

Caring Enough to Wait

Bureaucratic Care and Waiting Time Standards in an NHS clinic for Adults with ADHD

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Abstract

The drive in the UK National Health Service (NHS) to reduce the amount of time patients spend waiting to be assessed is generally accepted to be of positive benefit to all and remains at the top of the UK political agenda. In this article I examine how waiting is also done by administrative and clinical staff by drawing on ethnographic observations made in an Attention Deficit Hyperactivity Disorder (ADHD) diagnostic NHS clinic for adults. According to the criteria in the American Diagnostic and Statistical Manual (DSM), pervasive forgetfulness is recognised as part of ADHD symptoms, and in its persistence through consecutive life stages, it can become seriously disabling. Individuals referred to a clinic may repeatedly miss their appointments and delay their assessment and treatment. In this article, I look at how an NHS policy that facilitated the rescheduling of missed appointments due to the 'nature of illness' was superseded by the desire to shorten waiting lists. Thus, two competing NHS narratives, which I term 'the time to care' and 'the speed of access', became enacted in the administrative organisation of the clinic, resulting in the potential abandonment of the very patients who were meant to benefit from such change.

Introduction

During one of the support group sessions I attended as part of my fieldwork, Nick was updating his fellow members on his recent appointment at the diagnostic clinic.¹ The support group for adults with ADHD (Attention Deficit Hyperactivity Disorder) was divided almost equally between those waiting to be diagnosed and those who had already been diagnosed. An average of fifteen people attended the monthly support group sessions with slightly more men than women (52%/48%), and the majority were in their forties and fifties. The group sessions were facilitated by two founding members, one diagnosed with ADHD and the other the parent of an adult with ADHD. Conversations tracking progress through bureaucracy while waiting to be assessed were common. A couple of months earlier whilst in a bout of total disorganisation and chaos, Nick had missed his appointment, which was subsequently rescheduled. He looked uneasy and embarrassed as he described receiving a reminder call from the clinic, then setting out for his appointment, only to get lost in London. He had taken 'the wrong tube'² and arrived at the clinic so late that the psychiatrist could not see him. There was an audible groan in the room, and some laughter, as well as audible concern and disbelief. Anna, one of the facilitators, asked Nick if he wanted her to get in touch with the clinic and point out how crucial it was for him to attend the appointment, as without the assessment he could not be diagnosed and receive treatment and his problems at work and at home would continue. She reminded the group that there was a long waiting list for this specialist clinic. Nick described that to his surprise the clinic had given him yet another appointment without any problem. He explained, 'I was so embarrassed and angry with myself, but they were really nice about it, they didn't seem to mind at all'. Nick declared his determination not to miss the new appointment and the

¹ All names used in this paper are fictional in order to secure anonymity and I have withheld the names and locations of local organisations for the same reason. Informed consent was obtained for all interviews conducted with clinicians and support group members as well as for clinical observations of patient assessments and for each support group session I attended.

² The London Underground is locally known as 'the tube'.

conversation moved on to focus on other members of the group who were also exploring strategies for living with ADHD.

I had come across similar discussions in other support groups, where 'waiting' was a similarly important talking point, but Nick's experience of rescheduled appointments in the context of sparse NHS resources piqued my curiosity. I was at the time (2013) engaged in fieldwork situated in support groups for adults with ADHD in different parts of England, as well as within an ADHD specialist diagnostic clinic. ADHD has only recently been defined as a lifelong disorder and my research asked how a disorder that had only been associated with childhood can be reimagined in adulthood. In order to explore this question, I situated my research at a juncture between a specialist clinic *for* adults with ADHD and support groups run *by* adults with ADHD and tracked the diagnostic process across formal and informal sites.³ My broader argument is that in the UK we are in a unique window of time, when adults over the age of 30, for whom no diagnostic opportunities had existed during childhood, now have the possibility of re-imagining and/or confirming their lifelong difficulties in the light of the diagnosis of ADHD. Yet this new phenomenon may not last; as the rates of diagnosing ADHD in children increases in the UK (McCarthy et al. 2012; Polanczyk et al. 2014), it may be that the numbers of individuals diagnosed in adults will reduce.

According to the diagnostic criteria for ADHD, as described in the Diagnostic and Statistical Manual of Mental Disorders, the DSM5 (2013), the most common behavioural symptoms of ADHD fall into three categories – Inattention, Hyperactivity, and Impulsivity – with the stipulation that these must cause significant functioning impairments to be considered pathological. These impairments may be experienced through pervasive forgetfulness or impulsive behaviours. In other words, and according to clinicians and patients, people with ADHD do not do waiting very well. They either forget their turn or jump ahead of their turn.

³ See Das (2014) and Price and Walker (2014) for discussions on extending the clinical moment of diagnosis into a social process.

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In addition, ADHD is theorised as a neurodevelopmental disorder, which posits that as with other such conditions like autism, a cure is not an option. Instead, the work of medicine may be to alleviate symptoms and help individuals and their relatives to better live with ADHD. In this context, the role of specialist clinics in the UK is primarily diagnostic and their patients are offered one or two appointments for that purpose.

I met Nick and other adults diagnosed with ADHD as part of ethnographic research into the diagnostic process of ADHD in adults in the UK. Over the course of twelve months I attended four different support groups in three different cities in the West, North, and South of England, totalling over 80 hours of participant-observation and interviews. In the same period I was based four days a week in a national specialist clinic, where I was trained to use diagnostic tools and criteria and conducted 50 hours of observations of assessments as well as interviews. After receiving training on policies and guidance, I also provided administrative support to the clinic by organising the teaching and visiting sessions for local and international doctors as well as attending business meetings. Both support group members and clinicians were aware that I moved back and forth between these settings. Sometimes I was regarded with suspicion or sometimes, in contrast, I was sought out as an ally or asked for advice. Nevertheless, in both settings I was held as 'other'; a non-clinician in the clinic and a 'neurotypical' amongst neurodiverse in the support groups. Choosing to extend my fieldwork across clinical and non-clinical sites brought complications of positionality, yet it opened possibilities for me to consider differences and commonalities between the respective practices and concerns of the settings.

In this paper, I look at how waiting within the NHS, usually associated with delays endured by patients as they wait to be seen (Day 2015; Pope 1991), is also found in the clinic and experienced by clinicians. After examining the politics of waiting, I describe the policy context for managing attendance and non-attendance of appointments in the NHS. I then explore through ethnographic observations the administrative practices that were put in place to manage waiting in clinical settings. I show how paperwork routines can be thought of as caring practices and go on to ask if the 'waiting list' that is so often maligned could

be envisaged as holding people rather than as keeping them waiting at a distance.⁴ This paper contributes to enquiries into bureaucracy that situate materiality at its core (Hull 2003, 2012; Riles 2006) by asking how administrative tools are applied, and how bureaucracy is enacted through objects and translators (Hoag 2011, 2014; Mol 2003). Such a focus might make it possible to think beyond bureaucracy's regulatory and normative purposes, and contribute to improving administrative and clinical practices that are integral to it. This research is certainly pertinent, with the recent introduction of waiting time standards in NHS Mental Health services (NICE 2016). Standards have been received with a mix of anticipation and concern, as the opportunities to increase the reach of evidenced-based practice to a broader population are experienced in a period of austerity measures affecting the NHS (Docherty and Thornicroft 2015; McDaid et al. 2016). My concern is to ask what is at stake for users and workers of the NHS and what may be lost, if anything, through the changes in bureaucratic practices towards the reduction of waiting.

The Politics of Waiting

Waiting has convincingly been described as a strategy of domination in which keeping people waiting is keeping people in a place of inaction, passivity, and subjection (Auyero 2012; Bourdieu 2000). Roget's entry on the word 'wait' is helpful in showing the relations and connections between the senses of pause, protraction, being tentative, uncertain, the lack of action, and to follow, obey, and serve (Davidson and Roget 2002: 1210). In the last thirty years, the growth of the patient empowerment movement has brought issues of choice, quality, and timeliness of care to the forefront of policy making and influenced the delivery of health care (Day 2015; Mol 2008). Waiting has come to represent a power imbalance between the institutions that control the flow of services and the individuals dependent on them (Sellerberg 2008), as well as, in economic terms, a symptom of the inefficient management of resources. Thus we can think of bureaucracy in terms of structural violence that imposes impersonal rules and regulations through a threat of force,

⁴ See Sellerberg (2008) for a discussion on the organisational use of waiting lists as strategic delay.

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such as withdrawal of services (Graeber 2015). Most of us have had experiences of waiting in queues that make us sympathetic to this analysis. But rather than being solely an imposition and a subjectification, waiting may also be a period of time that spurs action and activism (Jeffrey and Young 2012). For the people I met during my fieldwork, waiting time was not 'dead time'. While waiting for their assessment, they were actively engaged in activities directly related to their long awaited appointment. Dumit (2006) accurately describes this process in relation to 'illnesses you have to fight to get', in terms of a struggle to be recognised as having a legitimate disorder and receiving treatment. For many, attending support groups provided a space where their *experience* of ADHD turned into *knowledge* of ADHD, and thus became *expertise* (Rabeharisoa et al. 2014). By the time they attended the clinic for their assessment, which could take eighteen months, they would have visited their General Practitioner (GP) with the aim of securing a referral to a specialist and in the process demonstrated more expertise than their doctors. They might have lobbied their local health commissioners to gain funding for their assessment at a national clinic. They had likely contributed to internet forums, attended conferences and, in some cases, written to newspapers they believed had written negatively about ADHD. However, this pro-active engagement with activism and lobbying must be moderated by other experiences that were described to me. The extended wait for the appointment also caused individuals to live through prolonged chaos and to despair at their persistent experiences of symptoms (Ginsberg et al. 2014; Matheson et al. 2013), which, as in the case of Nick, contributed to their missing of appointments.

For the remainder of this paper, I focus on the impact of missed appointments on an NHS clinic and examine what waiting is like from an organisational viewpoint. Just as Nick was surprised to see his second appointment rescheduled, I wondered how people who worked at the clinic managed and justified to themselves situations of this kind. In the next section, I explore how policies and guidance related to the management of time in the NHS are translated into administrative systems and their ethical implications for clinical practice.

DNA

The issue of missed appointments (referred to as DNA, Did Not Attend, in the NHS management lexicon) is particularly high on the agenda for managers, for its impact on costs generally, and on waiting time specifically. Various tools are used to analyse the rate of non-attendance and to explore the factors that contribute to DNAs. At the time of my fieldwork, the NHS Institute for Innovation and Improvement⁵ posed the question to managers of whether organisational factors, as well as parameters of specific services, could contribute to individuals not attending their appointments. 'Patient factors', as they were named, included age, childcare arrangements, and prohibitive transport costs, but also categories such as 'too unwell to travel' or 'the nature of illness'.⁶ Thus, services reviewed their systems, such as their mode of communication with patients, and adjusted the expected rate of DNA to their patient group in relation to the specific problems they experienced. In the case of the adult ADHD clinic, this meant taking into consideration that individuals referred were likely to suffer from pervasive forgetfulness and a lack of focus, and therefore were particularly likely to miss appointments.

The overall rates of DNA in psychiatric appointments were estimated to be 19% in 2003, ranging between 15% to 28% depending on sites and specialisation, in contrast to an average of 11% in the NHS as a whole (Mitchell and Selmes 2007). Outpatient referral statistics in England in the last quarter of 2014 were recording 8% DNA (NHS 2014). The figures collated in 2012 for the clinic in which I conducted my fieldwork ranged from 0% to 4% with an average of 1%. At first glance, these figures are surprising. What could be the reason for such difference between the local and national rate of non-attendance? Studies on this issue across all NHS services, including by the National Audit Office, list the main reason for non-attendance as 'forgetting', followed by 'too unwell' (Dockery et al. 2001;

⁵ The NHS Institute closed in February 2014.

⁶ For further details on the list of factors see *NHS Institute for Innovation and Improvement*. Available at: http://webarchive.nationalarchives.gov.uk/*/http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/dnas_-_reducing_did_not_attends.html (accessed 23 January 2018).

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Hamilton et al. 2002; Mitchell and Selmes 2007; Pal, Taberner et al. 1998). It seemed rather perplexing that a clinic geared towards individuals whose main symptoms are related to forgetfulness had such a low rate of non-attendance. Of course there are other reasons why patients may not attend appointments, and it may be that patients chose not to be connected with mental health services. However, I found that this was not the case for the large majority of people attending this clinic, as they had sought help and had been actively involved in their GP referral.

A number of factors could contribute to explaining the disparity between these figures, from the differentiation between first and follow-up appointments, to the reliability of data recording and reporting. My observations in the clinic suggested that there were other kinds of actions that could also suggest why the frequency of DNAs were so low. The appointments in question were not routine appointments in which clinicians regularly monitored the efficacy of treatment, or the course of an illness. Instead they were first assessment appointments, where a diagnosis can be formalised and legitimised. The clinic's main purpose was to diagnose; a process of identification and a differentiation between what is wrong and what is not (Jutel 2011). Diagnosis was followed by the prescription of treatments, whether psychological and/or pharmacological. The word diagnosis also refers to a medical description, a classification which can then be used in other bureaucratic encounters, at work or in education, in order to access support and benefits (Blaxter 1978; Bowker and Star 1999). There is a strong tradition in social sciences in thinking through this clinical encounter as the location for power relations, identity making, and generally, as a gatekeeping process (Singer 1990). I have argued elsewhere (Jousselin 2016) that diagnosing is a process rather than a moment that extends in time and in space to include non-clinical space, such as support groups, and that this process takes place as part of a looping connection between clinical and non-clinical sites, within which practices and concepts circulate. Nevertheless, for the people I met in support groups, the clinical encounter played an important gatekeeping role and not attending the appointment meant that people were left uncertain, and to their own devices in alleviating and managing their difficulties.

In the next section, I trace the work related to appointments in the clinic, starting at the point of referral that indicates the beginning of the clinic's involvement with the care of individuals, right up to the day of assessment. The description below arises from my participation in administrative tasks in the clinic.

Remembering Forgetfulness

The majority of referrals to the clinic came by mail from GPs or other medical professionals, in the form of a letter requesting an assessment, and describing the difficulties and symptoms of the patient. The receipt of a referral created work: it needed to be dated, stamped, and then scanned into an electronic register in order to track its progress. Next, a referral meeting comprising of three or four nurses, a psychiatrist and an administrator clinician followed a triage process: what kind of intervention was requested? Was it a new assessment, a follow-up assessment, a second opinion, or a medication titration? The referral was then entered into the electronic patient record, or a new record created and added to the waiting list. At this stage, the clinic needed confirmation from the relevant Primary Care Trust⁷ that funding was in place; a process that could take up to eight weeks. Once funding was confirmed, the patient was allocated a clinician and a paper file was created to include referral letters and other information, such as previous assessments. Initially the administrator created a paper file by printing electronic communications that were later scanned back into digital mode. At face value, this could be considered a process of de-materialisation, the making of virtual records. Hull suggests that files and records have not dematerialised but their 'thingness' is changed from paper to silicon, and that 'electronic technologies have increased rather than decreased the proliferation of paper documents' (Hull 2012: 260). In the clinic, I observed electronic forms being printed and then scanned to be re-entered in the electronic file.⁸

⁷ Primary Care Trusts were replaced by Clinical Commissioning Groups towards the end of my fieldwork on 1 April 2013.

⁸ Hull (2012) also provides a useful discussion of the relations between paper-mediated and electronic documents.

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At this point, the patient was sent what the team called a 'bookable letter', confirming the referral's acceptance and requesting the patient to make contact with the clinic. The 'bookable letter' was accompanied by one questionnaire for the patient and another one for relatives, which needed to be sent back prior to confirming the appointment. As weeks went by, if the patient had not made contact by the time he or she had reached the top of the waiting list, an administrator would call the patient to book a date. If successful, this call was followed by a letter of confirmation containing basic information about the clinic and a twenty-six page long questionnaire that needed to be completed prior to attending the appointment. The team openly acknowledged that behind their explicit administrative role of maintaining communications between all the parties involved lay an implicit expectation that they would remind the patient about their appointments. One administrator described it as 'keeping the patient on track' during the months of waiting. Finally, two or three days before the appointment, a 'courtesy call' was made by the administrator to remind the patient of the scheduled time and to bring the pre-assessment rating scales to the clinic. On the day of the appointment, communication with the patient became the role of the clinical team. If a patient had not presented at the reception desk at the allocated time, the clinician would make contact by phone, offering to reschedule the appointment.

Patients were sometimes rescheduled three or four times and became well known to the team even before attending the clinic. One administrator explained how she was often surprised to see what the patients looked like when they finally attended the clinic, having developed a picture of them in her mind through a number of phone calls and letters over a period of months. I found that the team's administrators were often the first deliverers of care in the clinic. They reassured patients who had missed appointments, rescheduled them and in this process often listened to patients' stories relating to their conditions. On one occasion, the administrator spent over thirty minutes on the phone giving directions to a patient who was lost and obviously distressed at the possibility of missing his or her assessment.

I witnessed administrators in this caring role, yet I am not aware that they had received any training to deal with patients who were sometimes quite upset on the phone (Strathmann and Hay 2009). The administrators represented bureaucracy as if 'seen from below', conducting the administrative tasks that interpret and adapt the policies dictated from governmental bodies; what workers and patients do with the regulations and rules. In their administrative roles, they did not fit Weber's (1978) description of bureaucracy as dependant on the impersonality of relations. Instead they developed personal relations with patients over time and patients often knew them by name.

For the team, the patient's non-attendance to the clinic created extra work: administrative tasks, phone calls, time spent accessing electronic patient records, contacting reception to book rooms and accessing doctors' calendars. But it also *created time*, as nurses and doctors often found themselves with a spare ninety minutes (the length of an appointment). In fact, this occurred so frequently that nurses completed other administrative tasks, such as writing assessment reports in these spots as a matter of routine, that is, as if they were scheduled within their working day. DNAs were the source of contradictory feelings in the clinic: on the one hand, a DNA could be a relief on a busy day, it gave the chance to do other things, such as reports and emails. On the other hand, the main task of carrying out assessments could not be performed. Staff knew that DNAs meant no income for the clinic, as payment would be deferred until the assessment took place. The specialist adult ADHD clinic was part of the mixed economy of health services that had been implemented in England and Wales over the last two decades. As a specialist service it had to generate income and did so on the whole through the commissioning branch of the NHS, the Primary Care Trusts. The arrangements were complicated, time consuming, and involved numerous communications between agencies that sometimes led to funding being refused for particular parts of the service offered by the clinic. Thus, some patients might have been funded for assessments only but not for treatments, or for pharmaceutical treatment but not for psychological therapy. Furthermore, in an era of declared economic austerity, concerns for the financial viability of the clinic became a worry for the clinical team and

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formed the basis of many informal conversations, wondering if staff numbers would be reduced if income failed to be generated.

The administrative practices I have described show the routinisation of forgetfulness within the clinic. Taking the advice of the NHS institute seriously, the clinic explicitly adapted its administrative procedures to address the needs of its patients, specifically those symptoms that would inherently create obstacles to being assessed and treated. In this way, forgetfulness and inattention oriented the work that was done or not done in a specific way; attention was given to the likelihood, greater than for most people according to diagnostic criteria, that the appointment might be forgotten. This was then operationalised through the use of technical mediators; the letters, phone calls, and electronic calendars that provided support towards remembering. Embedding concerns to palliate the effect of forgetfulness into the daily administrative practices of the clinic also had the effect of stabilising a particular version of ADHD, one in which forgetfulness and disorganisation is central.⁹

I have described the administrative and caring practices aimed at alleviating the problem of forgetfulness, which together facilitated the externalisation of the process of remembering (Latour 1994). The capacity for remembering was aided by embedding actions into the daily tasks of the clinic as a matter of routine. The waiting system held the patients, keeping them on track to be assessed, in the hope of alleviating their difficulties. As appointments were rescheduled, no DNA had taken place as long as patients eventually would be seen and assessed. Of course, as a counterbalance the waiting time remained high; rescheduled appointments could not be allocated to other patients. This tension started to affect the practices in the clinic as the priorities of NHS policies shifted and

⁹ The history of ADHD shows a conceptual tension between Hyperactivity and Inattention elements within the classification; Attention Deficit Disorder (ADD) was once the formal classification (DSM III 1980) and is still referred by a large number of adults as an acronym more applicable to them than ADHD (for a comprehensive history of the concept, see Taylor 2011).

concerns regarding those not attending assessments and the impact they might have on the system were superseded by the patients who were waiting for an appointment.

Competing Narratives

The aims of DNA policies and guidance were to bring efficiency into the system of managing appointments. The NHS has other initiatives to increase productivity in which temporal considerations play a central role, such as the 'Productive Ward' programme (subtitled 'releasing time to care') that was implemented in 2008. Behind this particular program seems to be the idea that NHS wards and community teams have been clogged up by unnecessary tasks and that the emphasis needs to change from non-clinical tasks to clinical care activities. In order to redistribute, maximise, and prioritise staff working time, tool kits, training manuals, and guidance are produced in the hope of training the workforce in 'evidence-based improvement techniques'. This programme, introduced nationally in 2008, has remained high on the political agenda. At the last parliamentary election, one of the Labour Party's pledges was to set up a fund called 'the time to care',¹⁰ which aimed to increase the speed of access to NHS services. The Conservative Party also had a plan for the NHS's temporal workings, aiming to extend the availability of services to, David Cameron pledged, 'truly seven-days' (Dominiczak 2015). My purpose here is to highlight the competing narratives of temporality regarding the workings of the NHS. On the one hand, clinical staff should have more 'time to care'. That is, they must take the time to care and not rush in their interactions with patients. On the other hand, services should be available for extended times and patients should be seen without delay. These narratives of slower and faster time, of time compression and acceleration, depend on bureaucratic procedures in order to be put into practice.

¹⁰ See the Labour Party's *Building an NHS with time to care*. Available at: https://shop.labour.org.uk/media/catalogue/pdfs/Building_an_NHS_with_Time_to_Care_Leaflet.pdf. Accessed 22 January 2018.

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Waiting time standards are probably the best known of the NHS improvement programmes: waiting time targets have been implemented for access to A&E and cancer services for a number of years already. There continue to be debates about the value of setting such standards, of their impact on patient care and on staff. It is often suggested that targets bring 'perverse incentives' not to exceed targets even when possible, and are prone to be met through 'gaming' and data manipulation strategies (Bevan 2009; Gubb 2009). In other words, the policy and guidance are translated, interpreted, and worked by the bureaucrats, administrators and clinical staff into their services with, at times, unintended consequences. As Paraskevas Vezyridis and Stephen Timmons (2014) show, the implementation of waiting time targets in A&E departments has resulted in re-organisation of space and personnel that has impacted on the interpersonal relations between clinicians and patients. Waiting time standards have only recently reached the NHS Mental Health services with the first programme being implemented from April 2016, requiring Early Intervention in Psychosis services to assess and treat patients within two weeks of being referred to secondary care.

To conclude, I will return to my clinical fieldsite and describe the changes that took place towards the end of my presence there. These lead me to suggest that the translation of policies into bureaucratic practices is made through choices that have serious implications for patients. While some patients are supported, others are potentially abandoned.

Handing Over the Work of Remembering

During my research between 2012 and 2014, the long waiting list for assessments at the clinic had come to the attention of commissioners, who felt it should be reduced. Contemporaneously, clinicians and managers had noted increased demand in assessments for ADHD in adults since the publication of NICE guidance (2009) and were reviewing their referral management systems. They decided to reschedule missed appointments only once. The structure of assessments was also reviewed. On average, an assessment takes three hours, including a structured interview with psychometric scales, the taking of

personal, family, and psychiatric history, and a mental state examination that focuses on the current functioning of the patient within seven domains (from mood through to perception and cognition). I had observed and experienced how tiring this process was for clinicians and patients. The new process would split the two elements across two days. Specialist nurses would conduct the first part and psychiatrists the second, with the aim of using staff time more efficiently. Following these changes, managers and clinicians hoped that patients could be seen faster and their experience of assessments improved. And yet, they now had not one but two appointments to attend, thus complicating work or childcare arrangements and potentially doubling their chances of DNA.

The emphasis the clinic placed towards its patients was shifting from considering the 'nature of illness' as important in delivering care to the need for increased productivity. A decision of this kind can be explained in economic terms. Indeed, the discourse of austerity and financial difficulty were part and parcel of everyday talk in the office. But it is also likely to be a typical dilemma faced by many organisations that must respond to client/patient's needs and manage the complexity of balancing competing demands. If the task of managing the complex range of needs across a large organisation becomes too unwieldy to achieve day by day, it will be simplified and reduced (Callon 2002). Most support group members have experienced very long waiting times and welcome the aim of reducing waiting lists. Those able to set up their own reminders with the help of relatives, friends, and technology will benefit from such a change. While helpful, setting reminders through friends or relatives was also described by some participants as a burden, a never-ending task accompanied with a sense of dependency. Similarly, smart phones offered support, but were also experienced by some participants as causing further distraction from tasks at hands. Yet others, who may not have a network of support and whose forgetfulness is pervasive, will not be seen, assessed, and diagnosed as they repeatedly DNA.

By changing its administrative practices, the clinic transferred the responsibility for the work of remembering it used to perform onto the patient, taking away the scaffolding and support structures for remembering appointments. As a result, individuals were expected

to find their own remedies and strategies for the problems they were seeking medical help for. Such an expectation may be beyond what some people could achieve, making it less likely that they would be assessed, diagnosed and treated. In the support groups I attended, those who waited the longest often missed their assessments and benefitted from the multiple re-allocations of appointments.

For Nick, rescheduling his appointments meant that his pervasive forgetfulness was considered and assessed by specialist clinicians. He hoped that, in time, receiving support and treatment from the clinic would improve his life at work and at home. In other words, it was better for him to be seen late by the clinic than not at all. As waiting time standards reach mental health services, it is likely that unintended consequences will arise when faced with the complexity and diversity of patients' situations and motivations. The challenge for local services implementing national policy will remain: how to hold together an urgency of response within a set timeframe, while caring enough to wait for patients to attend.

About the Author

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