Akin to the notion of therapeutic wastage discussed in Chapter 2, clinical psychologists can thus configure themselves as having highly specialist, uniquely important, and very valuable skills subject to selective apportionment between different patients and purposes.

Expertise and a discourse of scarcity also figured in Carl's account and that of some other senior clinical psychologists when discussing who they might themselves see for assessments and/or therapy (e.g. Esther in Scotland, and Irene in England). Since the capacity of clinicians in senior management roles to work with patients directly was limited, they or their team might carefully select individuals who would be deemed to benefit from their particular constellation of experience and expertise. As Carl described, his team 'would ask me to see particular people who they thought it would be a good idea if I saw them'. Carl went on to configure himself as follows: '[My team] know that I'm a reasonably flexible,

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integrative sort of therapist, and that I can form working alliances with, with difficult people.' For senior clinical psychologists, then, the uncertainty work regarding not just whether someone should be seen but also who should see them enjoined a reflexive process of configuring their own identity in relation to skillset, experience, and indeed disposition. Of course, central to this was also a configuring of patient ontologies prior to therapy itself: Were they the sort of person who required the costly resource of senior staff time – for example, were they sufficiently 'complex' (Irene)?

In this section, I have illustrated how the ontologies of both the good clinical psychologist and the expert clinical psychologist come into play within practices of referral and assessment, and the work of making certain that a particular patient should be seen for therapy. These ontologies are, again, also a function of the wider healthcare and political circumstances within which clinical psychologists are situated. For instance, claims to (greater) expertise are strategically useful in an economically orientated mental health policy context that positions other professionals, like CBT therapists, as the answer to the problem of restricted access to services. Constructions of the good clinical psychologist also legitimate difficult decisions made by practitioners when not taking on a person for therapy, or when contravening professional and epistemic norms to do so. Finally, the realisation of professional ontologies and the praxis of working the boundary between acceptance into and preclusion from therapy are reciprocally constituted. In other words, it is in part through ascertaining whether to take on someone for therapy that professional ontologies emerge and are validated and sustained, shaping future engagements with potential service users.

Reciprocal Configuration

Following a referral, decision-making about whom to accept for therapy (and how long to continue it) entails the (partial) resolution of uncertainty. In essence, clinical psychologists must address a question that has an answer which is only ever legible within particular epistemic, economic, and moral contexts: What, practically speaking, should happen next to the patient? This procedural uncertainty relates to the matter of therapeutic indeterminacy (cf., Hayes et al, 2020; Hollin, 2017): there are multiple possible outcomes of therapy, including null or even negative effects. The work of responding to procedural uncertainty entails a form of skilled

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judgement (Styhre, 2013) involving the configuring of three key ontologies: that of the patient, the service, and the clinical psychologist (as both an individual and a professional group). In this respect, movement through uncertainty moments is (psycho)socially productive: action, affects, and ontologies are realised through the synthesis of certitude (Kuiper et al., 2023; Moreira et al., 2009; Reed et al., 2016) as part of the prefacing of (potential) care.

Rather than merely reflecting realities, the processes of configuration clinical psychologists engage in can be regarded as helping to bring them into being (Hacking, 1995, 2002). While patients, professionals, and services obviously pre-exist uncertainty work, ontologies are clearly configured and sometimes reconfigured through this, as opposed to necessarily patterning outcomes in a straightforward fashion (Moreira et al., 2009; Pickersgill, 2011). Those seeking therapy – and, to an extent, those who might provide it – can be marked deeply, for better or for worse, by the certainties clinical psychologists produce at the point of referral or assessment, perhaps especially if a decision is reached to offer no treatment at all.

Even if accepted for therapy, working the boundary between certainty and uncertainty configures patients (and providers) in particular ways; given the intersubjective nature of psychological practice, this can be expected to have implications for future care. The configuring of ontologies within clinical psychology consequently has normative dimensions, beyond barriers to access per se. These further include the role of bias (Kugelmass, 2016): not as some kind of exogenous entity introduced into a dispassionate and objective professional appraisal, but as a constitutive element of clinical experience that shapes and directs the management of uncertainty and therapeutic (in)action. Clinical psychologists, it seems, are able to exert power to configure patients and services – even within limits imposed by wider economic and organisational factors – in a fashion that can stretch or shrink a service remit and facilitate or deny access to it to particular people. An epiphenomenon of this autonomy will likely sometimes be the reproduction of forms of structural discrimination within the micro-sociology of the assessment.

Navigating procedural uncertainties further participates in the configuring of clinical psychologists as both expert and good: synthesising certainties enjoins invocations and practices of the resourceful application of credentialed knowledge towards enabling or enhancing care. What is important to note, however, is that clinical psychologists can produce different modes of care that are moulded by context (Pols, 2003;

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Schwennesen and Koch, 2012). For instance, both seeing someone who is deemed unready for therapy *and* not seeing them can be configured as worthy acts. In effect, the denial of access to care can in some cases affirm professional identity as a good psychologist. As we will see in the chapters that follow, resonant issues can play out in the management of waiting lists and with regards to the sometimes involuntary discharge of individuals from therapy.

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